SECTION A

FUND ELIGIBILITY AND MEMBERSHIP

A. FUND ELIGIBILITY AND MEMBERSHIP

The following section describes member and dependent eligibility requirements for inclusion in Fund benefit programs, the enrollment procedure, and the circumstances resulting in termination of Fund membership and benefit eligibility. While these requirements apply to overall Fund membership, any variations or additional requirements that relate to specific benefit plan eligibility are described within the appropriate benefit plan section of this booklet.

Please note that the Fund does not provide enrollment cards to members.

WHO IS ELIGIBLE TO ENROLL

Active Employees

May enroll for coverage if your:

- Position title is ineligible for collective bargaining and is approved by the New York City Department of Citywide Administrative Services for inclusion in the Fund; **and**
- Position duties are managerial/confidential; **and**
- Regular work schedule is at least 20 hours per week.

Retired Employees

May enroll for coverage if you:

- Retired after June 30, 1970 ("Retirement" means cessation of active City employment and eligibility for pension benefits and current receipt of pension payments from an approved retirement system); **and**
- Were eligible for coverage (in an eligible title) in the Fund at the time of retirement or at cessation of active employment pending receipt of deferred payment of retirement benefits; **and**
- Are currently eligible for coverage under the New York City Health Benefits Program or New York State Health Insurance Program; **and**
- Are included in the welfare fund contribution paid by the employing agency from which you retired.

WHEN COVERAGE BEGINS

Active Employees

On the date you are appointed to an approved title or on the date your title is approved for inclusion in the Fund.

Retired Employees

On the effective date of your retirement (the first day of the period covered by your initial pension check).

Deferred Retirees

On the effective date you become eligible for pension payments.

Eligible Dependents

Your Spouse:
Covered unless legally separated from you. An eligible spouse is covered on the same day your coverage begins. If you marry after you become a Fund member, your spouse's coverage commences on the date of your marriage provided the Fund receives the necessary official documentation within 31 days of the date of your marriage.

Your Domestic Partner:

Covered if approved as an eligible Domestic Partner by the City of New York Employee Health Benefits Program or New York State Health Insurance Program (either plan referred to as the "Basic Plan"). A qualified Domestic Partner is eligible for Fund Superimposed Major Medical, Dental, Vision Care, Health Club Reimbursement, and Survivor Benefits as described in those sections of this booklet.

Under Internal Revenue Service (IRS) rulings, if your domestic partner is not a dependent within the meaning of the Internal Revenue Code (IRC), the amount paid by the Fund attributable to coverage of a Fund member's domestic partner is treated as part of the Fund member's gross income from City employment for Federal tax purposes.

Consequently, unless you have indicated and provided proof to the City's Health Benefits Program and Fund that your domestic partner is your dependent, the Fund benefit must be included as income in your Federal tax return for the applicable year. State and local tax treatment of the amount in question will vary among jurisdictions.

You should consult the applicable laws and/or a tax professional to ascertain how the amount should be treated in your case.

A Domestic Partner is defined as a person of the same or opposite sex who:

- Shares your permanent residence;
- Has resided with you for no less than one year;
- Is no less than 18 years of age;
- Is not a blood relative any closer than would prohibit legal marriage; and
- Has signed a notarized affidavit, jointly with you, which can be made available to the Fund upon request.

In addition, you and your Domestic Partner will be considered to have met the terms of this definition as long as neither you nor your Domestic Partner:

- Has signed a Domestic Partner affidavit or declaration with any other person within six months prior to designating each other as Domestic Partners hereunder;
- Is currently legally married to another person; or
- Has any other Domestic Partner, spouse or spouse equivalent of the same or opposite sex.

You and your Domestic Partner must have registered as Domestic Partners, if you reside in a state that provides for such registration.

A qualified Domestic Partner becomes eligible on the date he or she is approved by the Basic Plan, provided that the Fund receives necessary documentation within 31 days of the date the member receives Basic Plan approval of Domestic Partner coverage. If the Fund receives a late request with documentation for the addition of a Domestic Partner, the effective date of coverage, if approved, is the date determined by the Fund.

Your Dependent Children (natural or adopted) to age 26 (Effective January 1, 2011):

Dependent Children include natural and adopted children, and children for whom you are the legal guardian. Please note that there are no financial dependency, residency, student status, or marital status requirements for dependent children.

Dependent children are covered on the same day your coverage begins, except a dependent child who is not your natural child, who is covered at the earliest of the following dates:

- Are currently eligible for coverage under the New York City Health Benefits Program or New York State Health Insurance Program.
- From and after the moment the child is placed in the physical custody of the member when a court of law accepts a consent to adopt and you enter into an agreement to support the child. However, coverage for the child's initial hospital stay is not provided if the natural parent has insurance coverage available for the child's care.
- When a court of law makes you legally responsible for the support and maintenance of the child.

If your child is unable to support himself/herself due to mental illness, developmental disability, mental retardation, or physical handicap when insurance would end due to the child's age, insurance may be continued. This continuation applies only to children continuously covered by the member's basic plan and continuously covered by the Fund prior to attainment of age 26. The Fund Office should be contacted to obtain the appropriate continuation of coverage form for completion by the member and physician at least 31 days before the date your child's insurance would normally end. The determination of approval or denial of coverage continuation for disabled dependents is made by the Fund's Administrator.

Your Unmarried Dependent Children age 26 through age 29:

Dependent coverage terminates at age 26. Coverage may be extended through age 29 under the Direct Pay Coverage Continuation (DPCC) Young Adult Dependent Program 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. MBF will charge a monthly premium based on the type of coverage that the Young Adult Dependent elects.

To be eligible for MBF DPCC, 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 or eligible for covered under employer sponsored health insurance
- Live, work or reside in New York State, or the health insurance, dental or vision care program service area

You must be an active MBF member in order for your Young Adult Dependent to be eligible for DPCC.

If you would like to enroll your Young Adult Dependent to receive DPCC, you must complete a DPCC Enrollment Form within 60 days following the date coverage would otherwise terminate due to age or within 60 days after meeting the definition of dependent child.

The DPCC Enrollment Form can be downloaded from the MBF Web site at www.nyc.gov/olr.

Dependents who are Employees

If any dependent is eligible for Fund benefits as an employee or retiree, that person is not eligible for coverage as a dependent. If both you and your spouse are covered for Fund benefits as employees or retirees, your children may only be enrolled as dependents of either you or your spouse subject to whose date of birth occurs earlier in a calendar year. If said dates of birth are the same, coverage would be provided by the person who has been covered for the longest time.

Changes in Dependent Status

If you acquire a dependent through marriage, domestic partnership, birth or adoption, or lose a dependent due to death, divorce, legal separation, or termination of domestic partnership, the Fund must be notified. Active employees should submit written notice of such changes to their personnel office along with the required documentation. Retirees should write to the Fund Office regarding any changes in dependent status and include the necessary documentation.

HOW TO ENROLL

Active Employees

You must complete and submit an “Application for Membership” (Form 1060) to your agency personnel office within 31 days of your appointment. Prompt submission of this application form is required. You must also complete and submit this form, with necessary documentation, when requesting addition or deletion of dependents, within 31 days of the date of the change in dependent status.

Retiring Employees

Your agency benefits office must submit a completed “Notice of Change/Termination of MBF Membership “ (Form 1061) directly to the Fund Office within 31 days of your retirement date, so that you will be enrolled for retiree Fund benefits. You must submit a completed “Application for Membership” (Form 1060) with necessary documentation when requesting addition or deletion of dependents (with the necessary documentation), within 31 days of the date of the change in dependent status.

Deferred Retirees

You must submit a completed “Membership Application for Reinstatement After Deferred Retirement” (Form 1063) to the Fund Office within 31 days of becoming pension payable, so that you will be reinstated for retiree Fund benefits.

WHEN COVERAGE TERMINATES

Active Employees or Retirees

Coverage ends for a member when any of the following events occur:

- You go off pay status and are not eligible for, or do not apply for, coverage as a retiree;
- You are appointed to a title which is eligible for collective bargaining;
- Your title is made eligible for collective bargaining (active employees only);
- The Group Policy ceases; or
- Your death. (See “Survivor Benefits,” Section H.)

Dependents

Coverage ends for dependents when any of the following events occur:

- The member's coverage ends or;
- A dependent no longer qualifies as an "eligible dependent"; or
- Your death.

Where applicable, special provisions for extension of benefits or conversion to private coverage are specified in the individual benefit sections of the booklet.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA) RIGHTS

THIS INFORMATION DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The New York City Management Benefits Fund (the "Plan") is required by law to take reasonable steps to ensure the privacy of your personally identifiable health information and to inform you about:

- The Plan's uses and disclosures of Protected Health Information (PHI);
- Your privacy rights with respect to your PHI;
- The Plan's duties with respect to your PHI;
- Your right to file a complaint with the Plan and to the Secretary of the U.S. Department of Health and Human Services; and
- The person or office to contact for further information about the Plan's privacy practices.

The term "Protected Health Information" (PHI) includes all individually identifiable health information transmitted or maintained by the Plan, regardless of form (oral, written, electronic).

1) You may request that the Plan restrict uses and disclosures of your PHI to carry out treatment, payment or health care operations, or to restrict uses and disclosures to family members, relatives, friends or other persons identified by you who are involved in your care. However, the Plan is not required to agree to your request.
2) You have a right to inspect and obtain a copy of your PHI contained in a "designated record set," for as long as the Plan maintains the PHI. "Designated Record Set" includes the medical records and billing records about individuals maintained by or for a covered health provider; enrollment, payment, billing, claims adjudication and case or medical management record systems maintained by or for a health plan; or other information used in whole or in part by or for the covered entity to make decisions about individuals. Information used for quality control or peer review analyses and not used to make decisions about individuals is not in the designated record set.
    - If access is denied, you or your personal representative will be provided with a written denial setting forth the basis for the denial, a description of how you may exercise those review rights and a description of how you may complain to the Secretary of the U.S. Department of Health and Human Services.
3) You have the right to request the Plan to amend your PHI or a record about you in a designated record set for as long as the PHI is maintained in the designated record set.
    - The Plan has 60 days after the request is made to act on the request. A single 30-day extension is allowed if the Plan is unable to comply with the deadline. If the request is denied in whole or in part, the Plan must provide you with a written denial that explains the basis for the denial. You or your personal representative may then submit a written statement disagreeing with the denial and have that statement included with any future disclosures of your PHI.
4) At your request, the Plan will also provide you with an accounting of disclosures by the Plan of your PHI during the six years prior to the date of your request. However, such accounting need not include PHI disclosures made: (1) to carry out treatment, payment or health care operations; (2) to individuals about their own PHI; (3) prior to the compliance date.
    - If the accounting cannot be provided within 60 days, an additional 30 days is allowed if the individual is given a written statement of the reasons for the delay and the date by which the accounting will be provided.
5) You may exercise your rights through a personal representative. Your personal representative will be required to produce evidence of his/her authority to act on your behalf before that person will be given access to your PHI or allowed to take any action for you. Proof of such authority may take one of the following forms:
    - A power of attorney for health care purposes, notarized by a notary public;
    - A court order of appointment of the person as the conservator or guardian of the individual; or
    - An individual who is the parent of a minor child.

The Plan retains the discretion to deny access to your PHI to a personal representative to provide protection to those vulnerable people who depend on others to exercise their rights under these rules and who may be subject to abuse or neglect. This also applies to personal representatives of minors.

If you believe that your privacy rights have been violated or would like to request any of the information as previously specified, you may contact the Plan in care of the following officer: MBF HIPAA Compliance Officer, 22 Cortlandt Street, 28th Floor, New York, N.Y. 10007.

You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services, Hubert H. Humphrey Building, 200 Independence Avenue S.W., Washington, D.C. 20201.

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    - If access is denied, you or your personal representative will be provided with a written denial setting forth the basis for the denial, a description of how you may exercise those review rights and a description of how you may complain to the Secretary of the U.S. Department of Health and Human Services.
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If you believe that your privacy rights have been violated or would like to request any of the information as previously specified, you may contact the Plan in care of the following officer: MBF HIPAA Compliance Officer, 40 Rector Street, 3rd Floor, New York, N.Y. 10006.

You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services, Hubert H. Humphrey Building, 200 Independence Avenue S.W., Washington, D.C. 20201.