Management Benefits Fund: Superimposed Major Medical Plan: Coverage Period: 1/01/15-12/31/15

Summary of Benefits and Coverage: What this Plan Covers & What it Costs.**Coverage for:** Ind/Spouse/DP/Family|**Plan Type:** Last Payer

Important Questions	Answers	Why this Matters:
What is the overall deductible?	With primary health and Rx coverage: **$500** individual; **$1,000** 2 individuals; **$1,500** 3+ individuals. Doesn't apply to preventive care	You must pay all the costs up to the annual **deductible** amount before this plan begins to pay for covered services you use. Check plan document to see what deductible level applies if you don't have primary or Rx coverage. See the plan chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	**No.**	You don't have to meet **deductibles** for specific services, but see the plan chart starting on page 2 for other costs for the services covered by this plan.
Is there an out–of–pocket limit on my expenses?	**Yes. $2,500**	The **out-of-pocket limit** is the most you could pay during the calendar year for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Balance billed charges; hearing aids & audiometric exams; adult wellness; health care that this plan doesn't cover; deductibles;.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	**No**	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as home health care visits.
Does this plan use a network of providers?	**No**	This plan treats providers the same in determining payment for services unless your primary plan requires the use of a network for all or certain services, then out of network services aren't covered under this plan. See services with notation **" * "** starting on page 2.
Do I need a referral to see a specialist?	**No. You don't need a referral to see a specialist.**	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	**Yes**	Some of the services this plan doesn't cover are listed on page 5. See your plan document for additional information about **excluded services**

OMB Control Numbers 1545-2229, 1210-0147, and 0938-1146

Corrected on May 11, 2012

Questions: Call 212-306-7290 or 1-888-4000MBF outside of NYC. or visit us at www.nyc.gov/mbf.
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- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 10% would be $100. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- Your cost sharing does not depend on whether a provider is in a network.

Common Medical Event	Services You May Need	Your Cost		Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	10% co-insurance		**If your primary plan requires the use of a network for all or certain services, then those out of network services are not covered under this plan. This applies to all services with the notation " • ".**
	Specialist visit	10% co-insurance		none, except see notation • above
	Other practitioner office visit	10% co-insurance		none, except see notation • above
	Preventive care/screening/immunization	0% co-insurance		Not subject to deductible; doesn't accumulate to out-of-pocket maximum. See the Adult Wellness benefit in your plan document for additional information. Also, See notation • above
If you have a test	Diagnostic test (x-ray, blood work)	10% co-insurance		none, except see notation • above
	Imaging (CT/PET scans, MRIs)	10% co-insurance		none, except see notation • above

Common Medical Event	Services You May Need	Your Cost		Limitations & Exceptions
If you need drugs to treat your illness or condition. More information about **prescription drug coverage** is available at www.nyc.gov/mbf	Generic drugs Preferred brand drugs Non-preferred brand drugs Specialty drugs	20% co-insurance		Benefits for all drugs for Medicare-eligible members, spouses & domestic partners covered under Medicare Part D who reach the catastrophic level of coverage, are limited to the 5% coinsurance not paid by Medicare, subject to the plan deductible. Drugs covered by Fund's dental plan or any other plan are not covered.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% co-insurance		None, except see notation * on page 2 .
	Physician/surgeon fees	10% co-insurance		None, except see notation * on page 2
If you need immediate medical attention	Emergency room services	10% co-insurance		None, except see notation * on page 2
	Emergency medical transportation	10% co-insurance		None, except see notation * on page 2
	Urgent care	10% co-insurance		None, except see notation * on page 2
If you have a hospital stay	Facility fee (e.g., hospital room)	10% co-insurance		None, except see notation * on page 2
	Physician/surgeon fee	10% co-insurance		None, except see notation * on page 2
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	10% co-insurance		None, except see notation * on page 2 .
	Mental/Behavioral health inpatient services	10% co-insurance		None, except see notation * on page 2
	Substance use disorder outpatient services	10% co-insurance		None, except see notation * on page 2
	Substance use disorder inpatient services	10% co-insurance		None, except see notation * on page 2
If you are pregnant	Prenatal and postnatal care	10% co-insurance		None, except see notation * on page 2
	Delivery and all inpatient services	10% co-insurance		None, except see notation * on page 2

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Common Medical Event	Services You May Need	Your Cost		Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	10% co-insurance		40 visits per cal. year, ordered by physician. 1visit = 4 hours of skilled home care. Also, see notation • on page 2
	Rehabilitation services	10% co-insurance		Up to 180 days per confinement in Extended Care facility/Skilled nursing care facility. See your policy or plan document for additional information. Also, see notation • on page 2
	Habilitation services			Covered.
	Skilled nursing care	10% co-insurance		Services of RN or LPN covered on inpatient basis when medically necessary. Also, see notation • on page 2
	Durable medical equipment	10% co-insurance		Covered for purchase or rental, at option of Plan. See your policy or plan document for additional information. Also, see notation • on page 2
	Hospice service	10% co-insurance		Covered when provided by certified hospice provider, if physician certifies life expectancy is six months or less. Also, see notation • on page 2
If your child needs dental or eye care	Eye exam			Not covered.
	Glasses			Not covered.
	Dental check-up			Not covered.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your plan document for other excluded services.)

- Cosmetic surgery
- Dental Care (adult or child) except for accidental injury to sound natural teeth
- Habilitation Services
- If the primary plan requires the use of a network for all or certain services, then this plan will not provide any coverage if those services are received out of network.
- Long Term Care
- Routine eye care and glasses (adult or child)
- Routine foot care

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Acupuncture, if medically necessary
- Bariatric surgery
- Chiropractic care, if medically necessary
- 1 hearing test & hearing aid per ear, within 24 month period, up to $1,500 per hearing aid
- Infertility treatment, & limited coverage for artificial insemination & in vitro fertilization
- Non-emergency care if traveling outside U.S.

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- Private duty nursing, if inpatient.
- Weight loss programs, when part of wellness benefit.

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.
For more information on your rights to continue coverage, contact the plan at 212-306-7290 or 1-888-4000MBF outside of NYC. or visit us at www.nyc.gov/mbf**.** You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

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Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: If your claim for benefits is denied in part or in whole, you may call the administrator for the SMMP, Administrative Services Only, Inc. (ASO), at 1-877-844-SMMP(7667) to discuss the denial before requesting a formal appeal. If ASO cannot resolve the issue to your satisfaction over the phone, you have the right to file a written formal appeal. When filing the appeal, please provide ASO with the reason you believe the claim was improperly denied and submit documentation, questions or comments you deem appropriate to the following address: ASO, P.O. Box 9009, Lynbrook, NY 11563-9009. ASO will conduct a full and fair review of your appeal. ASO has one hundred eighty (180) days to review the appeal, investigate, and make a determination, subject to information and HIPAA authorizations being received. If necessary, you will then have an additional thirty (30) days to appeal to the Management Benefits Fund regarding this decision.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame Administrator ASO, al 1-877-844-SMMP(7667)

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans. **This Plan pays after all other Plans have paid. These examples assume $7,540 and $5,400 are balances owed to providers after primary plan payments were made.**

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different. See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540.
- **Plan pays** $6,320
- **Patient pays** $1,220

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$500
Copays	$0
Coinsurance – medical 10% Coinsurance – prescriptions 20%	$680 $40
Limits or exclusions	$0
Total	**$1,220**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $4,120
- **Patient pays** $1,280

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$500
Copays	$0
Coinsurance, medical –10% Coinsurance, prescription – 20%	$200 $580
Limits or exclusions	$0
Total	**$1,280**

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Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs might have been higher.

This is a Last Payer Plan. The examples on the prior page assume the amounts owed to providers are balances owed after primary plan payments were made. They are not useful to compare to costs of other primary plans, or to HRAs or FSAs.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

This plan does not require a premium contribution from the participant.

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