TIME TO ROCK
OPTION TRANSFER!

2025 Contract College Option Transfer Period
December 2 - 31, 2024

DECISION / ENROLLMENT GUIDE

- Review your benefits
- Decision worksheets
- How to enroll
- Benefair

hr.cornell.edu/enroll

Cornell University | Division of Human Resources

To Do:

You may not need to do anything!

You don't need to do anything if:

- you're happy with your current health plan choices (they'll simply roll over for next year)

AND

- you don't want a flexible spending account (FSA) in 2025

You need to take action if:

- you want to make certain changes to your health care coverage (see pages 3 - 7)

AND/OR

- you want a flexible spending account in 2025 (see pages 8 - 17)

HR Services and Transitions Center

WE'RE HERE TO HELP

LOOK ONLINE:
hr.cornell.edu/enroll

EMAIL US:
hrservices@cornell.edu

PHONE US:
(607) 255-3936

SEND US MAIL:
HR Services & Transitions Center
395 Pine Tree Road
East Hill Office Building, Suite 130
Ithaca, New York 14850

HOURS:
8:00 am - 4:30 pm EST, M-F

IMPORTANT:
All enrollment requests must be SUBMITTED in Workday by 4:00 pm EST, 12/31/2024 or postmarked by 12/31/2024.
Please note that the HR Services & Transitions Center offices will be closed at noon December 24 EST till Thursday, January 2, 2025. Please plan accordingly if you have questions or need to submit any documentation before the December 31st deadline!

CONTENTS

If you do need to make changes or enroll in an FSA, follow these tips to make enrollment easy!

☑ Not sure if you want to change anything?

Take a look at the 2025 Medical Comparison Chart* and the NYSHIP Health Insurance Choices for 2025 booklet to compare features between plan options, including participating and non-participating providers; and see the 2025 Rate Chart.

**click here for instructions* on how to use the online comparison chart tool, under "Plan Details > How To Compare Plans."*

☑ Enrolling in an FSA? Find your "Open Enrollment Event" in Workday

You should receive an email notifying you that your "Open Enrollment Event" is ready. Log in to Workday and follow the instructions on page 12 of this guide.

☑ Follow step-by-step instructions

This booklet shows directions to guide you through option transfer health plan changes and enrolling in an FSA. If you get stuck, contact us!

☑ Make sure your enrollments go to the right place!

- **Health plan** changes need to be submitted to HR Services & Transitions Center through Secure File Transfer (SFT) upload or postmarked by 12/31/2024 (see pages 5-6).
- **FSA enrollment** is submitted online via Workday by 4:00 pm EST 12/31/2024.
- **Legal Insurance** enrollment is submitted online or over the phone via Mercer Insurance by 12/31/2024. You may contact Mercer at 1-800-553-4861.

1 Do I need to make changes to my health plan coverage?

Permitted health plan changes

You can make three changes to your health plan coverage as part of the Option Transfer period, regardless of whether a qualifying event has affected you or your dependents' eligibility.

Changes will take effect December 26, 2024.

A. Change between the Empire Plan and a NYSHIP HMO
B. Remove dependents from family coverage
C. Voluntarily cancel your coverage

Health Plan Changes Outside of the Option Transfer Period

These changes to your NYSHIP health plan can be made at any time:

- enroll for the first time
- add coverage for your spouse, partner, or dependents
- remove dependents from your plan (the tier must remain family)

If enrolling for the first time or adding eligible dependents to coverage, then a 10-week waiting period applies, unless you have a qualifying event based on IRS guidelines. A qualifying event is a change of family status, such as marriage, birth of a child, etc. If your request is the result of a qualifying event, you must attach proof of that event within 30 days of the date it occurred; see documentation requirements.

How to make changes outside the Option Transfer period:

A PS404 New York State Health Insurance Transaction Form must be submitted for yourself and each dependent.

- Collect any required documentation
- Submit PS404s and documentation to:

HR Services & Transitions Center
395 Pine Tree Rd, Suite 130
East Hill Office Building
Ithaca, NY 14850

Documentation can also be submitted through the Cornell Secure File Transfer Site (DropBox): https://sft.cornell.edu

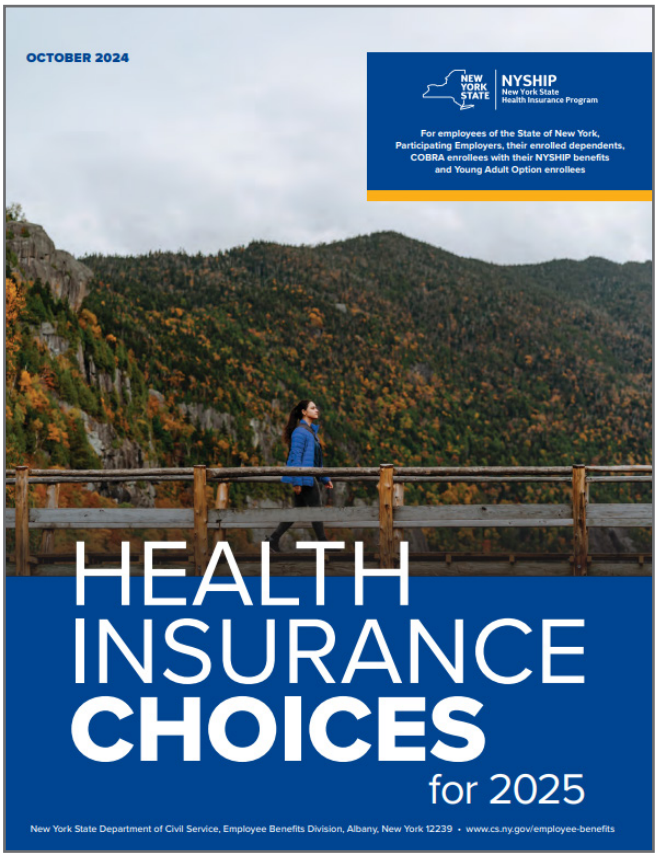
Note: When uploading, type in the email address tmw54@cornell.edu under "Prepare Upload," add your files, and select "21 days" for the expiration period.

Instructions and forms are downloadable at https://hr.cornell.edu/understand-your-benefits/open-enrollment-option-transfer/contract-college-option-transfer/option

Want to make a change? Let's get started!

All health plan changes require that you submit a paper PS404 Enrollment Form to HR Services & Transitions Center.

Download the Cornell version of the form, and then follow the instructions on the following pages depending on the type of change you want to make.



Questions about your coverage?

Get all the details about your health plan options with NYSHIP from the "Health Insurance Choices for 2025" booklet.

A. Change between the Empire Plan and HMOs

How to make the change: Complete sections 1-12 on the front, section 16 on the back and sign and date under the authorization section. Do not complete the dependent section as that will remain the same.

Submit this form by mail (postmarked by 12/31/24); online by 4:00 pm EST 12/31/24; or in person to the HR Services & Transitions Center by 12:00 pm EST 12/24/24:

HR Services & Transitions Center
395 Pine Tree Rd, Suite 130, East Hill Office Building,
Ithaca, NY 14850

To upload documentation online use the Cornell Secure File Transfer Site (DropBox):
https://sft.cornell.edu

Note: When uploading, type in the email address tmw54@cornell.edu under "Prepare Upload," add your files, and select "21 days" for the expiration period.

Front:

NEW YORK STATE | **Department of Civil Service**
Employee Benefits Division

PS-404 (10/2024)
11.2024 CU
NYSHIP Health Insurance Transaction Form for NYS & PE Employees
Department of Civil Service, Albany, NY 12239

INSTRUCTIONS: Read and complete both pages. Please print, check the appropriate choices and sign/date the document.

1–12 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 Address Street City State Zip
7. Date of Birth _ _ /_ _ /_ _ _ _ 8. Telephone 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 Dependent Name _____
Medicare ID Number _____
12. Is any of this information new? ☐ No ☐ Yes Box Number(s) _____ Effective Date of Ch

13 ELECT OR DECLINE COVERAGE

13A. Choose a Pre-Tax election
You are only eligible for Pre-Tax deductions if newly eligible or if requested during the Pre-Tax Contribution Proc
1. ☐ **Elect Pre-Tax Status** for Premium deduction 2. ☐ **Elect After-Tax Status** for Prem

13B. Select a NYSHIP Coverage Option *(Choose option 1, 2, or 3)*

1. Individual Enrollment Medical *(10)* *(Select Empire Plan or HMO)*
☐ Empire Plan ☐ HMO Code _____ HMO Name _____

2. Family Enrollment *(Complete box 14)* Medical *(10)* *(Select Empire Plan or HMO)*
☐ Empire Plan ☐ HMO Code _____ HMO Name _____

3. Decline Coverage ☐ Medical *(10)* ☐ Dental *(11)*

14 DEPENDENT INFORMATION

Must be provided when choosing to enroll in NYSHIP family coverage
(You may attach additional sheets if necessary) Date of Ev

CHECK ALL THAT APPLY: ☐ Add ☐ Remove ☐ Update CHECK ALL THAT APPLY: ☐ Medic
Last Name _____ First Name _____ MI ____ Rela
Date of Birth _ _ /_ _ /_ _ _ _ Gender ☐ F ☐ M ☐ X Social Security Number _ _ _
Address *(if different)* _____

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Date of Birth _ _ /_ _ /_ _ _ _ Gender ☐ F ☐ M ☐ X Social Security Number _ _ _
Address *(if different)* _____

☐ If you have additional dependents, please check this box and attach additional sheets with their info

Back:

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15 CHANGE OR CANCEL EXISTING COVERAGE

15A. Change Coverage ☐ Medical *(10)* ☐ Dental *(11)* Date of Event _ _ /_ _ /_ _ _ _

☐ **Change to FAMILY** *(Complete box 14 on page 1)*
☐ Marriage
☐ Domestic Partner
☐ Newborn
☐ Request coverage for dependents not previously covered
☐ Previous coverage terminated *(proof required)*
☐ Other_____

☐ **Change to INDIVIDUAL**
☐ 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
☐ 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. Final divorce decrees (first and last page) are required.

15B. Voluntarily Cancel Coverage ☐ Medical *(10)* ☐ Dental *(11)* Qualifying Event _ _ /_ _ /_ _ _ _

NOTE: If you are enrolled in the PTCP, you may only make changes during the Annual Option Transfer Period or when experiencing a PTCP qualifying event.

16 ENTER ANNUAL OPTION TRANSFER REQUEST(S) BELOW

Change NYSHIP Option Change to: ☐ Empire Plan ☐ HMO Code _____ HMO Name_____
Change Pre-Tax Status Change to: ☐ Pre-Tax ☐ After-Tax *Submit during the PTCP Election Period.*

17 DONATE LIFE REGISTRY ELECTION

You must fill out the following section. This question must be answered each time the form is filled out.

Would you like to be added to the Donate Life Registry? ☐ Yes ☐ Skip this question

By indicating yes in response to the question asking if you would like to be added to the Donate Life Registry, you are certifying that you are 16 years of age or older, consenting to donate your organs and tissues for the purposes of transplantation and research in the event of your death and authorizing NYSHIP to share your name and identifying information with the Registry.

ID Number on New York State Driver License, Learner Permit, or Non-Driver ID Card _____

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

This authorization is made now for future deductions that will occur at the time of retirement. Pursuant to the following Sections of NYS Retirement and Social Security Law: 110-a; 110-b; 110-c; 110-d; 410-a; 410-b or 410-c, I hereby authorize the NYS Department of Civil Service (DCS) to deduct an amount from my monthly retirement allowance from the New York State and Local Retirement Systems (NYSLRS) to cover any deductions for insurance premiums payable on behalf of DCS. Authorization is given to make any future adjustment deductions and/or changes DCS certifies to NYSLRS as necessary in the amount of such insurance premiums. I understand that all requests to begin, modify, or revoke deductions must be submitted to my current/former agency and provided to DCS. This authorization shall remain in effect until revoked by me by written notice or until otherwise revoked pursuant to law.

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** _ _ /_ _ /_ _ _ _

PAGE 2 OF 2

B. Drop all dependents and change from family to individual coverage

How to make the change: Complete sections 1-12; on section 15-A under "Change Coverage:"check "Medical", "Change to INDIVIDUAL" and "I voluntarily cancel coverage for my dependents." Sign and date the authorization section on the back of the form.

Submit this form by mail (postmarked by 12/31/24); online by 4:00 pm EST 12/31/24; or in person to the HR Services & Transitions Center by 12:00 pm EST 12/24/24:

HR Services & Transitions Center
395 Pine Tree Rd, Suite 130, East Hill Office Building,
Ithaca, NY 14850

To upload documentation online use the Cornell Secure File Transfer Site (DropBox):
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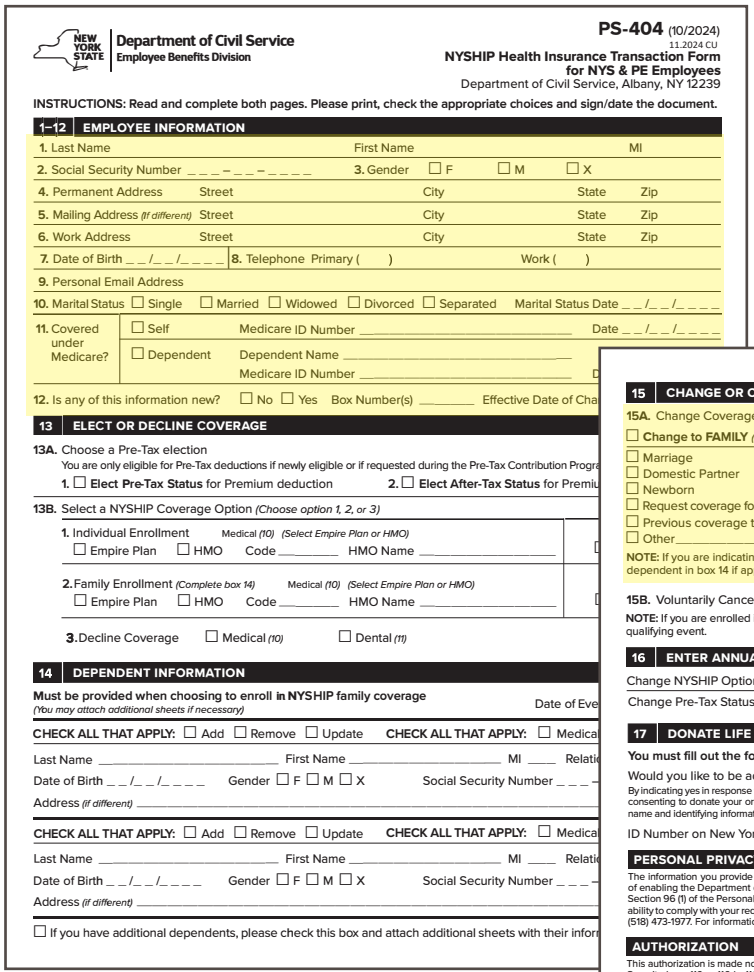

NEW YORK STATE | Department of Civil Service
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PS-404 (10/2024)
11.2024 CU
NYSHIP Health Insurance Transaction Form for NYS & PE Employees
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1–12 EMPLOYEE INFORMATION

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 Address | Street | City | State | Zip
7. Date of Birth _ _ /_ _ /_ _ _ _ | 8. Telephone 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 | Dependent Name _____ | Medicare ID Number _____
12. Is any of this information new? ☐ No ☐ Yes | Box Number(s) _____ | Effective Date of Cha

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13A. Choose a Pre-Tax election
You are only eligible for Pre-Tax deductions if newly eligible or if requested during the Pre-Tax Contribution Progre
1. ☐ **Elect Pre-Tax Status** for Premium deduction 2. ☐ **Elect After-Tax Status** for Premiu

13B. Select a NYSHIP Coverage Option *(Choose option 1, 2, or 3)*

1. Individual Enrollment Medical *(10)* *(Select Empire Plan or HMO)*
☐ Empire Plan ☐ HMO Code _____ HMO Name _____

2. Family Enrollment *(Complete box 14)* Medical *(10)* *(Select Empire Plan or HMO)*
☐ Empire Plan ☐ HMO Code _____ HMO Name _____

3. Decline Coverage ☐ Medical *(10)* ☐ Dental *(11)*

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Last Name _____ First Name _____ MI ____ Relati
Date of Birth _ _ /_ _ /_ _ _ _ Gender ☐ F ☐ M ☐ X Social Security Number _ _ _ –
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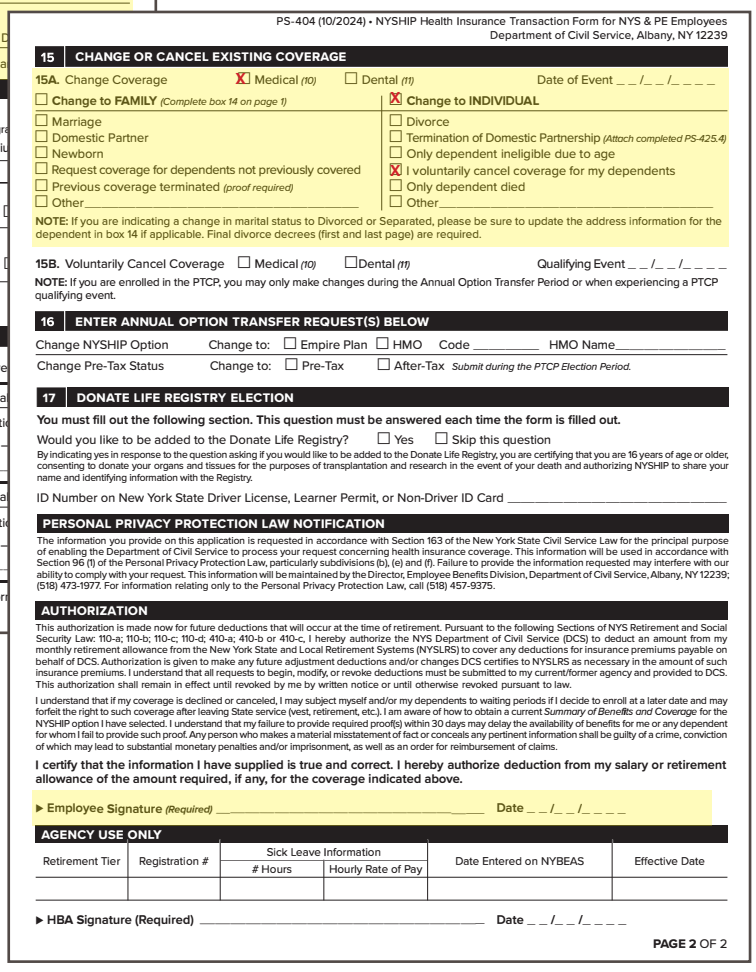

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15A. Change Coverage ☒ Medical *(10)* ☐ Dental *(11)* Date of Event _ _ /_ _ /_ _ _ _

☐ **Change to FAMILY** *(Complete box 14 on page 1)*	☒ **Change to INDIVIDUAL**
☐ 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
☐ 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. Final divorce decrees (first and last page) are required.

15B. Voluntarily Cancel Coverage ☐ Medical *(10)* ☐ Dental *(11)* Qualifying Event _ _ /_ _ /_ _ _ _

NOTE: If you are enrolled in the PTCP, you may only make changes during the Annual Option Transfer Period or when experiencing a PTCP qualifying event.

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By indicating yes in response to the question asking if you would like to be added to the Donate Life Registry, you are certifying that you are 16 years of age or older, consenting to donate your organs and tissues for the purposes of transplantation and research in the event of your death and authorizing NYSHIP to share your name and identifying information with the Registry.

ID Number on New York State Driver License, Learner Permit, or Non-Driver ID Card _____

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.

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This authorization is made now for future deductions that will occur at the time of retirement. Pursuant to the following Sections of NYS Retirement and Social Security Law: 110-a; 110-b; 110-c; 110-d; 410-a; 410-b or 410-c, I hereby authorize the NYS Department of Civil Service (DCS) to deduct an amount from my monthly retirement allowance from the New York State and Local Retirement Systems (NYSLRS) to cover any deductions for insurance premiums payable on behalf of DCS. Authorization is given to make any future adjustment deductions and/or changes DCS certifies to NYSLRS as necessary in the amount of such insurance premiums. I understand that all requests to begin, modify, or revoke deductions must be submitted to my current/former agency and provided to DCS. This authorization shall remain in effect until revoked by me by written notice or until otherwise revoked pursuant to law.

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		

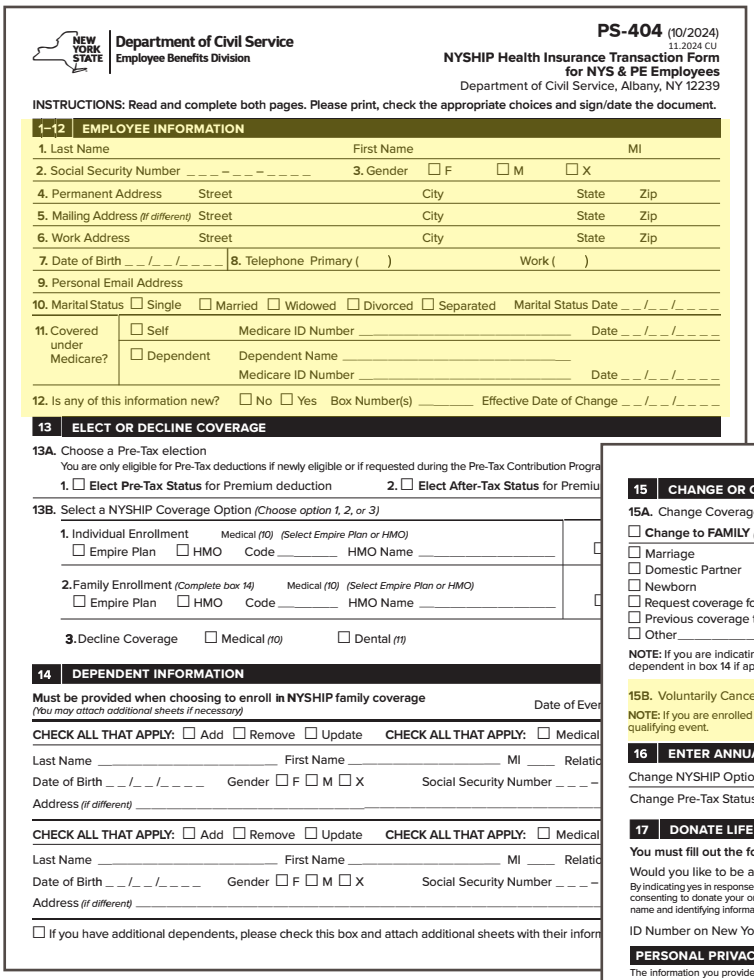
▶ **HBA Signature (Required)** _____ Date _ _ /_ _ /_ _ _ _

PAGE 2 OF 2

C. Voluntarily cancel your coverage

How to make the change: Complete sections 1-12; in section 15-B, "Voluntarily Cancel Coverage," check "medical;" and sign and date on the back.

Front:



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6. Work Address — Street — City — State — Zip
7. Date of Birth _ _ /_ _ /_ _ _ _ — 8. Telephone 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 — Dependent Name _____ Medicare ID Number _____ Date _ _ /_ _ /_ _ _ _
12. Is any of this information new? ☐ No ☐ Yes — Box Number(s) _____ — Effective Date of Change _ _ /_ _ /_ _ _ _

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Last Name _____ First Name _____ MI ____ Relatic
Date of Birth _ _ /_ _ /_ _ _ _ Gender ☐ F ☐ M ☐ X Social Security Number _ _ _ –
Address *(if different)* _____

CHECK ALL THAT APPLY: ☐ Add ☐ Remove ☐ Update **CHECK ALL THAT APPLY:** ☐ Medical
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Address *(if different)* _____

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IMPORTANT!
If you choose to voluntarily cancel your coverage, this results in the complete termination of your health insurance plan.

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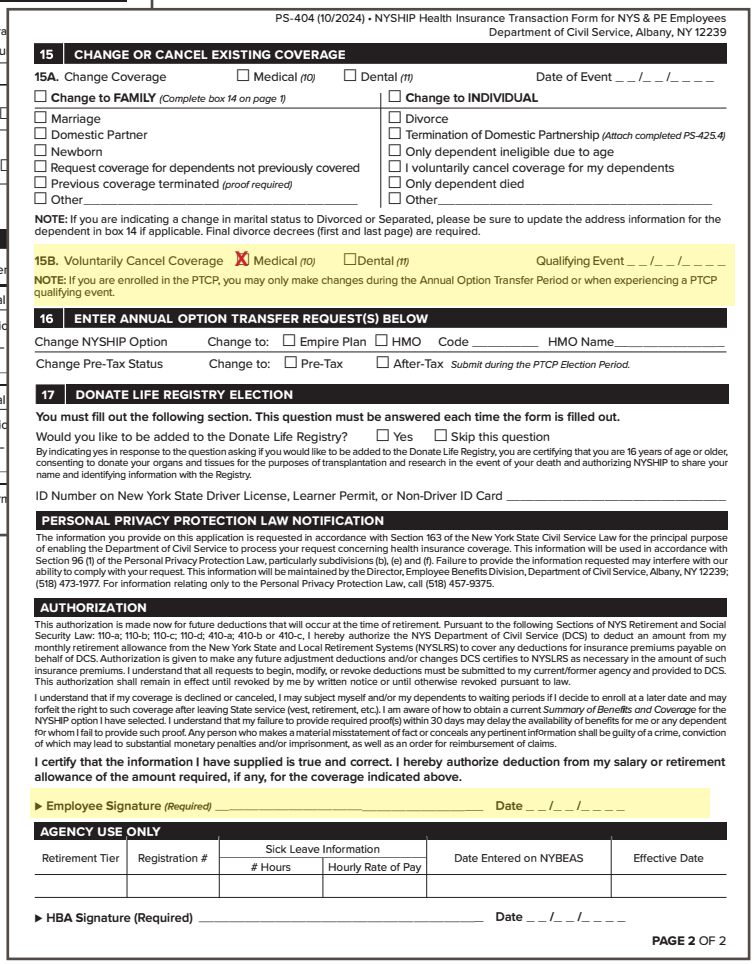

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PERSONAL PRIVACY PROTECTION LAW NOTIFICATION

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

This authorization is made now for future deductions that will occur at the time of retirement. Pursuant to the following Sections of NYS Retirement and Social Security Law: 110-a; 110-b; 110-c; 110-d; 410-a; 410-b or 410-c, I hereby authorize the NYS Department of Civil Service (DCS) to deduct an amount from my monthly retirement allowance from the New York State and Local Retirement Systems (NYSLRS) to cover any deductions for insurance premiums payable on behalf of DCS. Authorization is given to make any future adjustment deductions and/or changes DCS certifies to NYSLRS as necessary in the amount of such insurance premiums. I understand that all requests to begin, modify, or revoke deductions must be submitted to my current/former agency and provided to DCS. This authorization shall remain in effect until revoked by me by written notice or until otherwise revoked pursuant to law.

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 _ _ /_ _ /_ _ _ _

PAGE 2 OF 2

Submit this form by mail (postmarked by 12/31/24); online by 4:00 pm EST 12/31/24; or in person to the HR Services & Transitions Center by 12:00 pm EST 12/24/24:

HR Services & Transitions Center
395 Pine Tree Rd, Suite 130, East Hill Office Building,
Ithaca, NY 14850

To upload documentation online use the Cornell Secure File Transfer Site (DropBox):
https://sft.cornell.edu

Note: When uploading, type in the email address tmw54@cornell.edu under "Prepare Upload," add your files, and select "21 days" for the expiration period.

2 How much should I contribute to a flexible spending account?

Flexible Spending Account (FSA)

You have the option to enroll in two different FSAs:

A. **Health/Medical Care FSA: for medical expenses not covered by your health plan**

B. **Dependent Care FSA: for childcare or other dependent daycare expenses (not medical expenses).**

The worksheets on the next pages can help you determine how much you may want to contribute to an FSA.

IMPORTANT:

- FSA's must be elected every year you choose to participate!
- Enrollment is processed in Workday. See the step-by-step instructions on the following pages to guide you through the Workday enrollment process.

A. Health/Medical Care FSA -- Savings Calculator

How much should I contribute? A Savings Calculator can help you itemize unreimbursed health and dependent care expenses to assist you in determining your health care spending account contributions.

1. Medical expenses (only the portion not covered by insurance)

Deductibles, co-pays, co-insurance: _____

- Physican visits and routine exams: _____
- Prescription drugs: _____
- Over-the-counter items: _____
- Insulin, syringes and diabetic supplies: _____
- Annual physicals: _____
- Chiropractic treatments: _____
- Other medical expenses: _____

TOTAL MEDICAL EXPENSES: _____

2. Dental expenses (only the portion not covered by insurance)

- Check ups and cleanings: _____
- Fillings, root canals: _____
- Crowns, bridges and dentures: _____
- Oral surgery or orthodontia: _____
- Other dental expenses _____

TOTAL DENTAL EXPENSES: _____

3. Vision and hearing care expenses

- Vision exams: _____
- Eyeglasses, prescription sunglasses: _____
- Contact lenses and cleaning solution: _____
- Corrective eye surgery (LASIK, cataract, etc.): _____
- Hearing exams, aids and batteries: _____

TOTAL VISION AND HEARING EXPENSES: _____

GRAND TOTAL

OF MEDICAL, DENTAL, VISION & HEARING: _____

MINUS 2024 ROLLOVER - UP TO $640: – _____

EQUALS YOUR 2025 CONTRIBUTION: = _____

IRS maximum contribution limit

The 2025 contribution limit for FSA medical care is $3,300 per employee.

B. Dependent Care FSA -- Savings Calculator

How much should I contribute?

Keep the following in mind when estimating your expenses:

- Amounts you pay for dependent care while you are off work due to vacation, holidays, illness or injury are not eligible expenses.
- If your dependent is a student, your expense may be different during the months when school is not in session.

Dependent care expenses

Total dependent care expenses:		_____
Minus 2025 Cornell Child Care Grant:	–	_____
EQUALS 2025 CONTRIBUTION:	=	_____

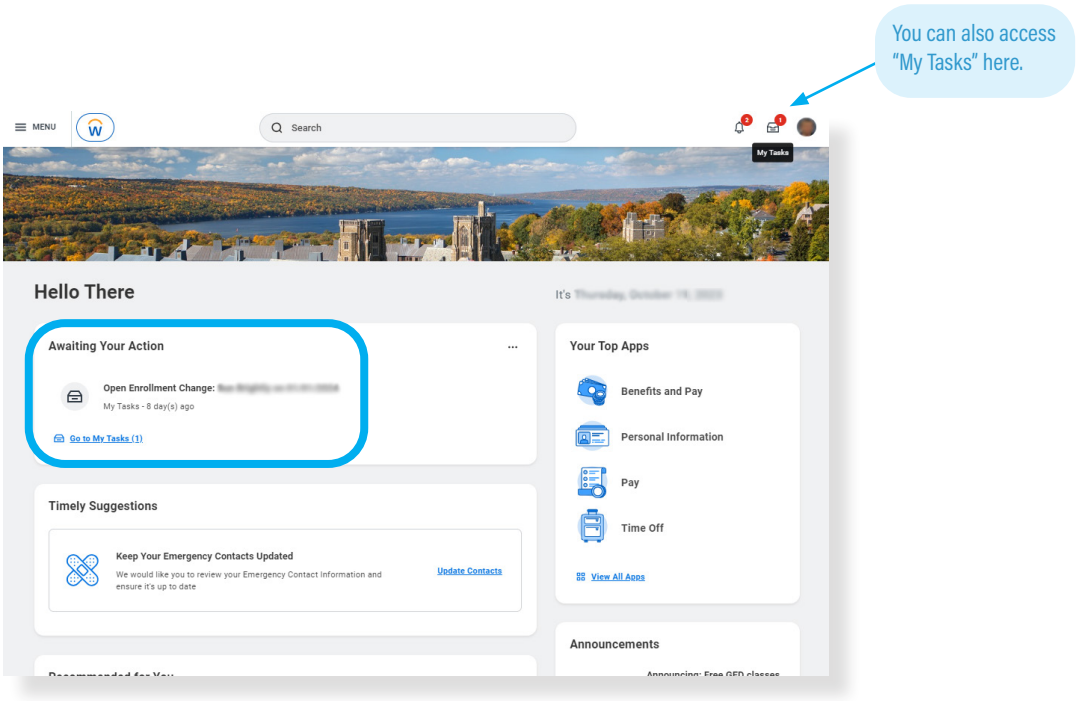
IRS maximum contribution limit

The 2025 limit for FSA dependent care is $5,000 per household (including any funds from the Child Care Grant).

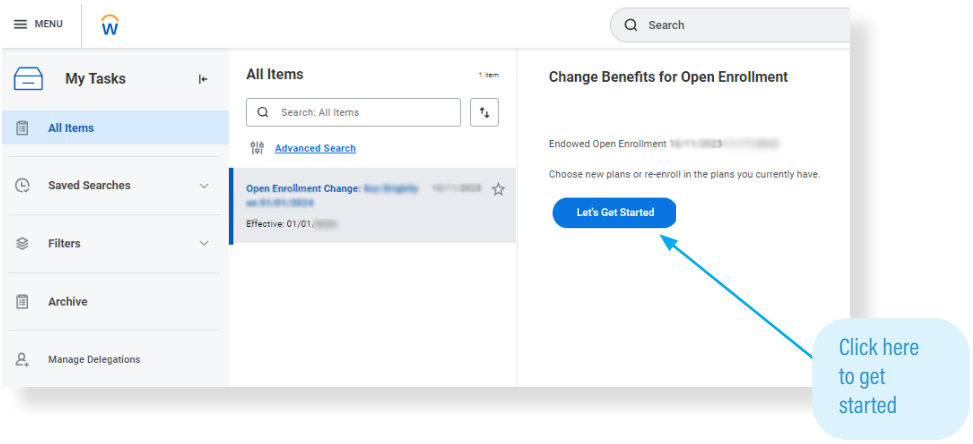
Ready To Enroll In An FSA?

Once you know how much you'd like to contribute, enroll in Workday before December 31, 2024.

Log in to Workday (https://hr.cornell.edu/workday). Your Open Enrollment Change event will be in the "Awaiting Your Action" block. You can also access the event via your "My Tasks" inbox.

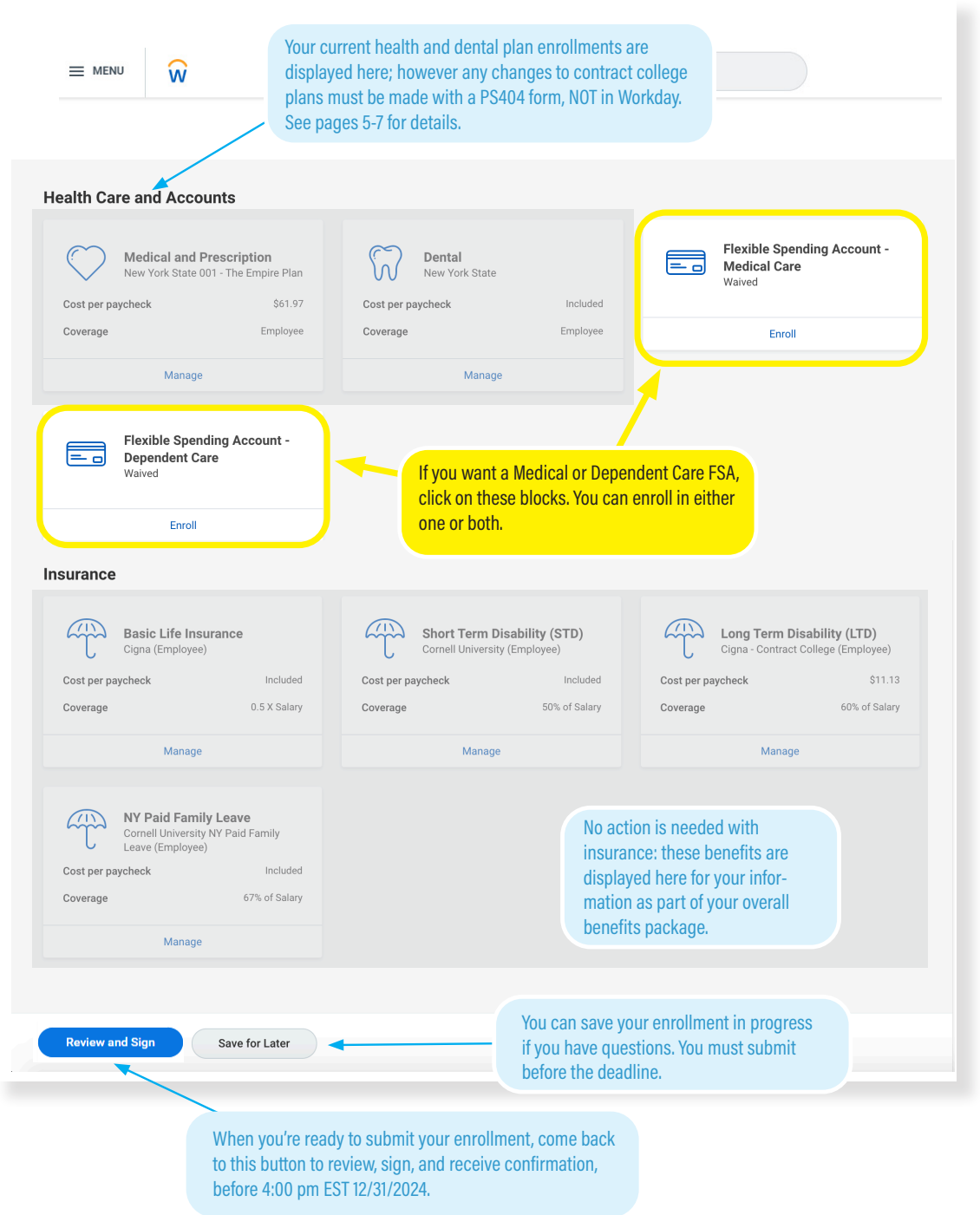


Click on the "Open Enrollment Change" event and then click the "Let's Get Started" button.

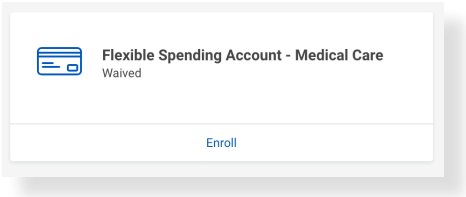


Dashboard Screen:

Just choose the FSA enrollments you want -- you don't need to click through options you don't need.



Medical Care Flexible Spending Account



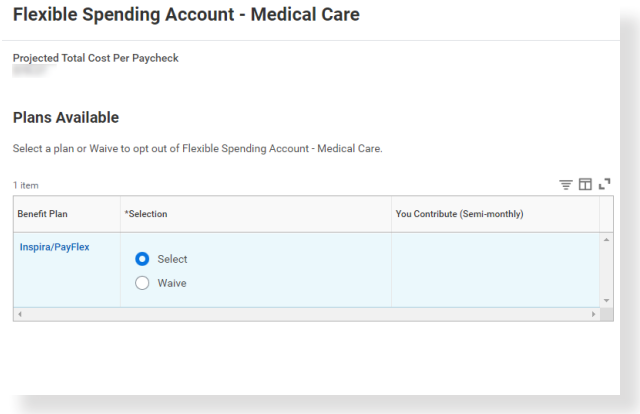
If you want to participate in a 2025 Inspira Medical Care account, you must re-enroll and enter your 2025 contribution amount!

The Flexible Spending Account - Medical Care block will show as "Waived." Click the "Enroll" link.

- You can choose whether you want to participate in either the Medical Care or Dependent Care FSAs, both, or neither.
- Refer to pages 9-10 of this booklet for a worksheet to help determine your contribution.

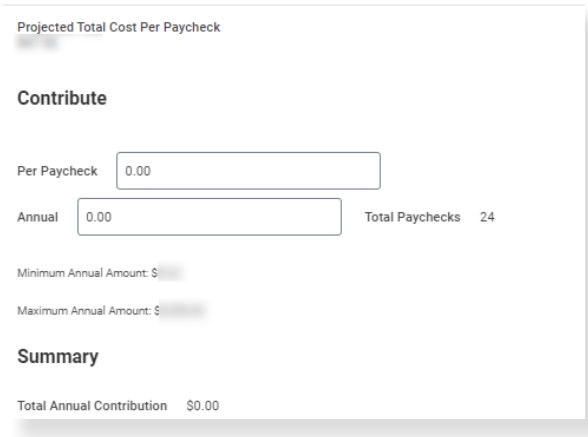
Learn more about Flexible Spending Accounts.

On this screen: Select "Inspira/PayFlex"



Click the "Confirm and Continue" button at bottom of screen.

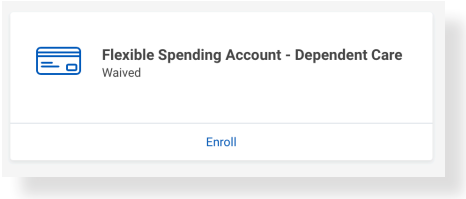
On this screen: Input your contribution



- Refer to pages 9-10 of this booklet for a worksheet to help determine your contribution.
- Type in either an annual amount or per paycheck deduction; the other field will calculate automatically.

Click the "Save" button at bottom of screen to return to the open enrollment dashboard.

Dependent Care Flexible Spending Account



If you want to participate in a 2025 Dependent Care account, you must re-enroll and enter your 2025 contribution amount!

The Flexible Spending Account - Dependent Care block will show as "Waived."
Click the "Enroll" link.

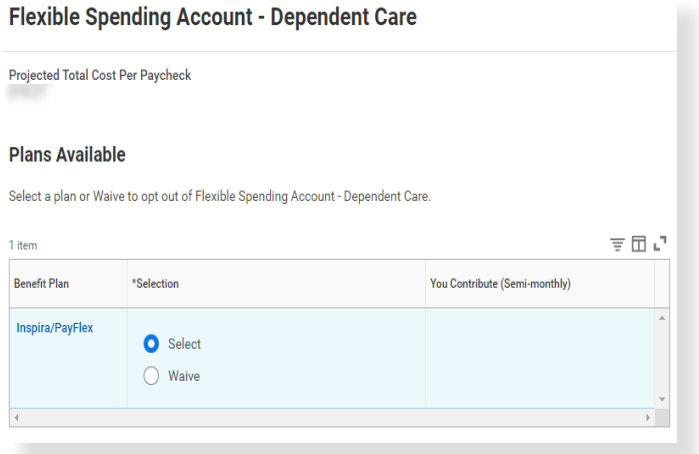
- You can choose whether you want to participate in either the Medical Care or Dependent Care FSAs, both, or neither.
- A Dependent Care FSA is not for a dependent's medical expenses.
- Refer to page 11 of this booklet for a worksheet to help determine your contribution.

Learn more about Flexible Spending Accounts.

IMPORTANT: CHILD CARE GRANT RECIPIENTS

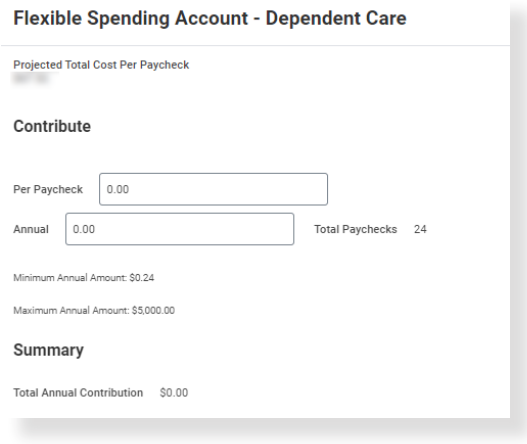
Recipients of a 2025 Cornell Child Care Grant *should not* include 2025 award amounts in their DEPENDENT CARE totals. Only include additional dollars you wish to be deducted from YOUR pay; i.e., if Cornell's award is $3,000, enter up to $2,000 in Workday as supplement from your own pay to stay within the $5,000 household limit.

On this screen: Select "Inspira/PayFlex"



Click the "Confirm and Continue" button at bottom of screen.

On this screen: Input your contribution



- Refer to page 9 of this booklet for a worksheet to help determine your contribution.
- Type in either an annual amount or per paycheck deduction; the other field will calculate automatically.

Click the "Save" button at bottom of screen to return to the open enrollment dashboard.

Review and Submit

You're almost done! When you've completed your enrollments and clicked the "Save" button, you'll be returned to the dashboard screen.

Review and Sign

Click the "Review and Sign" button at bottom of screen.

What you see in Workday:

Selected Benefits 4 items

Plan	Coverage Begin Date	Deduction Begin Date	Coverage	Dependents	Beneficiaries	Cost
Flexible Spending Account - Medical Care Inspira Financial	[redacted]	[redacted]	$1,200.00 Annual			$50.00
Basic Life Insurance New York Life Insurance Company (Employee)	[redacted]	[redacted]	0.5 X Salary			Included
Short Term Disability (STD) Cornell University (Employee)	[redacted]	[redacted]	50% of Salary			Included
NY Paid Family Leave Cornell University NY Paid Family Leave (Employee)	[redacted]	[redacted]	67% of Salary			Included

Remember: Your health coverage is not changed in Workday and will roll over unless you submit a paper PS404 Enrollment Form in person to the HR Services and Transitions Center by noon, December 24, or via postal mail postmarked by December 31, 2024.

- **Your Selected Benefits:** including coverage and coverage dates, dependents, and cost will be presented in a table. (Beneficiaries will not appear, since they are managed directly with the vendors.)
- **Automatic Benefits:** Your life insurance and leave benefits are also included, which require no action.
- **Waived Benefits:** Below this display is a list of benefits you have waived - make sure this is correct!
- **Benefits Cost:** The next display shows your per paycheck deduction and Cornell's contribution.
- **Document Upload:** An area to upload attachments appears near the bottom of page; please disregard -- we are unable to upload documents to Workday at this time. See page 5 for uploading details.
- **SCROLL TO BOTTOM OF PAGE FOR ELECTRONIC SIGNATURE: YOU MUST CHECK THE "I Accept" CHECKBOX TO CONFIRM THAT YOU HAVE REVIEWED YOUR ELECTIONS AND ARE SATISFIED WITH YOUR ENROLLMENT IN ORDER TO SUBMIT!**

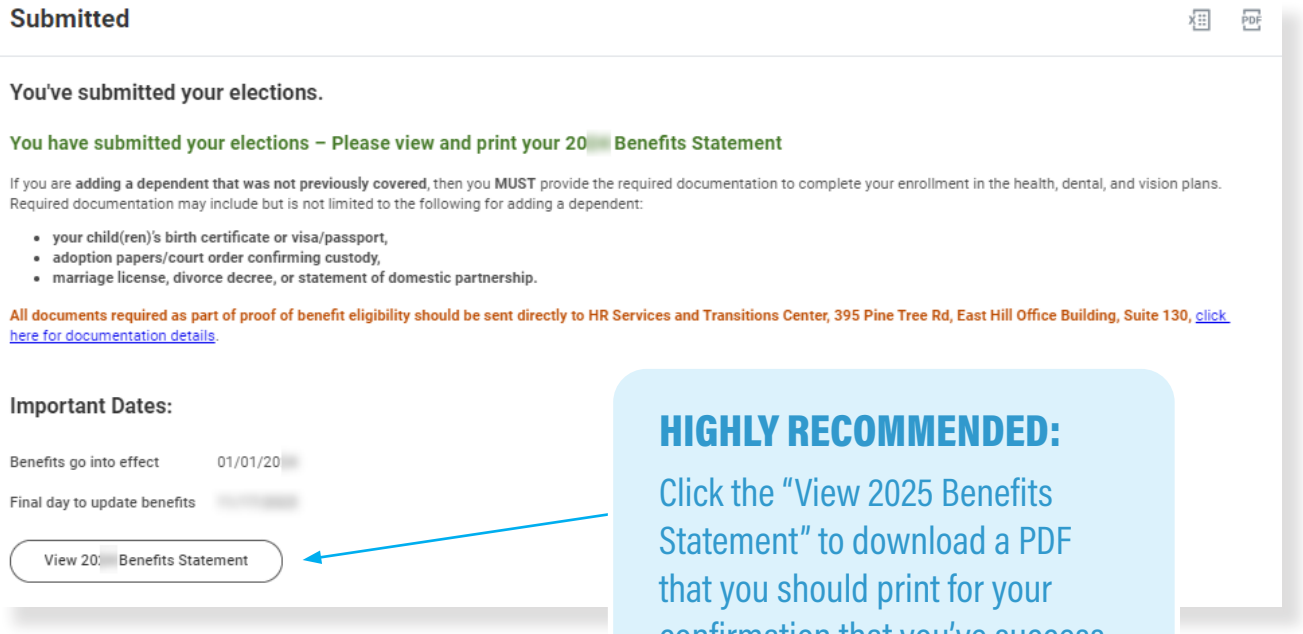
Submit

Everything looks good? You must click the "Submit" button at the bottom of the screen to complete your enrollment!

One more thing - your submission is not complete until you receive a confirmation message -- see next page.

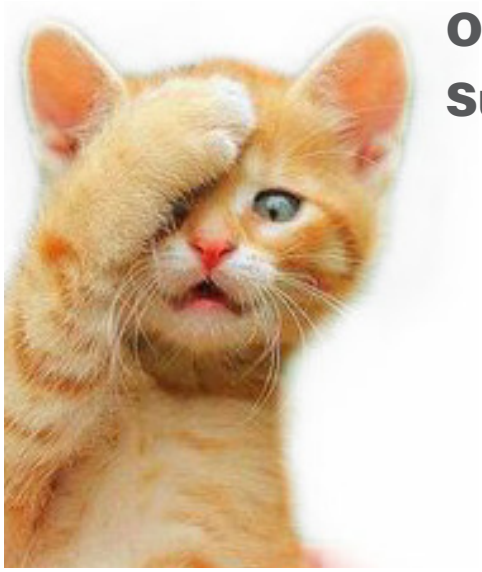
Confirmation

Your submission is not complete until you receive this Confirmation screen:



HIGHLY RECOMMENDED:

Click the "View 2025 Benefits Statement" to download a PDF that you should print for your confirmation that you've successfully submitted.



Oops!
Submitted, and need to make a change?

Don't worry -- it happens!

Log in to Workday and click on the "Benefits and Pay" icon in the menu link in the upper left corner of the screen.

Your Benefit Event is located under the "Needs Attention" heading in the middle of the page.

Click the "Edit" link to make changes.

This option will be available until 4:00 pm EST, December 31, 2024.

3 Should I get legal insurance?

Legal Insurance

Optional legal insurance has a separate open enrollment period:
October 28 - December 31, 2024.

This is the only time period you can enroll in or cancel coverage to be effective in 2025.

You must enroll directly with the insurer; you cannot enroll via Workday.

Is legal insurance right for you? Learn more about Legal Insurance.

Questions?

Join Us for BENEFAIR!

Ithaca: Tuesday, December 10

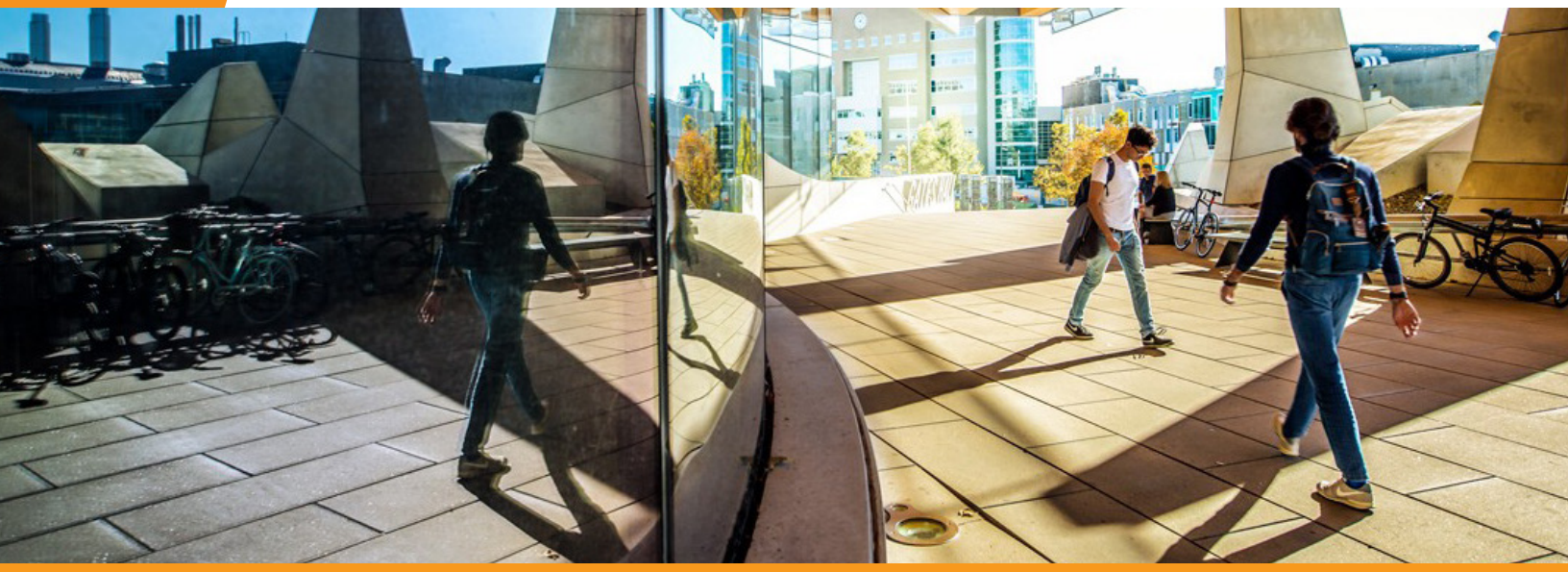
9:00 am - 1:30 pm, College of Veterinary Medicine, Takoda's Run Atrium

Geneva AgriTech: Wednesday, December 11

11:00 am - 1:00 pm, Jordan Hall, 2nd Floor

Visit hr.cornell.edu/Benefair for complete schedule & details.

Meet with Cornell benefits experts and representatives from benefits providers to get answers to your benefits questions and learn about all the benefits available to Cornell employees!



HR Services and Transitions Center

WE'RE HERE TO HELP

Have questions about your benefits?

LOOK ONLINE:
hr.cornell.edu/enroll

EMAIL US:
HRservices@cornell.edu

PHONE US: (607) 255-3936

SEND US MAIL:
HR Services & Transitions Center
395 Pine Tree Rd.
East Hill Office Building, Suite 130
Ithaca, NY 14850

HOURS:
8:00 am - 4:30pm EST, M-F

Please note that the HR Services & Transitions Center offices will be closed December 24 at 12:00 noon EST till Tuesday, January 2, 2025. Please plan accordingly if you have questions or need to submit any documentation before the December 31st deadline!