MTA Business Service Center
333 W. 34th Street
New York, NY 10001-2402
646-376-0123

Metropolitan Transportation Authority

Business Service Center

October 26, 2015

Welcome to Your Benefits Choices for 2016!

The Open Enrollment period for NYSHIP members is November 1 – December 31, 2015.

If you choose to continue your current health insurance plan, no action is necessary unless:

- **You are currently enrolled in the Aetna HMO for 2015, since it will no longer be available in 2016.** Consult the *2015 NYSHIP Choices Guide* (available in November) to select another plan.
- **You will become eligible for Medicare in 2016.** (See page 4 of the *Summary of Health Benefits.*)

This **Summary of Health Benefits** packet provides the information you need to make the best decisions.

Information on the following will be mailed to you separately:

- **2016 NYSHIP Employee Contribution Rates** available in December
- **Medical Insurance Opt-Out Program Brochure** from the MTA

Dates to remember …

- **The Annual Enrollment period is November 1 – December 31.**
- **The Opt-Out Program is available November 1 – 30.**
- **The Flexible Spending Account (FSA) period is November 1 – December 15.**

The MTA Business Service Center is available to answer your questions and provide assistance.

MTA Business Service Center
646-376-0123, 8:30 to 5 p.m., Monday-Friday bscservice@mtabsc.org
www.mtabsc.info

Summary of Health Benefits & Tax-Favored Programs

2016 Open Enrollment

Health Benefits: November 1 – December 31, 2015

Flexible Spending Accounts: November 1 – December 15, 2015

MTA Police (Represented)

MTA Business Service Center

Summary of Health Benefits & Tax Favored Programs

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I. INTRODUCTION

A) 2016 Annual Open Enrollment Period

Your Annual Open Enrollment Period for Benefit Plan Year 2016 will be from November 1 through December 31, 2015.

MTA Business Service Center (BSC) staff and various plan administrators will be available to explain your benefit plan choices and answer questions at an information sessions.. See the meeting schedule on the BSC Self-Service Portal (www.mtabsc.info) for details.

B) Sources of Information

- **The BSC Self-Service website www.mtabsc.info**, which is available from any computer with an internet connection, provides information and links to providers' websites. You can also check and update your personal information online and view your benefits and payroll information by using the "All About Me" link.

- **The BSC Customer Management Center (CMC)** provides assistance at 646-376-0123 from 8:30 a.m. to 5 p.m., Monday – Friday, or send an email to bscservice@mtabsc.org.

- **Section V Important Telephone Numbers and Websites** in this booklet provides contact information for your benefits providers.

II. HEALTH BENEFIT CHOICES

A) Electing/Changing Medical Coverage

To assist with your decision making, see the **2016 NYSHIP Choices Guide** listing your plan choices. To change your insurance online, click here for information on MyNYSHIP, a new secure website where active New York State employees can get online access to their own health insurance record.

The **2016 Employee Contribution Rates** are posted here on the BSC Portal. These include the following options:

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

➢ ***No action is required if you choose to continue your current health insurance plan, unless you are currently enrolled in the Aetna HMO for 2015, since it will no longer be available in 2016.***

If you opt to make a change, it is important that you choose carefully because you may not change your health insurance option after the December 31, 2015, deadline except if the option you are enrolled in no longer services the area in which you live. In addition, you may change your enrollment status if you experience a qualifying event, such as marriage, divorce, birth or adoption of a child, loss of dependent child status, or loss of coverage. When you experience a qualifying event, it is important that you update your records by submitting the appropriate forms to the BSC within 30 days of the qualifying event date.

- ***To change your health insurance plan effective January 1, 2016, complete and submit the 2016 NYSHIP Open Enrollment/Change Form (HR-BEN-060K) and NYSHIP HMO Enrollment/Change Form (HR-BEN-060L), if applicable. .***

- ***Please be reminded that medical insurance contribution costs to cover you and your family are withheld on a pre-tax basis; those that cover domestic partner contributions are withheld on a post-tax basis.***

Note to employees planning to retire in 2016: If you and/or your covered dependent(s) are at least age 65 when you retire, Medicare will be your primary medical coverage 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 well enough in advance so that you will be enrolled in Medicare Part A (hospitalization) and Medicare Part B (medical) upon retirement.

III. HEALTHCARE REFORM REQUIREMENTS

Coverage for Dependent Children from Ages 19 to 26

A dependent child age 19 to 26 is eligible for medical, hospital and prescription drug coverage, regardless of their student or marital status. If you wish to enroll a dependent child age 19 to 26, add the child's name on the **NYSHIP Annual Enrollment/Change Form (HR-BEN-060K)**, submit the required documentation listed on the back of the form and affirm, by signing the form, that your child is eligible.

- ***Note: This extended dependent child coverage does not apply to dental and vision coverage. (For more information see the BSC Self-Service Portal Benefits section under "Full-time Student Status Verification.")***

A) Social Security Number Requirement

The Medicare, Medicaid, and State Children's Health Insurance Extension Act of 2007 (MMSEA) requires that the MTA 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 your covered dependent's Social Security Number is missing from your benefits record by logging on to the BSC Self-Service website at www.mtabsc.info. Click the **All About Me** and then click the **My Benefits** tab to view your benefits information.

If your dependent's Social Security Number is not shown under SSN (only the last four digits will show), please submit a copy of your dependent's Social Security Card with your name and BSC ID number noted on the copy, along with the 2016 NYSHIP Open Enrollment/Change Form (HR-BEN-060K) to the BSC.

IV. TAX-FAVORED PROGRAMS

A) Flexible Spending Account (FSA)

You may enroll in the FSA Program during the annual enrollment period, November 1 – December 15, 2015, by contacting the P&A Group (see Section V and information posted on the BSC Self-Service Portal).

FSA is a program that allows you to set aside part of your paycheck on a pre-tax basis through automatic payroll deductions for eligible Health Care and Dependent Care expenses. This program allows you to reduce your taxable income thereby reducing your tax liability. Keep in mind that your FSA account cannot be used to pay for the cost of over-the-counter (OTC) medicines (such as ibuprofen and antacids), unless accompanied by a physician's written approval.

The FSA Health Care Account limit will be capped at $2,550 for 2016. The Dependent Care FSA annual maximum allowance per household is $5,000.

- ***If you enrolled in FSA for 2015, please note that you will not be automatically re-enrolled in FSA for 2016. You must re-enroll by contacting the P&A Group during this Open Enrollment Period.***

Examples of Eligible Expenses

- Health Care (FSA)
  - Medical, dental, vision and prescription drug deductibles and copayments
  - Eyeglasses, contact lenses, contact lens supplies, and prescription sunglasses

- Dependent (FSA)
  - Child care costs
  - Elder care costs (dependent must meet the definition of a qualifying relative per the IRS, based on a tax year)
  - Before-school and after-school programs
  - Summer day camp

B) MTA Deferred Compensation Program

You may enroll or make changes at any time by contacting Prudential (see Section V).

401(k)/457

Participating in the 401(k) and/or the 457 MTA Deferred Compensation Program may help you achieve a more comfortable and secure financial future. The program helps supplement your existing retirement/pension benefits by allowing you to save and invest before-tax dollars through the convenience of automatic payroll deductions. You are offered diversified investment options, access to local service representatives, financial education services, and planning tools that can help you better prepare for retirement. Contributions and any earnings are tax deferred until money is withdrawn, usually at retirement, when you may be receiving less income and are in a lower income tax bracket.

401(k)/457 Roth

In addition to the traditional pre-tax contributions, both the 401(k) Plan and 457 Plan now allow you to make after-tax contributions (also known as Roth contributions). The Roth contribution option combines the savings and investment features of a traditional retirement plan with the tax-free distribution features of a Roth IRA.

While income taxes on pre-tax contribution amounts are deferred until your account is distributed (for example, at retirement), Roth contributions are made on an after-tax basis, so the amount contributed is included in your W-2, just like regular income, in the year you make the contribution. However, earnings on Roth contributions may be distributed tax-free in retirement if you meet certain requirements.

C) New York's 529 College Savings Program

You may enroll at anytime by contacting the College Savings Program (see Section V).

This program is designed to assist families saving for college. You can elect to contribute to a choice of funds on a post-tax basis through automatic payroll deductions. If you use the money for higher education, earnings will be distributed tax-free.

D) Premium TransitChek

You may enroll at anytime by contacting the TransitChek Center (see Section V).

This program allows you to set aside money on a pre-tax basis through automatic payroll deductions for commuting expenses for you and your family, up to certain limits established by the IRS. Eligible expenses include using public transportation such as commuter trains, subways, buses, ferries, van-pool services and/or commuter parking for travel to and from work.

V. IMPORTANT TELEPHONE NUMBERS & WEBSITES

Carriers	Telephone	Website
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
Savings Programs		
P&A Group (FSA)	800-688-2611	www.padmin.com
Prudential (401k/457)	877-756-4682	www.prudential.com/mta
College Savings	800-420-8580	www.ny529atwork.com
TransitChek	866-823-3248	www.transitchek.com
COBRA & Government		
P&A Group (COBRA Administrator)	800-688-2611	www.padmin.com
Medicare	800-633-4227	www.MyMedicare.gov
Social Security Administration	800-772-1213	www.ssa.gov

Submit Open Enrollment/Change Forms by email, fax, or mail:
Email: bscservice@mtabsc.org
Fax: 212-852-8700
Mail: MTA Business Service Center, 333 W. 34th Street, 9th Floor, New York, NY 10001-2402

Contact the MTA Business Service Center (BSC) for assistance:
Phone: 646-376-0123, 8:30 a.m. - 5 p.m., Monday – Friday

All Open Enrollment information and documents can be accessed on the BSC Self-Service Portal: www.mtabsc.info

Please have your BSC ID ready when you contact us and be sure to include your full name and BSC ID on all emails and documents you submit.

State of New York
Department of Civil Service
Alfred E. Smith State Office Bldg.
Albany, NY 12239

EMPLOYEE BENEFITS DIVISION

INSTRUCTIONS FOR THE PS-404
NYS HEALTH INSURANCE TRANSACTION FORM PS-404-

Boxes 1 - 9	All enrollees must complete boxes 1 – 9 with their personal information. Note: Marital Status Date is used to show date of marriage, separation or divorce when those marital statuses are selected.

Box 10 (A – I)	Complete appropriate sections. The employee is entitled to make separate choices regarding their medical, dental and vision coverages. They may decline any of the three, all of the three, or none of the three different coverage options. Also, they many enroll in family coverage in one benefit and individual coverage in another. Reminder: Enrollees with a Benefit Fund (CSEA, UUP and DC-37) receive their dental and vision benefits through that Fund. **Do not** enter dental and vision information on NYBEAS for these enrollees.

New Enrollees (also complete 10.G for family coverage)

Note: for new enrollments in a Health Maintenance Organization (HMO), complete an HMO form in addition to this form.

10.A	Request Enrollment – Individual	Check box to enroll in individual coverage. Check Medical, Dental and/or Vision boxes for coverage being enrolled.
10.B	Request Enrollment – Family	Check box to enroll in family coverage. Check Medical, Dental and/or Vision boxes for coverage being enrolled.
10.C	Elect Pre-Tax Status?	New Enrollees choose to enroll in or decline the Pre-Tax Contribution Program for medical coverage.
10.D	Decline Coverage	Check box to decline coverage. Check Medical, Dental and/or Vision boxes for coverage being declined.

Cancellation or Change in Coverage

10.E	Voluntarily Cancel Coverage	The enrollee is entitled to make separate decisions regarding their medical, dental and vision coverages. Enrollees may cancel or change their dental and/or vision coverage(s) at any time during the year. Pre-tax medical enrollees may only cancel coverage during the Pre-Tax Open Enrollment Period, or with a qualifying event (enter the qualifying event). If you are going on **Leave Without Pay, also complete Box 12**.
10.F	Change Coverage	Check this box to change from Individual to Family, or from Family to Individual coverage. Pre-tax medical enrollees may only change their coverage from Family to Individual during the Pre-Tax Open Enrollment Period, or with a qualifying event (check the qualifying event and enter the Date of Event). Check Medical, Dental, and/or Vision boxes for coverage being changed.
10.G	Add/Change/Delete Dependents	Check the box to add or delete dependents or to change dependent information. Check Medical, Dental, and/or Vision boxes that apply. Complete all dependent information including **date of birth**. Additional documentation may be required to add the dependent.
10.H	Change Medical Benefit Plan	Complete during annual Option Transfer Period or with a qualifying event (for example, change of address outside of HMO area.)
10.I	Change Pre-Tax Status	Existing enrollees can only change pre-tax status during the annual Pre-Tax Open Enrollment Period in November.

State of New York
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EMPLOYEE BENEFITS DIVISION

INSTRUCTIONS FOR THE PS-404
NYS HEALTH INSURANCE TRANSACTION FORM

PS-404 I (1/07)

Box 11	Complete previous coverage information, if applicable.

Box 12	LEAVE WITHOUT PAY SECTION	Enrollees going on leave without pay who request cancellation of coverage at the time they leave the payroll must complete this section. To request permanent cancellation of coverage, check the appropriate box and cross out the sentence which reads "I wish to resume my coverage upon return to the payroll."
	RETIREMENT SECTION	Enrollees leaving the payroll due to retirement must complete this section to indicate their decision to either defer or continue health insurance coverage as a retiree. A PS-406.2 must be completed for enrollees requesting deferment of medical coverage, prior to retirement.

Box 13	Request for Empire Plan Cards Only – complete this section to order a duplicate or replacement Benefit Card. **Do not** complete this section if requesting a change to your health insurance coverage. A new card will be issued automatically.

AUTHORIZATION	Employees must SIGN and DATE this form.

AGENCY/EBD USE ONLY	This section is for Agency and/or EBD use only and is provided to assist in updating the enrollee's record on NYBEAS.
Action/Reason	Transaction that will be inputted into NYBEAS by HBA.
Date of Event	Date the event took place, which resulted in the enrollee requesting a change to benefits. Example: first day worked, first day on leave, date of birth, date of marriage.
Hire Date	Original date of hire or rehire. (Only needed for new enrollment).
Date of 1st Eligibility (PE only)	The first day the enrollee is eligible for coverage.
Percentage Working	Enrollee's percentage on payroll.
Agency Code	Enrollee's agency code.
Neg. Unit	Enrollee's negotiating unit.
Ret. System	The retirement system for the enrollee (ERS, TRS or PFS)
Retirement Tier	Tier 1, 2, 3 or 4.
Sick Leave Information - # Hours	Number of sick leave hours for enrollee at time of retirement.
Sick Leave Information - Hourly Rate of Pay	Enrollee's hourly rate of pay based on annual salary at the time of retirement. (See Hourly Rate Calculation memo NY99-22).
Date Entered on NYBEAS	Date HBA processes the transaction on NYBEAS.
Effective Date	The effective date assigned to the transaction by NYBEAS.

Note: When updating NYBEAS, use **Date** in **Authorization Box** as **Date of Request**.
Legal changed

EXAMPLES OF DOCUMENTATION REQUIRED TO PROCESS YOUR TRANSACTION

Employees	**Spouse/Domestic Partner**	**Children**
Copy of Birth Certificate	Copy of Birth Certificate	Copy of Birth Certificate
Copy of Social Security Card	Copy of Social Security Card	Copy of Social Security Card
	Copy of Marriage Certificate or Complete PS-425 series Domestic Partner, if Applicable	Completed PS-451 – Statement of Disability and Required Documentation, if Applicable
	For Changes of Coverage, copy of Marriage Certificate, Divorce Order, Death Certificate, PS-425.4 (Domestic Partner), as appropriate	Completed PS-457 – Statement of Dependence and Required Documentation, if Applicable

State of New York Department of
Civil Service Alfred E. Smith State
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EMPLOYEE BENEFITS DIVISION

NYS HEALTH INSURANCE TRANSACTION FORM

For Participating Employers PS-404 - OE**2014**

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. Street Address City State Zip		
5. Date of Birth	**6.** Telephone Numbers Home ( ) Work ( )	**7.** Work location and address
8. Marital Status ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated	Marital Status Date	
9. Covered under Medicare? Self ☐Yes ☐ No	Spouse/Domestic Partner/Dependent? ☐Yes ☐ No	

10. ENTER REQUEST(S) BELOW

A. ☐ Request Enrollment- **Individual**	*(Select Empire Plan or HMO)* ☐Empire Plan ☐ HMO* Code ☐ Name
B. ☐ Request Enrollment- **Family** (Complete G)	*(Select Empire Plan or HMO)* ☐Empire Plan ☐ HMO* Code ☐ Name
C. ☐ Elect Pre-Tax Status for Premium deduction?	☐ Yes ☐ No Note: pretax deductions may not be offered by all agencies. Verify eligibility with your agency.
D. ☐ Decline Coverage	*For Agency Use: (Process WAV/BEN transaction)*
E. ☐ Voluntarily Cancel Coverage	
F. ☐ Change Coverage	**Date of Event** _____

☐ **Change to FAMILY** *(Complete G)*

- ☐ Marriage
- ☐ Domestic Partner
- ☐ First dependent child acquired
- ☐ Dependent returned to full-time student status
- ☐ Request coverage for dependents not previously covered
- ☐ Newborn
- ☐ Previous coverage terminated *(Complete Section 11)*
- ☐ Other _____

☐ **Change to INDIVIDUAL**

- ☐ I voluntarily cancel coverage for my dependents
- ☐ I voluntarily cancel coverage for my domestic partner
- ☐ Only dependent died Only
- ☐ dependent married Only
- ☐ dependent graduated
- ☐ Divorce
- ☐ Only dependent disqualified by age
- ☐ Termination of domestic partnership *(Attach Completed PS-428.4)*
- ☐ Other _____

G. **DEPENDENT INFORMATION** *(use additional sheets if necessary)*

Check One: A (Add), D (Delete) or C (Change) **Date of Event** _____

	Last Name First Name MI	Relationship	Date of Birth	Sex	Address *(if different)*	Social Security Number
☐ A ☐ D ☐ C						
☐ A ☐ D ☐ C						
☐ A ☐ D ☐ C						
☐ A ☐ D ☐ C						
☐ A ☐ D ☐ C						

* ***A completed HMO form must be attached.***

10. ***Continued***. **ENTER REQUEST(S) BELOW**

H. ☐ Change Medical Benefit Plan Change to: ☐ Empire Plan ☐ HMO * Code ☐ HMO Name _____
* A completed HMO form must be attached.

11. PREVIOUS COVERAGE INFORMATION

If you were previously covered under NYSHIP or another health insurance plan (attach proof, i.e. insurance bill or letter stating former coverage), please complete this section.

Previous ID Number	Date Coverage Terminated

Enrollee's Name Under Which Previously Covered — Last — First — Middle Initial

12. LEAVE WITHOUT PAY AND RETIREMENT STATUS

LEAVE WITHOUT PAY

☐ I wish to continue coverage while I am on authorized leave. I understand that I will be billed for this coverage.

☐ I do not wish to continue coverage while I am on authorized leave. I wish to resume my coverage upon return to the payroll.

RETIREMENT

☐ I understand the requirements for continuing medical insurance coverage as a retiree and wish to continue my coverage.

☐ I understand the requirements for continuing medical insurance coverage as a retiree and wish to defer my coverage. *(A completed PS-406.2 must be attached.)*

13. REQUEST FOR EMPIRE PLAN CARD ONLY

For Health Maintenance Organization (HMO) cards, contact your HMO.

☐ DUPLICATE CARD
(Previously issued card remains valid.)
☐ REPLACEMENT CARD
(Previously issued card(s), lost or stolen, become invalid.)

FOR
☐ ENROLLEE
☐ ENROLLEE AND ALL DEPENDENTS
☐ INDIVIDUAL DEPENDENT
Name _____

Personal Privacy Protection Law Notification

This 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 of the Employee Benefits Division, NYS Department of Civil Service, Albany, NY 12239. For information concerning the Personal Protection Law, call (518) 457-9375. For information related to the Health Insurance Program, **contact your Agency Health Benefits Administrator**. If, after calling your Agency Health Benefits Administrator, you need more information, please call (518) 457-5754 or 1-800-833-4344 between the hours of 9:00 a.m. and 3:00 p.m.

AUTHORIZATION

I have read the Pre-Tax Contribution Program memorandum and have made my selection on Page 1 of this document, if applicable. I understand that if I voluntarily decline or cancel my coverage, I may subject myself and/or my dependents to waiting periods if I decide to enroll at a later date, and I may be forfeiting the right to such coverage after leaving State service (vest, retirement, etc.). **I certify that the information I have supplied is true and correct.** I understand that my failure to provide required proof(s) within 28 days (30 days for newborns) may delay the availability of benefits for me or any dependent for whom I fail to provide such proof. Any person who makes a misstatement of fact or conceals any pertinent information, commits a crime which is subject to a $5,000 penalty *and* the stated value of the claim for *each* violation. I hereby ***authorize deduction from my salary or retirement allowance*** of the amount required, if any, for insurance indicated above. This authorization shall be in effect until I revoke it in writing.

→ Employee's Signature **(Required)** _____ Signature Date **(Required)** _____

AGENCY/EBD USE ONLY

Action/Reason	Date of Event	Hire Date	Date of 1st Eligibility	Percentage Working	Agency Code	Neg. Unit	Ret. System

Retirement Tier	Registration #	Sick Leave Information # Hours	Sick Leave Information Hourly Rate of Pay	Date Entered on NYBEAS	Effective Date

HBA Signature: **Date:**