Office of Labor Relations
Management Benefits Fund

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Director, Employee Benefits Program
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Deputy Director, Operations

January 2023

Re: Management Benefits Fund (MBF) Coverage for Young Adult Dependents

Dear MBF Member:

MBF adopted the New York State law under which MBF will offer Direct Pay Coverage Continuation ("DPCC") for eligible dependent children of MBF members through age 29 ("Young Adult Dependent").

Eligibility: To be eligible for MBF DPCC coverage, the Young Adult Dependent does not have to live with an MBF Member, be financially dependent on an MBF Member, or be a student. However, the Young Adult Dependent must meet the following requirements:

- Be unmarried
- Be 29 years or younger
- Not be covered by Medicare
- Live, work or reside in New York State, or the health insurance, dental or vision care program service area

The MBF member must be active in MBF in order for his/her Young Adult Dependent to be eligible for DPCC.

Coverage: MBF DPCC is available for Young Adult Dependents for the continuation of (1) Superimposed Major Medical Plan (SMMP), and Dental & Vision Care Programs, (2) Dental & Vision Care Programs only, or (3) SMMP only.

Election: You must complete and submit the form on the reverse side of this letter on behalf of your Young Adult Dependent within the following timeframes:

- 60 days following the date coverage would otherwise terminate due to the dependent attaining the age of 26: or
- 60 days after newly meeting the requirements for dependent child status if coverage previously ended (for example, requalifying as a dependent under this new definition. Please note that Young Adult dependents are not limited to having DPCC only once, and may elect within 60 days of newly meeting the above requirements.)

Cost of Coverage: Effective January 1, 2023, you will receive a monthly bill from Administrative Services Only (ASO), the MBF DPCC billing administrator, for premiums depending on the option you select on behalf of your Young Adult Dependent. Please note that the individual rate will apply to each separate Young Adult Dependent.

Benefit	Monthly Cost Effective September 1, 2022
SMMP, Dental & Vision Care Programs	$37.41
Dental & Vision Care Programs only	$28.82
SMMP only	$8.59

For information regarding Young Adult Dependent coverage under your City health insurance plan, please visit the Office of Labor Relations Health Benefits Program Web site at www.nyc.gov/olr.

If you have any questions, please contact MBF via email at the link below:
https://www1.nyc.gov/site/olr/webforms/send-message-management-benefits-fund.page

These rates are effective as of September 2022 and will remain in effect until further notice.

Sincerely,
The City of New York
Management Benefits Fund

The City of New York

OFFICE OF LABOR RELATIONS
Management Benefits Fund
Tel: (212) 306-7290 (888) 4000-MBF (outside NYC)
TTY: (212) 306-7629 / Fax: (212) 306-7353

Forms and documents can be submitted electronically to: https://nyc-mbf.leapfile.net

MBF DIRECT PAY COVERAGE CONTINUATION (DPCC) FOR YOUNG ADULT DEPENDENT ENROLLMENT FORM

for the continuation of the Superimposed Major Medical Plan (SMMP) and/or Dental and Vision Care Benefit Programs

Prior to completing this Enrollment Form, please be sure the Young Adult Dependent meets the eligibility requirements on the reverse side of this form. This form is to be used per individual. Please do not include payment with this form. You will receive a monthly bill from the MBF DPCC billing administrator.

MEMBER INFORMATION (MUST BE AN ACTIVE MEMBER OF MBF)

SSN: ___ - ___ - ____ Date of Birth: __ / __ / ____ Telephone ___ - ___ - ____

Last Name: First Name: MI.:

Mailing Address - Number and Street: Apt:

City: State: Zip + Four: +

☐ Active Member ☐ Retired Member Agency/Former Agency (IF RETIREE):

YOUNG ADULT DEPENDENT INFORMATION (AGES BETWEEN 26 THROUGH 29)

If your Young Adult Dependent has never been enrolled in MBF due to ineligibility as a result of his or her age, you must provide a copy of the Young Adult Dependent's birth certificate in order to add him or her as your dependent under MBF.

☐ New Enrollment ☐ Cancellation (effective the1st day of the following month after the form is received by MBF)

SSN: ___ - ___ - ____ Date of Birth: __ / __ / ____ Relationship to Member

Last Name: First Name: MI.:

Mailing Address - Number and Street: ☐ Check here if the address is the same as above. Apt:

City: State: Zip + Four: +

DPCC OPTION - CHECK ONE

☐ SMMP*, Dental and Vision Care ☐ Dental and Vision Care only ☐ SMMP* only

* If you elect SMMP DPCC, please fill in the Young Adult Dependent's primary health coverage information:

Name of City/Other Group Health Plan: ***or*** ☐ None

Note: If the Young Adult Dependent does not have any primary health plan coverage, the SMMP deductible will be $10,000/Individual.

Prescription Drug Rider: ☐ Yes ☐ No (Note: If no drug rider, the SMMP deductible will be $2,500/Individual)

ACKNOWLEDGMENT

I, as the Young Adult Dependent, certify that I meet the eligibility requirements as stated above and that the above information is complete and correct. I agree that I will be fully responsible for payment of premiums due with respect to the DPCC coverage being requested as of the effective date.

Young Adult Dependent Signature: Date: __ / __ / __

I, as the MBF member, understand that any person who knowingly and with intent to defraud any insurance company or other persons who file an application for insurance or statement of claims containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime.

MBF Member Signature: Date: __ / __ / __

MBF Certification (For Office Use Only)

Coverage (CHECK ONE)	☐ SMMP, Dental and Vision Care	Certified by:	
	☐ Dental and Vision Care	Title:	
	☐ SMMP	Date Processed: __ / __ / __	
Monthly Premium Rate:	$	HealthPlex Group Number:	
Effective Date: __ / __ / __		End Date: __ / __ / __	

Print Form Clear Fields