The City of New York
Management Benefits Fund
Benefits Booklet

Office of Labor Relations

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Last updated May 2025

GENERAL INFORMATION

ABOUT THE MANAGEMENT BENEFITS FUND

Your membership in the Management Benefits Fund ("MBF") offers you and your eligible dependents supplemental benefits in addition to your Citywide employee benefits. All benefits, with the exception of Group Universal Life Insurance, are fully paid for by MBF.

MBF is administered by the City of New York ("City") Office of Labor Relations ("OLR"). An Advisory Board appointed by the Mayor makes recommendations to the Mayor on benefits and policy. The Advisory Board is chaired by the Commissioner of OLR. A Director is responsible for providing day-to-day management of MBF operations and recommends appropriate improvements. Continuing efforts are made to ensure that City contributions to MBF provide responsive and meaningful benefits to members and their eligible dependents. MBF's benefits are maintained for the exclusive benefit of MBF members and their eligible dependents and are intended to be continued for an indefinite period. However, the City maintains the right to amend or terminate any benefit as is deemed necessary.

ADVISORY BOARD

Mayor
Comptroller of the City of New York
Corporation Counsel
Commissioner, Office of Labor Relations (Chair)
Director, Office of Management and Budget
Commissioner, Citywide Administrative Services
President, NYC Health + Hospitals

CONTACTING MBF

22 Cortlandt Street, 28th Floor
New York, N.Y. 10007

Telephone: 1-212-306-7290
1-888-4000-MBF (1-888-400-0623) - Outside N.Y.C. only

Website: nyc.gov/mbf

EMAILING MBF

You may send questions via e-mail through the MBF website at nyc.gov/mbf.

SUBMITTING FORMS ELECTRONICALLY

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

IMPORTANT

MBF frequently updates its benefits. Therefore, we suggest that you visit our website at nyc.gov/mbf on a regular basis to obtain the latest benefits information.

BENEFITS AVAILABLE TO ACTIVE AND RETIRED MEMBERS

BENEFIT	ACTIVE	RETIREE
Basic Life Insurance	✓	✓ ($5,000, regardless of age)
AD&D	✓	✗
GUL*	✓ Via payroll	✓ Direct bill
Identity Theft Restoration Services	✓	✓
LTD	✓	✗
SMMP	✓	✓
Dental	✓	✓
Vision	✓	✓
Health & Fitness Reimbursement	✓ Via payroll	✓ Direct Deposit
Retiree Drug Benefits	✗	✓
Survivor Benefits	✓	✓

*Group Universal Life (GUL) is an optional benefit paid for by the member. MBF members can only enroll in GUL while active. Once retired, GUL premiums will switch from payroll deductions to direct bill.

MBF ELIGIBILITY AND MEMBERSHIP

The following section describes eligibility requirements for MBF in order to receive the various MBF benefits and how to enroll. The section also covers when MBF coverage terminates.

WHO IS ELIGIBLE TO ENROLL

For Active Employees

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

*Participating Employers: City University of New York, NYC Health + Hospitals, New York City School Construction Authority, Queensborough Public Library, Brooklyn Public Library, and certain Cultural Institutions.

For Retired Employees/Deferred Retirees

- Retired after June 30, 1970 ("Retirement" means cessation of active City or Participating Employer 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 MBF 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 the closed Unified Court System judges group covered under the New York State Health Insurance Program; and
- Are included in the welfare fund contributions paid by the employing agency from which they retired.

WHEN COVERAGE BEGINS

For Active Employees

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

For Retired Employees

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

For Deferred Retirees

On the effective date you become eligible for pension payments.

For Eligible Dependents

Your Spouse

Your spouse is covered under MBF on the same day your coverage begins. If you marry after you become an MBF member, your spouse's coverage commences on the date of your marriage, provided

MBF receives a government-issued marriage certificate within 31 days after the date of your marriage. An ex-spouse is not eligible for coverage.

Your Domestic Partner

An eligible Domestic Partner is covered on the same day your coverage begins. If you register as Domestic Partners after you become an MBF member, your Domestic Partner's coverage commences on the date your Domestic Partnership begins, provided MBF receives the government-issued Certificate of Domestic Partnership and a Domestic Partner Confirmation Letter from the City of New York Employee Health Benefits Program or New York State Health Insurance Program (either plan referred to as the "Basic Plan"), within 31 days of the date of your Domestic Partnership.

A qualified Domestic Partner is eligible for all MBF benefits as described in this booklet.

IMPORTANT NOTES: Tax Liability of MBF SMMP Benefit for Domestic Partners

You should be aware that, under IRS rulings, if your domestic partner is not a "dependent" within the meaning of the Internal Revenue Code, the amount paid by an employer attributable to coverage of a domestic partner is treated as part of the participant's gross income for federal tax purposes. Consequently, unless you have indicated and provided proof to the MBF (e.g. a copy of a recent tax return) that your domestic partner is your dependent, the value of the MBF SMMP benefit must be included as income on 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.

Your Dependent Children (natural or adopted) to Age 26

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 or their date of birth, whichever is later. For a dependent child who is not your natural child, coverage begins at the earliest of the following dates:

- When they are eligible for coverage under the New York City Health Benefits Program or New York State Health Insurance Program,
- From the moment the child is placed in your physical custody when a court of law accepts a consent to adopt and you enter into an agreement to support the child, or
- When a court of law makes you legally responsible for the support and maintenance of the child (Qualified Medical Child Support Order).

Continuation of Your Disabled Dependent Child's Coverage Over Age 26

If your child is unable to support himself/herself due to mental illness, developmental disability, or physical disability when insurance would otherwise end due to the child's age and they are certified as a disabled dependent by the City's Basic Plan or their non-City primary health insurance, MBF benefits may be continued. This continuation applies only to children continuously covered by the member's

Basic Plan or their non-City primary health plan, and continuously covered by MBF prior to attainment of age 26. Contact the MBF Office and provide the proof of disability that was approved by your health plan at least 31 days before the date the dependents reached age 26.

Your Unmarried Dependent Children Age 26 through Age 29

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

The available coverages are:

- Superimposed Major Medical Plan (SMMP), and Dental & Vision Care Programs,
- Dental & Vision Care Programs only, or
- SMMP only

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

1. Be unmarried,
2. Be 29 years of age or younger,
3. Not be covered by Medicare nor eligible for coverage under employer-sponsored health insurance, AND
4. Must reside or work in New York State, or the health insurance, dental or vision care program service area.

You must be an enrolled MBF member for your Young Adult Dependent to be eligible for DPCC.

If you would like to enroll your Young Adult Dependent in DPCC, you must complete a DPCC Enrollment Form within 60 days of 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 website at nyc.gov/mbf.

Dependents who are City Employees

If any dependent is eligible for MBF benefits as an employee or retiree, that person is not eligible for coverage as a dependent. Double coverage is not allowed since no person can be covered under MBF as an active member and a dependent at the same time.

If both you and your spouse are covered for MBF 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

You should notify MBF if you are adding or dropping a dependent due to a life event such as birth, adoption, marriage/domestic partnership, divorce, or death of a dependent, etc. Active employees

should submit the MBF form and legal documentation to their agency HR. Retirees should write to the MBF Office regarding any changes in dependent status and include the necessary documentation.

You may need to submit appropriate documentation to the City's Health Benefits Program in order to add/change your dependents with your Basic Plan.

HOW TO ENROLL

For Active Employees

You must complete an "Application for Membership" (Form 1060) which should be obtained from and submitted to your agency HR office, along with legal documentation, e.g. marriage certificate, birth certificate, or proof of domestic partnership.

For Retiring Employees

Your agency HR office will submit a "Notice of Change/Termination of MBF Membership" (Form 1061) directly to MBF when you are retiring so that you may transition to retiree status in MBF. MBF will also confirm your pension eligibility with NYCERS. If you are enrolled in a different pension system, then you must provide a pension eligibility statement/letter from your pension system.

If you are adding or removing dependents at the time of your retirement, then you must submit a completed Form 1060 with the legal documentation. MBF Retirees may also add/remove dependents at any time, provided they submit an MBF Form 1060 with the legal documentation.

For Deferred Retirees

You must submit a completed "Membership Application for Reinstatement After Deferred Retirement" (Form 1063) along with a pension confirmation letter to MBF within 31 days of becoming pension payable, so that you can be reinstated for retiree MBF benefits. You must request the form from MBF. MBF Deferred Retirees may also add/remove dependents at any time, provided they submit an MBF Form 1060 and legal documentation.

Member ID Cards

Please note that MBF does not issue MBF member ID cards to members. However, MBF members can obtain ID cards from certain MBF benefit providers, if applicable.

WHEN COVERAGE TERMINATES

For Active Employees or Retirees

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

Your last day of employment with the City 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);
- Your death (see Survivor Benefits), OR
- The Group Policy ceases.

For Dependents

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

The member's coverage ends.

A dependent no longer qualifies as an "eligible dependent":

for a spouse, when divorced or legally separated from an employee or retiree.

for a domestic partner, when domestic partnership terminates.

for dependent children (other than eligible disabled children or through DPCC) at the end of the month in which the child reaches age 26.

Upon the death of the member.

Please keep in mind that if a domestic partner is no longer covered as a dependent, the MBF member is no longer responsible for any tax consequences relating to the domestic partnership, as long as MBF is notified that any of the above life events occurred.

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

BASIC LIFE INSURANCE, ACCIDENTAL DEATH & DISMEMBERMENT AND IDENTITY THEFT RESOURCES

This section provides a general description of the Basic Life Insurance plan, Accidental Death & Dismemberment (AD&D) insurance benefit, and identity theft resources, which is fully paid for by MBF at no cost to the member. This benefit is only available to members, and not their dependents. MBF provides members only (no coverage is provided for dependents) with Basic Life Insurance and AD&D Insurance, which is fully paid for by MBF. This coverage is underwritten by The Prudential Insurance Company of America, Prudential Plaza, Newark, N.J. 07102.

The purpose of this section is to provide a general description of the Basic Life Insurance plan underwritten by the Prudential Insurance Group of America, Prudential Plaza, N.J. 07102. This description does not replace the Group insurance Certificate issued by Prudential. If a conflict should arise between this booklet and the terms of the Certificate, or if any provision is not covered or only partially covered here, the Certificate will govern in all cases.

The current claims administrator: The Prudential Insurance Company of America.

BASIC LIFE INSURANCE

COVERAGE

For Active Members:

- Under age 65: Coverage amount is 1x your annual salary (rounded to the next higher $1,000), subject to a minimum of $15,000 and a maximum of $50,000.
- Ages 65-69: Coverage amount is 66 2/3% of your annual salary (rounded to the next higher $1,000), subject to a minimum of $10,000 and a maximum of $34,000.
- Age 70+: Coverage amount is 50% of your annual salary amount (rounded to the next higher $1,000), subject to a minimum of $7,500 and a maximum of $25,000.

For Retired Members:

Coverage is $5,000, regardless of age.

Basic Life Insurance Protection While Approved for Benefits under MBF Long-Term Disability

If, while insured as an active employee, you become Totally Disabled (approved for benefits under MBF Long-Term Disability) before you reach age 60, MBF will continue your Basic Life Insurance protection as long as you remain Totally Disabled, even if on disability retirement.

If, while insured as an active employee, you become Totally Disabled on or after age 60, your Basic Life Insurance protection can be continued for up to one year. After this time, you have the option to convert to an individual policy. Please contact Prudential at 877-889-2070.

The term “Total Disability” means that during the first 24 months of benefits, you are unable, due to sickness or accidental bodily injury, to perform the material and substantial duties of your occupation. Thereafter, the term means you are unable to perform the material and substantial duties of any occupation for which you are reasonably fitted by education, training or experience. To be considered

Totally Disabled, you must be under the regular care of a doctor and not working at any job for wage or profit.

If you first became entitled to this benefit after October 1, 1992 but prior to January 1, 2000, your Basic Life Insurance will be continued at $15,000 to age 65 at which time it will be reduced to $10,000 and it will be further reduced to $5,000 when you reach age 70, as if you had remained actively at work until age 70 and had retired at that age under the Program in force at the time of your disabling event.

BENEFICIARY

The beneficiary(ies) for your Basic Life insurance means the individual(s) or entity selected by you on the MBF Form 1060 to receive the insurance benefits. You may change your beneficiary at any time by completing MBF Form 1060, which can be obtained from your agency HR office, if you are an active employee. If you are a retiree, please contact MBF directly to obtain the beneficiary change form. The beneficiary change is effective on the date the form is signed by the MBF member provided it is received by MBF before the claim is paid.

If there is a beneficiary for the insurance, it is payable to the named beneficiary. It is your responsibility to ensure that your beneficiary information is up-to-date with MBF. After your death, your beneficiary may name an individual or entity (such as a funeral home) to receive any amount payable to him or her.

If there is more than one beneficiary but the beneficiary form does not specify their shares, they will share equally. If a beneficiary dies before you, that beneficiary's interest will end. It will be shared equally by any remaining beneficiaries, unless the beneficiary form states otherwise.

If there is no surviving beneficiary at the time of your death, then the insurance proceeds will be paid as follows: (a) surviving spouse; (b) surviving children in equal shares; (c) surviving parents in equal shares; or (d) surviving brothers and sisters in equal shares. If none survives, it will be paid in a lump sum to your Estate.

If you die after having applied to convert your Group Basic Life Insurance to Individual Life Insurance, the beneficiary named under the Individual Policy or on the application for it will receive any benefits payable under the Group Basic Life Policy.

If a minor beneficiary has no legal guardian, the minor's share may be paid to the adult or adults who, as determined by Prudential, have assumed the custody and support of the minor, and according to the state statutes governing payment to minors.

AD&D INSURANCE

COVERAGE

For Active Members Only:

Coverage amounts are equal to the Basic Life Insurance coverage amount described above.

General Provisions

Payment of Benefits

- Basic Life Insurance: If you die while insured, the amount of your Basic Life Insurance is payable to your beneficiary.
- AD&D Insurance: If you receive a bodily injury covered by the terms of the policy and have any of the losses named in the Table of Losses for AD&D Insurance below, benefits are payable as shown in the table. The loss must: (a) occur while you are a covered person; (b) result directly from that injury and from no other cause; and (c) occur within 90 days after sustaining the injury. Please note, for any of the plegias (see below for definition), the loss must occur within 365 days of the injury. All benefits other than for loss of life will be paid to you. Benefits for loss of life will be paid to your beneficiary. You may change your beneficiary at any time. This AD&D policy provides ACCIDENT insurance only. It does not provide basic hospital, basic medical or major medical insurance as defined by the New York Insurance Department.

Definitions of Accidental Loss

Accidental Loss means your:

- Loss of life;
- Total and permanent Loss of Sight;
- Total and permanent Loss of Speech;
- Permanent loss of hand or foot by severance at or above the wrist or ankle;
- Total and permanent loss of hearing in both ears;
- Loss of thumb and index finger of the same hand by severance at or above the metacarpophalangeal joint;
- Loss of hand or foot means loss by cutting off at or above the wrist or ankle joint. Loss of sight means total loss that cannot be recovered.
- Loss due to Quadriplegia, Paraplegia or Hemiplegia.

Definitions of Plegias

- Quadriplegia means the total and permanent paralysis of both upper and both lower limbs.
- Paraplegia means the total and permanent paralysis of both lower limbs.
- Hemiplegia means the total and permanent paralysis of the upper and lower limbs on one side of the body.

Table of Losses for AD&D Insurance

1. The full amount of AD&D Insurance is paid for loss of:
    - Life;
    - Both hands or both feet;
    - Sight of both eyes;
    - Any two or more: one foot, one hand, sight of one eye;
    - Total and permanent loss of speech and hearing in both ears;
    - Quadriplegia (complete and irreversible paralysis of both upper and lower limbs).

2. Three-quarters of the amount of AD&D Insurance is paid for:
    - Paraplegia (complete and irreversible paralysis of both lower limbs).
3. One-half the amount of AD&D Insurance is paid for loss of:
    - One hand;
    - One foot;
    - Sight of one eye;
    - Hearing in both ears;
    - Speech; or
    - Hemiplegia (complete and irreversible paralysis of the upper and lower limbs on one side of the body).
4. One-quarter of the amount of AD&D Insurance is paid for:
    - Loss of thumb and index finger of the same hand by severance at or above the metacarpophalageal joint.

Additional Benefits Related to Losses

An amount equal to the lesser of 10% of your Amount of Insurance and $10,000 of AD&D Insurance is paid for loss of life in a four-wheel vehicle while using a seatbelt. Additionally, an amount equal to the lesser of 10% of your Amount of Insurance and $10,000 of AD&D Insurance is paid for loss of life in a four-wheel vehicle while using a supplemental restraint system.

An amount equal to the lesser of the actual cost charged for counseling sessions and $150 of AD&D Insurance is paid for up to 52 weeks if you require bereavement and trauma counseling sessions because you suffer an accidental loss.

An amount equal to the lesser of 10% of your Amount of Insurance and $500 of AD&D Insurance is paid for rehabilitation expense if you suffer an accidental loss and a doctor determines that rehabilitation is necessary.

An amount equal to the lesser of 100% of your Amount of Insurance and $50,000 of AD&D Insurance is paid for your loss of life if you sustain an accidental injury resulting in the accidental loss while you are boarding, leaving, or riding as a passenger on a Common Carrier.

No more than your amount of insurance under this coverage will be paid for all losses resulting from injuries sustained in the same accident. Payment will be made only for the loss that results from the accident without regard to any former loss.

Limitations (AD&D Insurance)

AD&D Insurance does not cover loss due to:

- Suicide or attempted suicide;
- Intentionally self-inflicted injuries;
- Participation in any riot or insurrection;
- War or certain military duties;
- Aviation (including getting in, out, on or off any vehicle used for aerial navigation), This does not include an Accidental Loss if: (a) it results from aviation as a fare-paying passenger on a scheduled or charter flight operated by a scheduled airline, or (b) you are riding as a passenger in an aircraft

owned, operated, controlled or leased by or on behalf of the Contract Holder or any of its subsidiaries or affiliates;

- Participation in a felony;
- Legal intoxication; or
- Participation in certain hazardous sports.

ASSIGNMENT OF BASIC LIFE INSURANCE AND AD&D INSURANCE

Please be advised that you have the option to assign your Basic Life Insurance and AD&D Insurance. Keep in mind that when you assign your insurance policy, any rights, benefits or privileges that you have as an Employee may be assigned without restriction. Assignments can be made as gifts, but not for collateral. Should you wish to assign your insurance coverage, please contact MBF at 1-212-306-7290.

BASIC LIFE INSURANCE AND AD&D CLAIMS PROCESS

Notifications of an MBF member's death should be reported to MBF. MBF will send the applicable claim form to the designated beneficiary on file. The claim form for both the Basic Life Insurance and AD&D Insurance, along with a copy of the MBF member's death certificate, should be submitted electronically to MBF via the following link:

https://nyc-mbf.leapfile.net

APPEAL OF DENIED BASIC LIFE OR AD&D CLAIMS

If you are not satisfied with the resolution of your claim and you feel your claim for AD&D or your beneficiary's claim for Basic Life has been improperly denied, you or your beneficiary or estate may submit the issues and comments in writing relating to the claim denial that you are appealing to Prudential at the following address:

Prudential Insurance Company of America
Group Life Claim Operations
P.O. Box 8517, Philadelphia, PA 19176

You must submit your appeal within 180 days after you receive notification that your claim has been denied. Prudential will review the appeal within 45 days, with two additional 45-day periods if necessary. If you have any questions regarding your claims, please contact Prudential at 1-800-524-0542.

CONVERSION PRIVILEGE

If your Basic Life Insurance coverage is reduced or terminated, protection will continue for 31 days. During this time, you may choose one of the following options:

- **Purchase** an Individual Policy through Prudential **with** proof of good health, or
- **Convert** your Group Basic Life Policy to an Individual Policy through Prudential **without** proof of good health.

For information, please contact Prudential at 1-877-889-2070.

Please be advised that there are no conversion rights or individual policies available for AD&D Insurance.

IDENTITY THEFT RESOURCES

Effective January 1, 2024, an identity theft resource, called IDResources, is available to you and your eligible dependents through ComPsych, a company partnering with Prudential, at no cost to you.

Unlike credit monitoring services that merely alert customers after an information breach has already occurred, this benefit provides you with comprehensive identity restoration benefits if you experience identify theft. ComPsych will be able to assist you with legal, financial, and other issues that arise as a result of identity theft.

Included in this benefit are the following services to restore credit and recover from identity theft:

- assistance navigating the identity restoration process,
- notifying creditors and banks,
- completing and submitting appropriate documentation to credit card companies and credit reporting agencies, etc.
- unlimited telephonic legal assistance,
- step-by-step guidance from a staff attorney to help complete the restoration process, and
- limited power of attorney that allows a staff attorney to complete the restoration process on the victim's behalf.

To obtain additional information on or to utilize this benefit, please contact ComPsych directly at 1-800-311-4327, or at (TTY) 1-800-697-0353 if hearing impaired.

GROUP UNIVERSAL LIFE (GUL) INSURANCE

This section provides a general description of the Group Universal Life voluntary insurance plan, which is fully paid for by the MBF member. This benefit is only available to members, and their eligible dependents. All benefits and coverages described in this booklet are subject to the terms of the Group Contract (under which the benefits are provided). If there is any conflict between this booklet and the Group Contract, the Group Contract will always govern.

Current claims administrator: The Prudential Insurance Company of America

ELIGIBILITY

MEMBER

In order to enroll, you must be:

- an active employee,
- an eligible member of MBF, and
- actively at work, working at least 20 hours per week when your coverage takes effect under GUL.
    - Actively at work means actively at work at the employer's place of business, or any other place that the employer's business requires you to go.
    - If you are not actively at work on the day your insurance would normally begin, you will be insured on the day you are actively at work.
    - You are considered actively at work during normal vacation if you were actively at work on your last regular scheduled workday.

SPOUSE/DOMESTIC PARTNER

In order to enroll your spouse/domestic partner in GUL:

- You must be enrolled in GUL, since the member is the owner of the coverage,
- The spouse/domestic partner must be enrolled in MBF as a dependent, and
- The spouse/domestic partner must not be confined for medical care or treatment at home or elsewhere on the effective date of the coverage.

DEPENDENT CHILDREN

In order to enroll your dependent child(ren):

- You must be enrolled in GUL, since the member is the owner of the coverage,
- The dependent child(ren) must be enrolled in MBF as dependents,
- The child(ren) must be at least 15 days old to 26 years of age, and
- The child(ren) must not be confined to a hospital on the effective date of the coverage.

Coverage for a child may be continued beyond the limiting age of 26 if the child otherwise meets the definition of a dependent child and is mentally or physically incapable of earning a living on the day coverage would otherwise end. Coverage is subject to proof of continuing incapacitation, which Prudential may request periodically.

A child placed with you for adoption prior to legal adoption is considered your Qualified Dependent from the date of placement for adoption, and is treated as though the child were a newborn child born to you. Your children also include each of your stepchildren, provided the stepchild's biological parent(s) has given written consent

Each child has the option to convert his/her elected child coverage amount to an individual life insurance policy within 31 days of when the child no longer satisfies the definition for eligibility.

GUL ENROLLMENT

NEW MBF MEMBERS

Upon enrollment in MBF, you will receive a letter from Prudential with a link to the Prudential GUL enrollment site and instructions on how to enroll in GUL. You will have 90 days to complete the GUL enrollment process, without having to complete medical evidence of insurability (EOI), up to the guaranteed issue coverage amount. If you enroll in GUL beyond 90 days, then you will be subject to medical EOI.

CURRENT MBF MEMBERS

For current MBF members who are not participating in GUL:

- Contact Prudential at 800-562-9874 to obtain a form to enroll and you will be required to complete medical EOI.

For current MBF members who are participating in GUL and want to make a change/addition:

- You must call Prudential at 800-562-9874 to obtain a form to add coverage for your covered dependents or change your GUL coverage amount. You may be required to complete medical EOI.

Note: If a member transfers to a new agency in an MBF-eligible title and they are presently enrolled in GUL, the member must complete an MBF Form 1060 (obtained from their new agency HR) and submit it to their HR representative at their new agency who will forward the form to MBF to update their record and ensure that GUL payroll deductions continue under the new agency. Failure to do so may result in a lapse in coverage.

EFFECTIVE DATE OF COVERAGE

Prudential will provide notification of the effective date of coverage. Generally, coverage is effective on the first day of the month following approval of the application:

1. For amounts up to the guaranteed amounts,
2. For amounts over the guaranteed amounts, with satisfactory Medical EOI, and
3. If received within 90 days of the member and/or spouse/Domestic Partner/dependent satisfying eligibility requirements.

"Guaranteed amounts" refers to coverage that is offered without medical EOI.

If a member is not actively at work when coverage would otherwise begin, the effective date of coverage would be deferred until the member returns to active work.

If a member leaves active employment on Disability or approved Leave of Absence, and then returns to an MBF-eligible position at a later date, the member is not treated as a new member for the purposes of GUL coverage.

If a member had GUL coverage before the leave, the member is entitled to continue the same amount of coverage on payroll deduction upon return from leave, as long as the member continued to pay premiums during the leave on a direct bill basis, so that coverage remained in effect. If premiums are not paid during the leave and, as a result the coverage lapses, the member may be subject to medical EOI if reinstatement of coverage to the amount previously in effect is allowable. In either case, any requests for additional coverage amounts will be subject to medical EOI.

If a member had no GUL coverage and leaves active employment due to Disability or approved Leave of Absence, when the member returns from leave, he/she will be subject to medical EOI for the full amount of coverage applied for.

COVERAGE OPTIONS FOR THE MEMBER

- You may enroll for one of the following life insurance options:
  a) Multiple of Salary: Either 1, 2, 3, 4, 5, 6, 7 or 8 times annual salary* rounded to the next higher $1,000. This option allows automatic annual increases in coverage without medical EOI when salary increases.
  b) Increments of $10,000 up to $100,000: With this option, you will not be eligible for automatic increases in coverage as your annual salary* increases.
- The minimum coverage for any member is $10,000.
- The maximum coverage for any member is the lesser of 8 times annual salary or $1,000,000.
- If you have not smoked or used any form of tobacco for 12 consecutive months prior to applying for coverage, you qualify for a lower non-smoker rate.

Please refer to the rate charts below.

*Annual salary means basic yearly salary excluding overtime, bonuses, or other special compensation.

EVIDENCE OF INSURABILITY (EOI)

If you are eligible as a member for the first time and enrolled within 90 days of becoming eligible, there are no EOI requirements for amounts of insurance up to the guaranteed amount of the lesser of 3 times your annual salary* or $500,000. For coverage beyond that amount, you must satisfy the medical EOI requirements of Prudential.

If you enroll beyond 90 days after your initial eligibility date, you must provide medical EOI to Prudential regardless of the amount of insurance being requested. Medical EOI refers to the completion of a statement of health form, which is reviewed and approved by Prudential before coverage is issued. In certain instances, additional medical information and/or medical exam may be required, at the member's expense.

COVERAGE INCREASE OPPORTUNITY FOR THE MEMBER

Salary Increase

If you experienced a salary increase as of November 15 of the previous year, your coverage will automatically increase on January 1 of the following year, subject to the program maximum, without medical EOI. Your premium cost will also be adjusted to reflect any coverage increases. You must have elected coverage in a multiple of your annual salary (not an increment of $10,000) and be actively at work on the effective date to qualify for this automatic increase.

Special Annual Enrollment Period

You will have an opportunity each year to increase your coverage by one $10,000 increment (if you are in the incremental plan) or 1x your annual salary, up to the guaranteed amount of the lesser of 3x salary or $500,000 without EOI. If you are eligible to participate in this Special Annual Enrollment Period, you will receive an enrollment form from Prudential and you must apply within the special annual enrollment period and be actively at work on the effective date of coverage.

Coverage Amount Increase with EOI

If you are an active member, you may increase your coverage at any time, subject to EOI, up to the maximum allowable limit by requesting an enrollment/change form from Prudential by contacting Prudential at 800-562-9874.

COVERAGE AMOUNTS FOR THE MEMBER'S SPOUSE/DOMESTIC PARTNER

- Coverage is available in $10,000 increments up to $100,000. It is also available for $120,000, $150,000, $200,000 or $250,000.
- Minimum coverage: $10,000 and Maximum coverage: up to the lesser of 5x member's salary or $250,000.
- A spouse/Domestic Partner age 64 or under can be covered for up to $30,000 without EOI if enrolled within 90 days of the member's eligibility date or within 90 days of the date he/she becomes an eligible spouse/Domestic Partner.
- A spouse/Domestic Partner age 65 or older must submit EOI regardless of the amount of coverage.

COVERAGE FOR DEPENDENT CHILDREN

Coverage is available in flat amounts of $10,000, $15,000, or $20,000 for each dependent child between the ages of 15 days to 26 years regardless of the number of children in the family. No EOI is required.

DESIGNATING BENEFICIARY(IES)

You must name a beneficiary, other than yourself, when you enroll in GUL. You may designate one or more primary beneficiary(ies), however, the total percentage for your primary beneficiaries must equal 100%. You may also designate one or more contingent beneficiary(ies) and the total percentage for your contingent beneficiaries must equal 100%.

Your GUL coverage amount will be paid in the following order:

1. To your surviving primary beneficiary(ies).
2. If there are no surviving primary beneficiaries, to your surviving contingent beneficiary(ies).
3. If there are no surviving primary/contingent beneficiaries or if there is no beneficiary designation in effect at the time of death, then in accordance with the Group Certificate.

Please note that you may change your beneficiary designation at any time by visiting the Prudential website at https://www.prudential.com/gulgvul.

COVERAGE FOR RETIREES

If your status changes from active to retiree, you can keep your entire coverage in force at the group retiree rates as long as you continue paying premiums via direct bill. MBF will notify Prudential of your change in status and Prudential will direct bill you. Please refer to the retiree rate chart below.

Note: The GUL face amount of the coverage will end at the end of the year that the MBF member attains age 99, and premiums will no longer be due. The death benefit would be equal to balance of the CAF, if any, less any loan and any interest due on the loan and any past due monthly charges.

COVERAGE FOR DEFERRED RETIREES

If you are returning to MBF as a deferred retiree and you continued paying GUL premiums while you were terminated from MBF, then you may continue your coverage as a deferred retiree, subject to the retiree group rates. MBF will notify Prudential of your change in status and Prudential will direct bill you at the retiree group rate. Please refer to the retiree rate chart below.

GROUP UNIVERSAL LIFE RATE CHART
CITY OF NEW YORK MANAGEMENT BENEFITS FUND
ISSUED BY THE LIFE INSURANCE CARRIER

Rates Effective January 1, 2025 - GUL (Member and Spouse/Domestic Partner)**
Monthly Rates per $1,000 of Coverage

(Biweekly Deduction Amount = Rate x Amount Coverage ÷ 1,000 x 12 ÷ 26)

Active Members and Members on Leave of Absence Monthly Cost of Insurance*			
Age	**Non-Smoker Member**	**Smoker Member**	**Spouse/Domestic Partner****
20-29	$0.039	$0.045	$0.030
30-34	$0.043	$0.052	$0.035
34-39	$0.054	$0.058	$0.057
40-44	$0.071	$0.079	$0.083
45-49	$0.101	$0.117	$0.140
50-54	$0.164	$0.192	$0.201
55-59	$0.241	$0.288	$0.314
60-64	$0.401	$0.482	$0.436
65-69	$0.696	$0.824	$0.602
70-74	$0.839	$1.078	$1.081
75-79	$1.058	$1.382	$1.391
80-84	$2.310	$2.796	$2.974
85-89	$3.609	$4.347	$5.037
90-94	$5.159	$6.235	$7.315
95-99	$6.859	$8.295	$9.713
Dependent Term Life Child(ren) - Monthly Rates per $10,000 of Coverage			
Cost of Insurance		$0.240	

*Rates are subject to change pursuant to proper notice

**Spouse/Domestic Partner rates will change based on spouse's/domestic partner's age. Rates will change based on the above age schedule and rates may change if the plan experience requires a change for all insurers.

Retired Members Monthly Cost of Insurance*			
Age	**Non-Smoker Member**	**Smoker Member**	**Spouse/Domestic Partner****
20-29	$0.070	$0.082	$0.044
30-34	$0.078	$0.094	$0.051
34-39	$0.097	$0.105	$0.082
40-44	$0.129	$0.143	$0.120
45-49	$0.183	$0.212	$0.202
50-54	$0.296	$0.349	$0.291
55-59	$0.437	$0.522	$0.453
60-64	$0.727	$0.872	$0.629
65-69	$1.260	$1.493	$0.869
70-74	$1.519	$1.953	$1.561
75-79	$1.916	$2.502	$2.008
80-84	$4.184	$5.065	$4.293
85-89	$6.539	$7.874	$7.270
90-94	$9.345	$11.295	$10.558
95-99	$12.424	$15.026	$14.019
Dependent Term Life Child(ren) - Monthly Rates per $10,000 of Coverage			
Cost of Insurance		$0.340	

*Rates are subject to change pursuant to proper notice.

**Spouse/Domestic Partner rates will change based on spouse's/domestic partner's age. Rates will change based on the above age schedule and rates may change if the plan experience requires a change for all insurers.

NOTE:

Cost of Insurance

- The rates shown in the charts above are the premium contributions for active members and retirees for GUL only, not including any contributions to the Cash Accumulation Fund. The cost of insurance indicated above reflects a 2.71% charge to cover taxes attributable to the premium tax. The cost of insurance will change as you and your spouse move from one age bracket to the next. Any increased cost will be effective January 1 of the following year. Spouse/Domestic Partner rates are determined by the age of the spouse/Domestic Partner, not that of the member.
- If you terminate from MBF and continue to maintain GUL insurance, the rates for premium contributions to cover life insurance protection are determined by Prudential's portable coverage rates for terminated members.

- If a terminated member returns to MBF as a Deferred Retiree, and continued to maintain GUL insurance, the rates for premium contributions to cover life insurance protection are shown above for retirees.

CASH ACCUMULATION FUND (CAF)

If you enroll yourself or your spouse/Domestic Partner for GUL, you may contribute an additional amount of money toward a CAF, an element of your GUL coverage. The CAF is voluntary and allows savings through payroll deductions on an after-tax basis. These additional savings earn tax-deferred interest. Key features of this option include:

- The amounts contributed to the CAF will earn competitive interest rates. New rates are declared each year. The rate is guaranteed never to be less than 4%.
- Earnings are income tax deferred until withdrawn. Under current law, no federal income tax is due upon withdrawal, if the total amount of your contributions plus the cumulative cost of insurance is greater than the amount you withdraw.
- The balance in the CAF (less the amount of any outstanding loans and interest charged) can be withdrawn at any time in minimum amounts of $200.
- The balance in the CAF can be borrowed against. The minimum amount that can be borrowed is $200. The maximum amount that can be borrowed is 90% of the CAF balance (less the amount of any outstanding loans and interest charged including 2 months of the cost of insurance). The annual net interest charged is the current interest rate plus 1.5% of the amount borrowed.
- Members who cover their spouse/Domestic Partner for life insurance may also establish a CAF element for their spouse/Domestic Partner coverage.
- In the event of a member's death, the beneficiary may receive the benefits of the life insurance amount PLUS any CAF balance on an income-tax-free basis. However, the interest earned on these accounts could be subject to taxation.
- Currently, the only assessment on monthly contributions is a 2.71% premium tax (e.g., a $100 monthly contribution would be assessed a $2.71 premium tax. The remaining $97.29 would earn the current interest rate).

The minimum optional contribution is $1.00 per month regardless of the amount of coverage selected. The maximum figures shown in the above chart are averages based on IRS guidelines. Prudential will review contribution levels to ensure contributions are within IRS guidelines. Spouse/Domestic Partner maximums are determined by the age of the spouse, not that of the member. Contributions are subject to a 2.71% charge to cover taxes attributable to the premium tax.

Please note, if your cash contribution exceeds certain limits and your GUL coverage becomes a Modified Endowment Contract (MEC), different tax rules and, in some cases, penalties apply for lifetime distributions such as loans, withdrawals, and assignments including distributions made in the two years prior to becoming a MEC. A MEC can result from premium payments or from a reduction in coverage (such as the purchase of paid-up life insurance). If this applies to you, Prudential will notify you in writing of your status and advise you of your current options (if any) and by when you must respond. Loans and withdrawals can reduce policy values and may have tax consequences. Prudential is not authorized to give tax advice. Please consult your tax advisor.

All CAF enrollments and/or changes are processed by Prudential directly. In order to enroll in/change your CAF, please visit Prudential's website at the following link www.prudential.com/gulgvul.

ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE (AD&D)

This benefit is automatically included for active members under age 70 enrolled in GUL. It provides the following:

- an additional payment to the beneficiary, equal to the amount of life insurance coverage, if death occurs as a result of a covered accident.
- in the case of dismemberment, you would receive a certain percentage (depending on the injury) of the insurance coverage amount. Not all accidental losses are covered. Some exclusions apply.

The accidental death and dismemberment coverage terminates at the later of retirement or the attainment of age 70.

Please refer to the Basic Life and AD&D section for losses not covered under AD&D Insurance.

ACCELERATED DEATH BENEFIT

Accelerated Death Benefit option is a feature available to GUL participants. If this option is elected, the GUL is reduced by the Terminal Illness Proceeds (the amount of the GUL benefit placed under this option) and Accelerated Payment Fee. The Terminal Illness Proceeds are equal to a portion of your face amount minus an Accelerated Payment Fee not to exceed $600. Receipt of accelerated death benefits may affect eligibility for public assistance and may be taxable. The federal income tax treatment of payments made under this rider depends upon whether the insured is the recipient of the benefits and is considered terminally ill. You may wish to seek professional tax advice before exercising this option.

TERMINAL ILLNESS BENEFIT

The terminal illness benefit applies to member's coverage only. In order to qualify, you must have a life expectancy of six months or less as certified by a licensed medical doctor. Please refer to the "Option to Accelerate Payment of Certain Death Benefits Under Universal Life Coverage" section of the booklet certificate for additional information. You may elect to receive an amount up to the lesser of 50% of your life insurance coverage amount to a maximum of $250,000. For example, coverage in the amount of $100,000 could provide an amount of up to $50,000. The death benefit would be reduced by the amount paid out. Your cost of insurance would also be reduced. If your coverage is assigned, this benefit is not available.

PORTABILITY FOR TERMINATED MEMBERS

If you terminate employment with the City of New York, but are not retired from MBF, or if you are no longer eligible for MBF benefits, you can keep your entire coverage in force at the portable coverage rates. Your GUL coverage can be continued on a direct bill basis by Prudential. Please contact Prudential at 1-800-562-9874 for terminated premium rates.

ADMINISTRATION

This group plan made available to members of MBF is underwritten by The Prudential Insurance Company of America, 751 Broad Street, Newark, N.J. 07102, and is provided under Group Policy No. UG-24768-NY, written on contract series 83500. Prudential is also the insurance administrator and handles administrative responsibilities. Participants will receive a benefit summary confirmation after enrollment. Each year, participants will receive a statement showing the current status of their accounts. Members can obtain additional information directly by contacting The Prudential Insurance Company of America at 1-800-562-9874, and providing policy number 24768.

TAX WITHHOLDING

Federal and some state tax laws may require The Prudential Insurance Company of America to withhold income taxes from the taxable portion of a disbursement such as a Withdrawal, Loan, or Surrender of Coverage. If you request a check to be mailed to a non-U.S. address, you cannot elect out of withholding. Your disbursement value may also be subject to state withholding taxes in certain states. If your resident state requires mandatory withholding, we will withhold the default amount your state requires.

Notice: THIS POLICY IS NOT A MEDICARE SUPPLEMENT POLICY. If you are eligible for Medicare, review the Guide to Health Insurance for People with Medicare available from the company.

LONG TERM DISABILITY INSURANCE (LTD)

This section provides a general description of the Long-Term Disability (LTD) Insurance benefit, which is fully paid for by MBF. This benefit protects active employees against loss of income due to a total or partial disability that exceeds a period of six continuous months.

Retired members are not eligible to receive LTD coverage. However, any claims or benefit payments in progress for a disability which occurred prior to retirement will continue.

Current claims administrator: The Prudential Insurance Company of America

DEFINITIONS

Below are the definitions used throughout this section.

Active Member

An MBF member who is on active pay status.

Actively at Work

Active employment means you are working for your Employer for earnings that are paid regularly and that you are performing the material and substantial duties of your own occupation. You must be working at least 20 hours per week. Your worksite must be a) your Employer's usual place of business; b) an alternate work site at the direction of your Employer other than your home unless clear specific expectations and duties are documented; or c) a location to which your job requires you to travel. Normal vacation is considered active employment. Temporary and seasonal workers are excluded from coverage. Individuals whose employment status is being continued under a severance or termination agreement will not be considered in active employment.

Basic Monthly Earnings

Your rate of pay, excluding overtime, bonus or additional compensation, for your normal work month.

Benefit Waiting Period

The Benefit Waiting Period commences when you become disabled and disability continues for a six-month period, or until disability ceases, whichever is earlier.

Pre-existing Condition

Accidental injury or sickness, that begins within the 12 months after your effective date of coverage, which is diagnosed by a doctor or for which any charges were incurred for prescription drugs or treatment that was rendered during the 3 months immediately preceding your LTD coverage effective date.

WHAT ARE THE BENEFITS

LTD benefits are payable when you are **totally or partially disabled** due to a sickness or accidental bodily injury which extends continuously throughout a six-month period or longer.

Benefits start after six months of continuous disability unless you elect to continue to receive unused sick leave (please refer to General Provisions - Annual Leave or Sick Leave Pay below for more information).

The amount of benefits is 66 2/3% of your *pre-disability Basic Monthly Earnings*, subject to a maximum benefit of $7,500 per month*, effective for any claims incurred on or after January 1, 2024, and a minimum benefit of $150 per month. These benefits will be reduced by income from other sources (please refer to General Provisions - How Other MBF Benefits are Affected by Disability below). The minimum benefit, however, is always payable, but Prudential may apply this amount toward an outstanding overpayment.

*For any claims incurred prior to January 1, 2024, the maximum monthly benefit is $5,000.

If you were approved for LTD benefits prior to January 1, 1999, your benefits will be continued at 50% of your basic monthly earnings. If you were approved for LTD benefits by Prudential after January 1, 1999, your benefits will be 66 2/3% of basic monthly pre-disability earnings, effective July 2001.

If you are disabled for six months or more and receive benefits under this coverage, upon your death, a benefit equal to six times the scheduled monthly benefit will be paid in a lump sum to your surviving spouse or child(ren) under age 25. If there is no surviving spouse or child(ren) under age 25, payment will be made to the estate.

WHEN COVERAGE BEGINS

You are eligible for LTD Coverage beginning on the date you are appointed to an approved title or on the date your title is approved for inclusion in MBF, provided you are actively at work and enrolled in MBF.

If you are not actively at work on the day you would normally become eligible, you are eligible on the first day you are actively at work. The actively at work requirement is waived for employees not actively at work on the effective date for reasons other than disability, injury, or sickness.

WHEN COVERAGE TERMINATES

Your coverage ends when any of the following events occur:

- You go off active pay status;
- Your title is made eligible for collective bargaining;
- You are appointed to a title which is eligible for collective bargaining; or
- Your Group Contract is canceled;
- You are no longer a member of the covered classes;
- Your covered class is no longer covered;
- You leave active service, except:

  If your active service terminates because of injury or sickness for which disability benefits are or may become payable, your eligibility for benefits for this disabling injury or sickness will continue during the *Benefit Waiting Period* and will not terminate until the end of the period for which monthly benefits are payable.

DURATION OF BENEFITS

Benefits are payable as long as your condition satisfies the definition of total disability or partial disability under the plan.

If Disabled	Maximum Duration of Benefits
Prior to age 60	To Normal Retirement Age*
Age 60-65	5 Years
Age 66	4 Years
Age 67	3 1/2 Years
Age 68	3 Years
Age 69	2 1/2 Years
Age 70	2 Years
Age 71	1 3/4 Years
Age 72	1 1/2 Years
Age 73	1 1/4 Years
Age 74 and older	1 Year

** Normal Retirement Age is defined by the Social Security Act where your retirement age is dependent upon your date of birth and may range from 65 to age 67.*

WHAT IS TOTAL DISABILITY

The term "total disability" means that, during the first 24 months of benefits, you are unable, due to sickness or accidental bodily injury, to perform the material and substantial duties of your occupation. Thereafter, the term means you are unable to perform the material and substantial duties of any occupation for which you are reasonably fitted by education, training or experience. To be considered totally disabled, you must be under the regular care of a doctor and not working at any job for wage or profit.

WHAT IS PARTIAL DISABILITY

Partial disability is when, due to sickness or accidental bodily injury, you are unable to perform your job on a full-time basis, but can work at your own job on a part-time basis or at another occupation on either a part-time or full-time basis, and do not earn more than 80% of your pre-disability earnings. The partial disability benefit paid will equal the percentage of your pre-disability basic monthly salary lost, times the benefit which would have been payable if you were totally disabled. However, if your earnings are less than 20% of your pre-disability earnings, benefits will be paid as if you were totally disabled. This benefit will not be less than $150 per month.

Each July 1, the lesser of the current annual percentage rate per the LTD certificate or 10% will be added to your pre-disability earnings figure. However, there is no limit on the number of increases you can receive up to a maximum of $7,500 (or $5,000 for any claims incurred prior to January 1, 2024). You must, however, be partially disabled on that date and have been disabled for the 12 months prior to July 1. Any cost-of-living increase to other periodic benefits, i.e., Social Security, pension, or

workers' compensation, which occurs after you begin receiving LTD benefits will **not** be used to reduce the monthly disability benefit.

GENERAL PROVISIONS

Offset of Income from Other Sources

Your disability benefits will be reduced by the following other income items for the same period, including but not limited to:

- Loss of time disability benefits where the City or State has paid all or part of the cost or made payroll deductions;
- Disability or retirement benefits payable under the Federal Social Security Act on your behalf;
- Retirement benefits from the City or State, to the extent that they are funded by employer contributions, including early retirement benefits;
- Any salary or wage continuance payments made to you by the City or State;
- Loss of time disability benefits payable under a workers' compensation law, occupational disease law or similar law;
- Statutory (state) disability benefits.

Note: For full listing of benefit offsets, please see "What Are Deductible Sources of Income?" section of LTD Certificate.

Any cost-of-living increase to these periodic benefits which occurs after you begin receiving LTD Benefits will not be used to reduce the monthly benefit. Your benefit will not be affected by income received on account of military service, vacation pay, the Deferred Compensation Plan or benefits received under any individual insurance policies paid for entirely by you.

Social Security and Workers' Compensation

If you are covered under the Federal Social Security Act, Prudential will reduce your monthly benefits by a Social Security disability benefits estimate, unless you submit proof to Prudential that you have applied for Social Security disability benefits and sign Prudential's Reimbursement Agreement promising to repay any overpayment on your LTD claim due to Social Security disability benefits.

Any cost-of-living increase in the amount of disability or retirement benefits payable under Social Security will be disregarded if the increase becomes effective after your disability benefits become payable.

Your monthly benefit will be reduced by any periodic or lump sum payment provided on account of your disability for loss of wages under or on account of any workers' compensation law, occupational disease law or similar law, and amounts realized in conjunction with any compromise or release of claim under such law. Any lump sum payment will be considered to have been payable in monthly payments equal to the amount you would have received under the applicable law if there had been no lump sum award and will reduce your monthly benefits until completely exhausted.

Any lump sum payment will be considered to have been made solely for loss of time disability benefits unless otherwise stated in the award.

How to File for Social Security Disability Benefits

In order to receive disability benefits through Social Security, you must apply at your local Social Security office once you become disabled. These benefits are not paid automatically. You may be eligible for these benefits once you have been disabled for five months. Please contact your local Social Security office for eligibility and benefits information.

If you are receiving LTD benefits and Social Security has not accepted you as disabled, Prudential may be able to assist you in pursuing your Social Security disability claim. Often, LTD recipients are not immediately accepted as disabled when applying for Social Security disability benefits. Since proper third-party representation throughout the LTD process greatly increases the chances of a Social Security award being made, Prudential may be available to help you apply for benefits through Social Security.

Because Social Security's definition of disability differs from MBF's definition, many claimants entitled to benefits from MBF may not be eligible or immediately eligible for benefits from Social Security. There are, however, several advantages if you receive Social Security disability benefits. These advantages include:

- You are eligible for Medicare insurance after two years of Social Security disability benefits;
- You are able to protect your retirement benefits; and
- Your family to be eligible for Social Security benefits.

Pre-existing Conditions

A *pre-existing condition* is an accidental injury or sickness which is diagnosed, treated, or has caused expenses to be incurred during the 90-day period immediately preceding your LTD coverage effective date. No benefit will be paid during the first 12 months that you are eligible to receive LTD payments due to any disability that arises during the first year of LTD coverage and is due to a *pre-existing condition*.

Annual Leave or Sick Leave Pay

During the first six months of disability, all accrued annual leave must be used. If unused sick leave exists beyond the 6-month waiting period, (1) sick leave can either be continued to be used by you, in which case no LTD benefits are payable; or (2) sick leave can be left unused with LTD benefits payable.

Benefit Duration for Mental and Nervous Conditions

For claims with a date of disability prior to March 1, 2010, benefits are payable for up to 24 months caused, at least in part, by alcoholism, drug abuse, or a mental, psychoneurotic or personality disorder. If you are confined in a hospital at the end of this 24-month period, benefits will continue for the duration of confinement and may continue up to 3 additional months after confinement ends. In addition, if after the 24 months, you are confined for at least 14 consecutive days, while disabled, benefits are payable for that confinement and for up to three additional months after confinement ends.

These benefits will not continue beyond the maximum benefit duration. A hospital must be accredited under the Hospital Accreditation Program of the Joint Commission on Accreditation of Health

Organizations. A nursing home, convalescent center, home for the aged or similar institution is not considered a "hospital."

For claims with a date of disability on or after March 1, 2010 benefits are payable for the maximum duration of benefits as indicated above.

Pregnancy

Disability resulting from pregnancy will be considered the same as any other disability.

Benefits for Expenses for Rehabilitation

While disabled and receiving benefits, you may participate in a rehabilitation program to help you return to employment.

With Prudential approval, Prudential may elect to offer you and pay for a rehabilitation program, vocational evaluations to assess disability in employment options, job placement services, etc.

Recurrence

If you return to work full-time and again become disabled caused by a worsening in the same condition within 6 months of the end of your prior claim, your recurrent disability will be subject to the same terms of the plan as your prior claim. This does not apply if you become disabled due to a different condition or if you become covered under a different plan during the six-month period.

Extension of Benefits

If a disability for which monthly benefits are payable commences while this Plan is in force, benefits will be payable after termination of the Group Policy to the same extent as if the policy had not terminated.

Limitations

Payment will not be made under this plan for any disability:

- which is a result of war (declared or undeclared) or any act of war;
- arising from an intentional, self-inflicted injury or attempted suicide;
- if you are not under the care of a legally licensed physician;
- that arises during the first year of the employee's LTD coverage due to a pre-existing condition;
- participation in a riot; or
- commission of a felony for which you have been convicted under state or federal law.

In addition, no benefit will be paid for any period of disability that occurs while you are confined in a prison or other house of correction due to a conviction in a court of law.

Payment will stop and claim will end on the earliest of the following:

- during the first 24 months of payments, when you are able to work in your own occupation on a part-time basis but you choose not to; after 24 months of payments, when you are able to work in any occupation on a part-time basis but you choose not to.
- the end of the maximum period of payment.
- the date you are no longer disabled under the terms of the plan.
- the date you fail to submit proof of continuing disability satisfactory to Prudential.

- the date your disability earnings exceed the amount allowable under the plan.
- the date you die.

HOW OTHER MBF BENEFITS ARE AFFECTED BY DISABILITY

The table below summarizes the effect of total disability on your MBF benefits.

Basic Life Insurance	Disability occurring before age 60: MBF will continue your Basic Life Insurance as long as you remain totally disabled, even if on disability retirement. Once approved, Basic Life Insurance is continued at no cost to you for up to one year provided you submit continued proof of disability. Disability occurring on or after age 60: MBF will continue your Basic Life Insurance for up to one year only. After this time, you have the option to convert to an individual policy. Please contact Prudential at 1-877-889-2070.
Group Universal Life (GUL) Coverage	Your disability has no effect on GUL coverage. You may continue GUL coverage, with the insurer billing you directly for premiums.
Superimposed Major Medical Plan (SMMP), Dental and Vision Care Benefits & Basic City Health Benefits	If you are certified as disabled under the LTD program and your coverage ends (for reasons other than reaching the maximum benefits), MBF will extend benefits beyond the termination date. Full benefits coverage will continue under the Basic City Health Benefits Program and MBF's SMMP, Dental and Vision Care programs on behalf of you and your eligible dependents. Under this extended benefit provision, coverage may be continued until (a) 29 months from the date of disability, (b) Medicare benefits commence, (c) you return to work, (d) receive City pension benefits, or (e) LTD benefits cease, whichever is earliest.
MBF Survivor Benefits	Once you are totally disabled, your dependents' eligibility for MBF Survivor Benefits Program ceases unless you are receiving a disability or service pension and continue MBF membership as a retiree.

CONVERSION

Conversion to an individual policy of insurance is not available.

CLAIM PROCEDURES

You may obtain claim forms needed to file for benefits under this policy by contacting MBF at 1-212-306-7290, or if outside New York City 1-888-4000 MBF (1-888-400-0623).

The completed claim forms and supporting documents should be returned to MBF at the following link:

https://nyc-mbf.leapfile.net

APPEAL OF DENIED CLAIMS

In the event a claim has been denied in whole or in part, you can request a review of the claim by Prudential. This request for review should be sent to The Prudential Insurance Company of America, Disability Management Services, P.O. Box 13480, Philadelphia, PA 19176 within 180 days after you receive notice of claim denial. When requesting a review, please state the reason you believe the claim was improperly denied and submit any data, questions or comments you deem appropriate. Prudential will re-evaluate all the information and you will be informed of the decision in a timely manner.

INSURER

The insurance described in this booklet is insured by The Prudential Insurance Company of America, 751 Broad Street, Newark, NJ 07102 under group contract form series 83500 for MBF. If there is any discrepancy between this document and the Group Contract and Group Certificate (collectively referred to as “plan documents”) issued by Prudential, the terms of the Group Contract will govern. To obtain a copy of the plan documents, please contact MBF at 1-212-306-7290, or 1-888-4000 MBF if outside New York City.

This policy provides DISABILITY INCOME insurance only. It does not provide basic hospital, basic medical or major medical as defined by the New York State Insurance Department.

SUPERIMPOSED MAJOR MEDICAL PLAN (SMMP)

OVERVIEW

The Superimposed Major Medical Plan (SMMP) is a supplemental (last-payer type) plan that provides coverage for those members and covered dependents who have qualifying out-of-pocket medical expenses, which remain after all other health coverages have been applied.

Current administrator: Administrative Services Only (ASO), Inc., PO Box 9005, Lynbrook, NY 11563.

For information regarding covered services, visit asombf.com or call ASO at 1-877-844-7667 (dedicated MBF Customer Service Line).

ELIGIBILITY

Members and their eligible dependents are eligible for SMMP benefits as long as they satisfy the eligibility and enrollment requirements as outlined in the "MBF Eligibility and Membership" section of this booklet.

If you are certified as disabled under the LTD Program and your coverage ends (for reasons other than reaching the maximum benefit), MBF will extend benefits beyond the termination date. Full benefits coverage will continue under the Basic City Health Benefits Program and MBF's SMMP, Dental and Vision Care programs on behalf of you and your eligible dependents. Under this extended benefit provision, coverage may be continued until (a) 29 months from the date of disability, (b) Medicare benefits commence, (c) you return to work, (d) receive City pension benefits, or (e) LTD benefits cease, whichever is earliest.

BENEFIT YEAR

The SMMP benefit year runs from January 1st through December 31st.

DEDUCTIBLE

The following table summarizes individual and family annual deductibles based on participation in a primary health plan with a prescription drug rider*.

Primary Group Health Coverage	Prescription Drug Plan/Rider	One Individual	Two Individuals	Three or More Individuals
Yes	Yes	$500	$1,000	$1,500
Yes	No	$2,500	$5,000	$7,500
No	No	$10,000	$20,000	$30,000

*Prescription drug coverage under a non-City group health plan may also fulfill the prescription drug rider requirement. However, those members with coverage limitations (of less than $5,000 annually) through a non-City group health plan will be treated as not having any prescription drug coverage, and covered charges will be subject to deductibles (see above chart). Discounted plans do not qualify as prescription drug coverage. Documentation for non-City group health plan prescription coverage, in effect at the time the expense was incurred, must be submitted to the SMMP administrator.

IMPORTANT:

1) All claims are subject to review for medical necessity and appropriateness. Claims must be submitted within 24 months of the service date.
2) This plan does not cover services provided by an Out-of-Network Provider, if you or your eligible dependents are covered under a Health Maintenance Organization (HMO) plan or Exclusive Provider Organization (EPO).
3) This plan does not cover services where the primary plan of coverage provides a benefit for services through a network of participating providers only, with the exception of co-pays and deductibles.
4) This plan does not cover long-term care for which medical services are primarily custodial care or to aid in daily living.
5) This plan is not a basic (primary) health plan.
6) This plan does not provide coverage for prescription drugs for retired members, their spouses and/or other dependents, who are eligible to receive prescription drug coverage through a Medicare Part D plan.

Note: Through December 31, 2023, this plan will provide reimbursement, subject to the deductible requirement, for Medicare-eligible members and/or their Medicare-eligible spouse/domestic partner for the 5% out-of-pocket co-insurance incurred once the person reaches the catastrophic level of coverage under Medicare Part D. Please refer to the Medicare Part D Catastrophic-Level Coinsurance section for additional information.

As of January 1, 2024, after the member has exceeded $8,000 of true out-of-pocket costs in this catastrophic phase of coverage, the member will pay $0 copay.

DEFINITIONS

Doctor (Physician)

This term means:

(a) a physician legally licensed to practice medicine or surgery.

(b) any other legally licensed practitioner of the healing arts who renders services within the scope of his/her license. For health expenses, such services will include those covered under the Plan for which benefits must be provided by law when rendered by that practitioner. This would also include the services of a chiropractor.

This term does not include: (a) a resident doctor; (b) an intern; or (c) a person in training.

Hospital

This term means a legally constituted and operated institution which has on its premises organized facilities (which include those for diagnosis and major surgery) to care for and treat sick and injured persons. There must be supervision by a staff of doctors with a Registered Nurse (R.N.) on duty at all times.

This term does not include an institution, or part of one, used mainly for: (a) rest care; (b) nursing care; (c) convalescent care; (d) care of the aged; (e) care of the chronically ill; (f) custodial care; (g) rehabilatory care; or (h) educational care.

Ambulatory Care Center

This term means a public or private establishment with an organized staff of Doctors and with permanent facilities equipped for surgical or medical care. It does not provide services or accommodations for patients to stay overnight but it has the services of a doctor and a Registered Nurse (R.N.) at all times when a patient is present and it has arrangements for the transfer of patients who are in need of inpatient care. This term does not include a doctor's office.

Charges/Fees/Expenses

The terms "charges," "fees," and "expenses," as they relate to health care, will not include any amount:

a) for a service or supply which is not medically necessary, even if ordered by a Doctor.

   "Medically Necessary" means services or supplies which, as determined by the plan, are:

   (i) provided for the diagnosis or treatment of a medical condition;
   (ii) appropriate for the symptoms, diagnosis or treatment of a medical condition;
   (iii) performed in the proper setting or manner required for a medical condition; and
   (iv) within the standards of generally accepted health care practice.

b) for a service or supply which is provided only as a convenience, even if ordered by a Doctor.
c) for repeated tests which are not deemed medically necessary by the SMMP, even if ordered by a Doctor;
d) for more than what the R&C is in the locale where incurred, as determined by the SMMP and as elected by MBF.

Non-Reimbursed Covered Charges

Covered Charges as noted below not reimbursed by all other coverage.

Extended Care Facility

This means an institution that provides room and board and skilled nursing services for medical care. It must have (a) one or more Licensed Practical Nurses or Licensed Vocational Nurses on duty at all times and supervised on a 24-hour basis by a Registered Nurse or a Doctor; and (b) the services of a Doctor available at all times by an established agreement. It must also comply with the legal requirements which apply to its operation and keep daily medical records on all patients.

This term does not include an institution, or part of one, used mainly for:

a) rest care;
b) care of the aged;
c) care of drug addicts or alcoholics;
d) custodial care; or
e) educational care.

Note: The SMMP covers traditional medical care for acute care conditions. It does not cover long-term care conditions for which medical services are given to maintain the person's present state of health and which cannot be expected to improve a medical condition to a significant degree. It does not cover room and board and other institutional or nursing services which are provided for a person due to age or mental or physical condition and are primarily custodial care or to aid in daily living.

Home Health Agency

This term means a public or private agency or organization, or part of one, that mainly provides skilled nursing and other therapeutic services. It must be legally qualified in the state or locality in which it operates. It must keep clinical records on all patients. The services must be supervised by a Doctor or Registered Nurse (R.N.) and they must be based on policies set by associated professionals, which include at least one Doctor and one Registered Nurse (R.N.).

This term does not include a home health agency used mainly for the care and treatment of mental, nervous or emotional conditions.

Note: The SMMP plan does not cover services that are provided for a person due to age or mental or physical condition which are primarily custodial care or to aid in daily living.

Custodial Care

This term means:

a) room and board and other institutional or nursing services which are provided for a person due to their age or mental or physical condition, which are mainly to aid the person in daily living; or
b) medical services which are given merely as care to maintain the person's present state of health and which cannot be expected to improve a medical condition to a significant degree

BENEFIT PAYMENT/CO-INSURANCE

Once you have satisfied your annual SMMP deductible, benefits are reimbursed at 90% of the Reasonable and Customary (R&C) allowance for medical services and 80% for out-of-pocket costs for prescription drugs, after benefit payments from all other health plans have been applied. The R&C allowance is the amount allowed for medical services in a geographic area based on what providers in the area usually charge for the same or similar medical services/supplies.

The remaining 10% of the R&C allowance for medical services (or 20% for prescription drugs) is accumulated towards your out-of-pocket maximum (see below section). You are responsible for paying any charges in excess of the R&C allowance.

Example: A member, who is enrolled in the City's basic health plan and the prescription drug plan/rider, incurs $10,000 in covered medical expenses and submits a claim to SMMP. Of the $10,000 incurred, $9,000 is considered the R&C allowed amount as determined by SMMP. The member's primary health carrier is responsible for $3,000 and pays $3,000 towards the claim. In this case, the member's SMMP claim payment calculation is as follows:

Total Medical Charges	*$10,000*
R&C allowance	$9,000
Less: Amount paid by the primary health carrier	-$3,000
Remaining Out-of-Pocket Eligible Amount	$6,000
Less SMMP Deductible*	-$500
Benefit Payments Based on	$5,500
SMMP reimbursement @ 90%	$4,950
Member co-insurance**@10%	$550

* Deductibles may differ depending on the member's primary health coverage

** The co-insurance amount is accumulated towards the out-of-pocket maximum.

As illustrated in this case, the plan would pay $4,950 and the member would be responsible for $2,050 (SMMP deductible ($500), 10% member co-insurance ($550) plus the $1,000 in excess of the R&C allowance). The $550 co-insurance amount only would be applied toward the calendar year out-of-pocket maximum, as explained below in "Out-of-Pocket Maximum."

OUT-OF-POCKET MAXIMUM

Each calendar year, when your out-of-pocket expenses reach $2,500, the Plan pays 100% of the R&C allowance for out-of-pocket expenses after benefit payments from all other health plans are applied.

Note: Charges for hearing aids and audiometric examinations will not be reimbursed at 100%, even if the out-of-pocket maximum is reached.

The following are not considered toward the out-of-pocket maximum:

- Any amount used to meet your plan deductible,
- Expenses which are not considered Covered Charges,
- Amounts that exceed the R&C allowance or maximum benefit limitations,
- Amounts for which another plan is responsible under the coordination of benefits provision, and
- Amounts covered outside of the deductible (e.g., hearing aids, audiometric exams, the SMMP Wellness Benefit, and the Family Building Benefit).

WHAT IS COVERED

SMMP covers the below medical services/equipment, subject to your primary health coverage. Please refer to your health plan for rules on covered services/equipment. If you do not have primary health coverage, SMMP covers the services and supplies as described in this section. Exceptions and limitations are noted throughout this booklet. The following is not an exhaustive inventory of all coverages and limitations under SMMP but rather a summary program description. For additional information or if you have any questions concerning covered services, please contact the SMMP administrator.

Acupuncture - Charges covered subject to medical necessity.

Ambulance - Charges for local transportation by a vehicle that is designed, equipped and used only to move people who are sick and injured from your home, the scene of an accident or a medical emergency to a hospital; between hospitals or skilled nursing facilities or from a hospital or skilled nursing facility to your home. All ambulance service coverage is subject to medical necessity. Ambulette and other services for which the primary purpose is to provide transportation to a health care professional for outpatient visits is not covered.

Ambulatory Surgical Facility - Charges for care rendered in connection with a covered surgical procedure which is performed in an approved ambulatory surgical facility.

Dental Services for Accidental Injury - Charges due to an accidental injury to sound natural teeth, jaw, mouth or face.

Diabetic Care - Charges made by a doctor, certified diabetes nurse educator, certified nutritionist, certified dietitian or registered dietitian for diabetes self-management are covered. Equipment and medical supplies determined by the New York State Department of Health to be medically necessary for the treatment of diabetes are also covered.

Diagnostic Services - Charges ordered by your physician for:

- Diagnostic x-ray, laboratory, radiology, magnetic resonance imaging (MRI), positron emission tomography (PET) scan, ultrasound or nuclear medicine;
- Diagnostic medical procedures, including electrocardiogram (EKG) and other electronic and physiological medical testing; and
- Allergy testing consisting of percutaneous, intracutaneous and patch tests.

Doctor Visits - Charges for medical care and services for diagnosis, treatment and surgery.

Durable Medical Equipment - Charges for the purchase or rental of durable medical equipment such as hospital bed, wheelchair or oxygen equipment. The plan covers repairs and necessary maintenance of purchased equipment. Also covered are sutures, casts, splints, braces, trusses and crutches or other specialized medical supplies ordered by a doctor.

Extended Care Facility/Skilled Nursing Facility (SNF) - Services are covered in an SNF or extended care facility up to 180 days per confinement. Care must be medically necessary and ordered by the primary physician. Refer to “Extended Care Facility Coverage” for additional information.

Hearing Aid and Testing – Refer to "Hearing Aid and Audiometric Exam Benefits" section.

Home Health Care – Benefits are limited to 40 visits per calendar year. One visit equals four hours of skilled home health care services. Services must be ordered by a physician and are subject to medical necessity. Services for custodial care are not covered. Refer to the relevant sections in this booklet for additional information.

Hospice Care - Charges for services, supplies or treatment to assist terminally ill patients. Coverage is available if a physician certifies the terminally ill patient's life expectancy to be six months or less. Refer to "Hospice Benefits" for additional information.

Hospital Services - Charges made by a legally constituted and operated hospital for room, board and medical supplies. Room charges up to the hospital's most common charge for semi-private rooms will be covered. If the hospital does not have semi-private rooms, charges up to 90% of the hospital's lowest private room charges will be covered. However, private room charges will be covered at the R&C rate provided there is a medically necessary justification for a private room.

Infertility, Artificial Insemination, and In-Vitro Fertilization - Covered Charges are those charges incurred by MBF members and their eligible dependents for the diagnosis or treatment of infertility, including, but not limited to, In-Vitro Fertilization and Artificial Insemination, up to specified plan maximums.

Mastectomy and Breast Cancer Reconstruction - Charges for a mastectomy performed on an inpatient or outpatient basis, as well as surgery to re-establish symmetry. This includes, but is not limited to augmentation, mammoplasty, reduction mammoplasty, and mastoplexy. Also covered is the use of prosthetic devices to replace all or part of the removed breast. Treatment of physical complications of all stages of mastectomy is also covered, including lymphedemas.

Maternity Care and Newborn Coverage - Charges for normal pregnancy, complications of pregnancy and routine nursery care for the newborn child are covered at the same level as benefits for any other condition. Newborn coverage includes well baby care, including room and board, circumcision, immunizations, medical tests or tests not related to an injury or illness, within 13 days of birth.

Nutritional Supplements - Charges for medically necessary nutritional supplements that are formulas that enable the body to process or metabolize amino acids for the treatment of phenylketonuria (PKU), branched-chain ketonuria, galactosemia, and homocystinuria when administered under the direction of a doctor are covered.

Oral and Dental Surgery Coverage

- Charges for dental work or treatment that is due to an accidental injury to the jaw or to sound natural teeth.
- Hospitalization charges for the extraction of diseased or impacted teeth are covered on an inpatient basis only if the person is confined for at least 18 hours, the confinement is ordered by the doctor and the life or health of the person will be in danger if the surgery is performed on an outpatient basis. Charges for the extractions are covered under the MBF Dental Plan or your basic health coverage with the City, depending on the type of extraction.

- Charges for oral surgical procedures (cutting procedures only) that are medically necessary but are not covered under the MBF Dental Plan, but must be performed in order for dental procedures that are covered under the MBF Dental Plan to be achieved.

Orthotics - Charges for fitting, adjusting, repairing and replacing a rigid or semi-rigid supportive device that restricts or eliminates motion of a weak or diseased body part. A letter of medical necessity must be provided by the primary physician for coverage.

Prescription Drugs - Charges for prescribed drugs, as allowed by the NYS Department of Financial Services, for (a) active members and (b) members' spouse/domestic partner and or other dependents who are either (i) under age 65 or (ii) over 65 and for whom Medicare is not the primary health plan, are covered. This excludes drugs prescribed for a dental condition (which are covered under MBF's dental plan). If you are covered under a City health plan and not eligible for Medicare, certain drugs must be purchased under the PICA Plan. Members must follow guidelines established under their primary health plan regarding prescription drug coverage.

Private Duty Nursing - Services of a practicing registered nurse (RN) or licensed practical nurse (LPN) are covered on an inpatient basis when there is medically necessary justification that is in accordance with the plan's definitions for "Charges/Fees/Expenses".

Prosthetic Appliances - The purchase, fitting, adjustment, repair and replacement of prosthetic devices that replace all or part of:

- A missing body part or organ and adjoining tissue; and
- The function of a permanently useless or malfunctioning body part or organ.

Replacement prostheses are covered if due to pathological changes or normal growth.

Surgery - Services for surgeons, assistant surgeons, anesthesia, anesthesia supplies and medical or surgical dressings are covered in and out of the hospital.

Therapy Services - Charges for acupuncture, chiropractic therapy, physical therapy, occupational therapy, respiration therapy, speech therapy (except voice modulation, educational training or testing, or lisp), audio therapy, visual therapy, cardiac rehabilitation therapy, and physical therapy. All therapy services are covered only after medical necessity is established and treatment is appropriate. For all therapy services, a licensed therapy provider, under the direction of a physician, must perform the services.

Well-Child Care - Pediatric care, including routine physical examinations and diagnostic services is covered. Charges for immunizations covered under the City's primary plans are covered.

IMPORTANT: See "Other Important Facts" for other conditions that may affect this coverage.

EXTENDED CARE FACILITY COVERAGE

Covered Charges will include charges made by an Extended Care Facility for:

- the daily room and board charge for each day of confinement.
- the facility's other charges incurred for medically necessary care on a day for which room and board benefits are payable.

Note: SMMP covers traditional medical care for acute care conditions. It does not cover long-term care for which medical services are given to maintain the person's present state of health and which cannot be expected to improve a medical condition to a significant degree. It does not cover room and board and other institutional or nursing services which are provided for a person due to age or mental or physical condition, and which are primarily for custodial care or to aid in daily living.

To qualify as Covered Charges, the covered person's attending doctor must certify that 24-hour nursing care is medically necessary. In addition to medical justification, the charges must be in accordance with the Plan's definitions for "Charges/Fees/Expenses".

Benefits will be paid at 90% of the R&C allowance for non-reimbursed Covered Charges for an Extended Care Facility incurred by a covered person in a calendar year, subject to the deductible requirement.

The maximum benefits allowable will depend on whether or not the confinement is within a Period of Extended Care Facility Confinement. A "Period of Extended Care Facility Confinement" means a period that:

- begins with confinement to an Extended Care Facility within 14 days after discharge from a hospital confinement of three or more days for the same or a related cause;
- ends on the 14th day in a row after the date the covered person is not confined to the Extended Care Facility or a hospital.

AND

For Covered Charges made by the Extended Care Facility and incurred during a period of Extended Care Facility Confinement, payment will be made:

- for any daily room and board charge: up to (a) the facility's most common charge for its semi-private rooms; or (b) 90% of the facility's lowest private room charge, if the facility does not have semi-private rooms.
- for up to 180 days per period of confinement.

For Covered Charges incurred outside a period of Extended Care Facility Confinement, payment will be made:

- for any daily room and board charge: up to (a) the facility's most common charge for its semi-private rooms; or (b) 90% of the facility's lowest private room charge, if the facility does not have semi-private rooms.
- for up to 60 days per period of confinement.

IMPORTANT: See "Other Important Facts" and "What is not Covered" for other conditions that may affect this coverage.

HOME HEALTH AGENCY BENEFITS

The term "Home Health Services" means services for:

1. Part-time nursing care rendered in the covered person's home by a:
    a. Registered Nurse (RN).
    b. Licensed Practical Nurse (LPN).
    c. Licensed Public Health Nurse.
    d. Licensed Vocational Nurse under the supervision of a Registered Nurse (RN).
2. Physical, occupational or speech therapy provided in the covered person's home.
3. Physical, occupational, or speech therapy or the use of medical equipment provided on an out-patient basis by a:
    a. Home Health Agency; or
    b. hospital or other facility, if arranged with a Home Health Agency.

Note: The SMMP does not cover services that are provided for a person due to age or mental or physical condition and which are primarily custodial care or to aid in daily living.

4. Part-time home health aide services which are mainly for the care of the covered person.

    This term does not include a service:

    a. done by a member of the covered person's immediate family;
    b. done by a person who normally lives in the covered person's home;
    c. not needed for the treatment of an injury or sickness; or
    d. provided in a hospital, SNF or other institution.

Covered Charges will include charges for Home Health Services made by a Home Health Agency or a hospital certified to provide Home Health Services. A doctor must prescribe these services in place of services in a hospital, SNF or other covered institution.

Covered Charges under the SMMP do not include charges for local ambulance service to or from:

a. Home Health Agency; or
b. hospital or other facility for the purpose of obtaining Home Health Services.

You will be paid for Home Health Services charges, subject to the deductible requirement, at 90% of the R&C allowance for non-reimbursed Covered Charges.

The maximum limit in any calendar year for each covered person for Home Health Services is 40 home health care visits. Each visit made by a member of a home health care team is considered as one home health care visit; four hours of home health aide services is considered as one home health care visit.

IMPORTANT: See "Other Important Facts" and "What is Not Covered" for other conditions that may affect this coverage.

HOSPICE BENEFITS

The term "Hospice Services" means a multidisciplinary health plan provided by a certified hospice provider providing quality palliative end-of-life care including pain management for terminally ill patients and support for their families. The SMMP Hospice Benefit is available to MBF members and their eligible dependents only when Hospice Care coverage under Medicare and/or the member's Primary City Health Plan and/or other group health plans has been exhausted.

Typical hospice treatment services include:

- Nursing, Home Health Aide and Homemaker Services;
- Physician Services;
- Physical, occupational or speech therapy provided in the covered person's home;
- Social Worker Services;
- Medications for pain relief and symptoms management;
- Medical supplies and equipment;
- Short-term inpatient care for acute crisis management;
- Respite care for the caregiver; and
- Bereavement support services.

Hospice services do not include services:

- Performed by a member of the covered person's immediate family;
- Performed by a person who normally lives in the covered person's home; or
- For the treatment of an injury or sickness not related to the terminal illness.

Pre-Certification

In order to qualify for hospice benefits, Pre-Certification procedures must have been implemented through Medicare and/or the member's Primary City Health Plan and/or other group health plan(s), prior to the commencement of the hospice benefit period.

The term "Pre-Certification" means review to determine that a hospice program is reasonable and necessary and that the scope of hospice services is medically necessary for the care or treatment of the patient's condition. The treating physician and/or hospice medical director must have provided certification of terminal illness with prognosis of six months or less life expectancy.

Benefits will be paid for Covered Charges if the Hospice Benefit was initially pre-certified and approved by Medicare and/or the member's Primary City Health Plan and/or other group health plan(s). Please note that the SMMP Hospice Benefit is available to MBF members and their eligible dependents only when Hospice Care coverage under Medicare and/or the member's Primary City Health Plan and/or other group health plans has been exhausted.

Coverage

To qualify as Hospice Covered Charges: (a) the covered person's attending doctor must certify that the patient has a short prognosis (i.e., that if the illness follows its normal course, the life expectancy is six months or less.); (b) a written plan of care must have been established for the patient and approved by Medicare and/or the member's Primary City Health Plan and/or other group health plan(s); (c) the

patient must receive services from a certified hospice program and (d) the patient must sign an agreement that they choose hospice care in lieu of standard hospital benefits.

Benefits will be paid based on an R&C allowance for Covered Charges for Hospice charges incurred by a covered person in a calendar year in which the deductible has been met.

INFERTILITY, ARTIFICIAL INSEMINATION, IN-VITRO FERTILIZATION AND SIMILAR PROCEDURES

Individuals may be eligible for IVF coverage if they are diagnosed with infertility, which is defined as a disease or condition characterized by the incapacity to impregnate another person or to conceive, due to the failure to establish a clinical pregnancy after 12 months of regular, unprotected sexual intercourse or therapeutic donor insemination, or after six months of regular unprotected sexual intercourse or therapeutic donor insemination for a female 35 years of age or older. The condition may be present in one or both sexual partners. An individual may also be eligible for IVF coverage if they are unable to conceive due to their sexual orientation or gender identity.

Covered infertility treatments may consist of, but are not limited to, the following procedures:

- In-Vitro Fertilization is a means of assisted reproduction that surgically removes eggs from a woman's ovaries, combines the eggs with sperm in the laboratory and, if fertilized, places the resulting embryo into the woman's uterus.
- Gamete Intra-Fallopian Transfer is a method of assisted reproduction in which eggs are surgically removed from a woman's ovaries, combined with sperm outside of the body, and then injected into the female's fallopian tube.
- Artificial Insemination is the deposit of semen in the vagina or cervix by artificial means as an attempt to induce pregnancy.

Covered Charges are those charges incurred by MBF members and their eligible dependents for the diagnosis or treatment of infertility, including, but not limited to, In-Vitro Fertilization and Artificial Insemination. Only treatment and services provided directly to MBF members and their eligible dependents will be considered for payment.

SMMP covers three cycles of IVF, including all treatment that starts when preparatory medications are administered for ovarian stimulation for oocyte retrieval with the intent of undergoing IVF using a fresh embryo transfer or medications are administered for endometrial preparation with the intent of undergoing IVF using a frozen embryo transfer.

Costs associated with the fertilization of a donor oocyte and/or with the use of donor sperm for an MBF member or eligible dependent are covered, including preparation of the oocyte/sperm, fertilization and culture of embryos, genetic testing of embryos (if medically necessary), cryopreservation of embryos/sperm, thawing of embryos/sperm, and preparation of an embryo for transfer. However, treatments/procedures on any individual who is not an MBF member or eligible dependent are not covered. This includes the costs of any treatment associated with oocyte retrieval from a donor, sperm donation, and the costs of embryo transfer to a surrogate/gestational carrier. Costs associated with procurement of donor oocytes/sperm/embryo and gestational carrier/surrogate compensation are also not covered.

Medications, including prescription drugs, are covered. Injectable medications used to treat IVF are available through the City's PICA Program for active employees of MBF.

SMMP shall provide coverage for standard fertility preservation services for individuals when a medical treatment will directly or indirectly result in "iatrogenic infertility," which is an impairment of fertility by surgery, radiation, chemotherapy, or other medical treatment affecting reproductive organs or processes.

PLEASE NOTE: Effective November 1, 2024, MBF offers a Family Building Benefit, as a part of SMMP. MBF reimburses for the following family building expenses up to a maximum of $10,000 per child/attempt to conceive or adopt:

- Eligible adoption expenses associated with adopting an Eligible Child
- Eligible surrogacy parenting arrangement expenses
- Eligible expenses related to purchase of donor tissue

Please refer to the Family Building Benefit in this SMMP section for adoption/ surrogacy expenses, exclusions, limitations and maximums.

MEDICARE PART D CATASTROPHIC-LEVEL COINSURANCE (THROUGH DECEMBER 31, 2023 ONLY)

Under Medicare Part D, once a Medicare-eligible individual reaches the catastrophic level of coverage for prescription drugs, the Medicare Part D plan pays 95% of the cost of prescription drugs, with the individual responsible for the remaining 5% co-insurance. The SMMP will reimburse Medicare-eligible MBF members and their Medicare-eligible spouse/domestic partner for eligible prescription drug expenses incurred at the catastrophic level for the remaining 5% subject to the deductible requirement.

Medicare-eligible members must complete and submit one Medicare Part D Reimbursement Claim Form for themselves, and/or one Claim Form on behalf of their Medicare-eligible spouse/domestic partner, for each year that reimbursement is being claimed. When submitting this Claim Form, the member and/or member's spouse/domestic partner must include the annual Explanation of Benefits (EOB) that they receive from their prescription drug plan at the end of the year. This EOB indicates the 5% co-insurance that the individual paid out-of-pocket in excess of that year's maximum catastrophic coverage amount. The member and the member's spouse/domestic partner must wait for this annual EOB before submitting a claim.

Note: As of December 31, 2023, SMMP will no longer reimburse Medicare-eligible MBF members and their Medicare-eligible spouse/domestic partner for eligible prescription drug expenses incurred at the catastrophic level.

Effective January 1, 2024, Medicare Part D Plans will pay 100% of covered prescription drugs once the Medicare-eligible member and/or spouse or domestic partner reaches the catastrophic level. Therefore, Medicare-eligible MBF members and their Medicare-eligible spouse/domestic partner will not have any out-of-pocket prescription drug expenses once the catastrophic level is reached.

EXTENDED BENEFITS

If a person becomes ineligible for SMMP benefits and that person is Totally Disabled (as defined below) on the date coverage ends, they may apply for an extension of benefits.

Benefits are payable for a Totally Disabled person for charges incurred for the disabling condition on or after the date the coverage ends if both of the following are true:

1. the charges are Covered Charges under the SMMP and
2. the charges are incurred for the disabling condition while the person remains Totally Disabled.

For purposes of determining if charges are Covered Charges under the plan, benefits will be based on the SMMP in force for that person at the time the coverage ended.

A person is "Totally Disabled" if, due to an accidental injury or sickness, they are not able to: (a) in the case of an MBF member, do any work for compensation or gain; and (b) in the case of a dependent of an MBF member, do all normal tasks for that person's age and family status.

Extended benefits are payable for those Covered Charges a person incurs during the rest of the calendar year in which the person's insurance ends and the next calendar year.

No payment will be made for Covered Charges incurred on or after the date that person is eligible for benefits under any other arrangement for members in a group, whether insured or self-insured.

WHAT IS NOT COVERED

Charges for the following services and supplies are not covered:

- not ordered by a doctor, except as specified under the section "What is Covered."
- for preventive care, other than that specified for adults and dependent children under "What is Covered" and the SMMP Wellness Benefit.
- for dental work, treatment or dental x-rays (except as listed as Covered Charges or due to an accidental injury which occurs to sound natural teeth or jaw).
- for transportation (except as listed as Covered Charges).
- in a Government or Veteran's Administration Hospital for a covered person with a military service-connected disability.
- for which payment is provided, even in part, under the laws of the United States, a state, or a municipality.
- for replacement of lost or stolen hearing aids, replacement parts for hearing aids or repair of hearing aids, unless the replaced hearing aid has been in use for at least 2 years and if the replacement is requested in writing by an otolaryngologist or otologist; or for drugs or other medication with respect to hearing aids.
- due to war, whether declared or not.
- covered by mandatory automobile No-Fault benefits.
- where a covered person would not legally have to pay if there were no coverage.
- for hospital room and board when the covered person is confined primarily for physical therapy or physical rehabilitation.

- for all clinical lab services, pharmacy services, x-ray and imaging services, if referred by a practitioner who has a financial relationship or whose immediate family member has a financial relationship with the provider of these services.
- for health exams that are required for employment.
- for health exams except:
  a) when it is necessary due to an accidental injury or illness; or
  b) for children as described in well-child benefits; or
  c) for adults as described under "Adult Wellness Benefit."
- for eye exams or the fitting or cost of eyeglasses or contact lenses.
- for any injury or sickness for which benefits are payable under Workers' Compensation or similar law.
- for diagnosis or treatment of:
  a) weak, strained, unstable or flat feet; or
  b) any tarsalgia, metatarsalgia or bunion, except for operations which involve the exposure of bones, tendons or ligaments.
- for treatment of:
  a) toenails, other than removal of nail matrix or root; or
  b) superficial lesions of the feet, such as corns, callouses or hyperkeratoses.
- for cosmetic reasons except as a result of:
  a) an accidental injury;
  b) surgery for a congenital anomaly of a covered child to improve the function of a body part.
- The term "cosmetic reasons" will not include reconstructive surgery when:
  a) it is because of or follows surgery done as a result of trauma, infection or other diseases of the involved part;
  b) it is because of a birth defect of a covered dependent child which results in a functional defect.
- educational testing or training.
- for Long-Term Care, including health or personal needs and activities of daily living that are primarily custodial in nature.
- for drugs prescribed for certain types of cancer unless the drug is recognized for treatment of the specific type of cancer for which it has been prescribed in one of the following established reference compendia:
  a) the American Medical Association Drug Evaluations;
  b) the American Hospital Formulary Service Drug Information;
  c) the United States Pharmacopoeia Drug Information; or
  d) recommended by a review article or editorial comment in a major peer-reviewed professional medical journal.
- for non-surgical treatment of temporomandibular joint (TMJ) disorders (and all other craniomandibular disorders) or injections other than those made directly into the temporomandibular joint.
- for vitamins, minerals, food supplements, and exercise programs of any kind, except for benefits covered under the Adult Wellness Benefit, mentioned above.
- for a procedure to reverse voluntary sterilization.

- if provided by an Out-of-Network Provider, if you or your eligible dependents are covered under an HMO or EPO plan, or where the primary basic plan of coverage provides a benefit for services through a network of participating providers only.
- after the coverage period for these benefits ends. If the covered person is totally disabled on the date this coverage ends, see "Extended Benefits." If the member enrolls in COBRA, please refer to the "Consolidated Omnibus Budget Reconciliation Act (COBRA)" section of this booklet.
- for charges, or a portion of a charge, that are in excess of R&C as determined by SMMP.
- for prescription drugs for retired members, their spouses and/or other dependents, who are eligible to receive prescription drug coverage through a Medicare Part D plan (see section Medicare Part D Catastrophic-Level Coinsurance).
- for ambulette and other services for which the primary purpose is to provide transportation to a health care professional for outpatient visits or treatment.
- charges incurred for or in connection with a procedure held to be experimental or investigational by SMMP at the time it is done. The SMMP will rely on the findings and assessment of:
  a) the Office of Medical Application of Research of the National Institutes of Health, the Office of Technology Assessment of the United States Congress, or a similar entity;
  b) national medical associations, societies and organizations;
  c) NYCHSRO, IPRO, other independent review organizations.

ADDITIONAL COVERED BENEFITS

HEARING AID AND AUDIOMETRIC EXAM BENEFITS

Effective September 1, 2023, the maximum benefits payable for a covered person (after the 6-month hearing aid trial period, if applicable) are:

- Up to $2,000* per hearing aid (90% of allowable charges up to $2,222) and
- 90% of the R&C allowance per audiometric examination

* Hearing aid benefits are subject to the SMMP Coordination of Benefits provision. SMMP must take into account other group health and welfare fund benefit payment(s) already received, and will pay benefits up to the maximum amount of $2,000 per hearing aid between all plans. If the other plan(s) pay $2,000 or more in benefits for the hearing aid, SMMP will pay nothing.

Note: For hearing aid services on or before August 30, 2023, maximum benefits payable per covered person is $1,500 per hearing aid.

Limitations:

- No more than one hearing aid per ear will be covered in a 24-month period,
- No more than one audiometric examination will be covered in a 24-month period.

Note: The SMMP deductible is waived for hearing aid(s) and/or audiometric examinations.

SMMP WELLNESS BENEFIT

The SMMP Wellness Benefit provides coverage for treatment or services that promote prevention or result in early detection and intervention before a serious disease or chronic condition develops for MBF members, their spouse/domestic partner, and dependent children through age 26.

Benefits are reimbursed at 100% of R&C allowances after offsetting benefit payments from all other health plans. Deductibles are not applied to charges submitted for SMMP Wellness Benefits, and any out-of-pocket expenses will not be accumulated towards the SMMP out-of-pocket maximum.

Covered Procedures

Complete Physical (No more than one routine physical will be covered in a 12-month period)

Nutritional weight counseling and treatment (ingestible products are not covered)

Diagnostic Procedures

- Electrocardiogram
- Chest X-Rays
- Spiral CT
- Pulmonary Function Testing
- Sigmoidoscopy
- Colonoscopy
- Bone Densitometry

Laboratory Tests

- Urinalysis
- Complete Blood Count
- SMAC 23
- Stool for Occult Blood
- VDRL
- Hepatitis C
- Immunoassay (EIA)
- TB Testing

Gender Specific

- Prostate Specific Antigen (PSA)
- Pap/Pelvic Exam
- Mammography

Immunization

- Rubella Titer
- Tetanus-Diptheria
- Influenza
- Pneumococcal
- Hepatitis B
- Shingles
- Chicken pox

FAMILY BUILDING BENEFIT

Effective November 1, 2024, the Management Benefits Fund (MBF) offers a Family Building Benefit, as a part of SMMP. MBF reimburses for the following family building expenses up to a maximum of Ten Thousand Dollars ($10,000) per child/attempt to conceive or adopt:

- Eligible adoption expenses associated with adopting an Eligible Child
- Eligible surrogacy parenting arrangement expenses
- Eligible expenses related to purchase of donor tissue

Adoption

This benefit applies to the legal adoption of an Eligible Child. An Eligible Child includes: (i) child not biologically related to MBF member/spouse/domestic partner; (ii) child resulting from a surrogacy arrangement where it is required for the intended MBF member/spouse/domestic partner to legally adopt the child via surrogacy post birth; or (iii) any disabled individual physically or mentally unable to take care of himself or herself regardless of age. Expenses will be reimbursed for both successful and unsuccessful/disrupted adoptions. For successful adoptions, the adopted child must become a legal dependent of the MBF member and must live in the household of the MBF member following adoption.

Adoption Eligible Expenses

- Private and public adoption agency and placement fees
- Legal fees and court costs
- Fees related to immigration, immunization and translation of legal documents
- Reasonable and necessary travel expenses required for the purpose of obtaining physical custody of the adopted child (e.g. meals, flight, hotel and gas)
- Costs associated with State required home study
- Expenses related to an unsuccessful or disrupted adoption
- Other reasonable expenses which are directly related to and the principal purpose of which is for the legal adoption of an Eligible Child

Adoption Non-Reimbursable Expenses

- Adoption of individuals over 18 years of age (except as noted above)
- Medical expenses prior to finalization
- Voluntary contributions such as donations (monetary gifts provided to the MBF member for adoption purposes)
- Guardianship or custody costs that are not associated with the legal adoption of the child
- Expenses or costs incurred by the birth mother (including medical expenses)
- Expenses incurred prior to active employee/retiree enrollment in MBF
- Expenses reimbursed, paid or funded under any state, local or federal program
- Expenses reimbursed under another employer-sponsored adoption assistance plan
- Expenses claimed as a credit or deduction on your personal tax return
- Loss of income of MBF member due to complications related to the administration of the adoption process
- Charges that are in violation of federal or state law

Surrogacy

This benefit applies to surrogacy arrangements where (a) the active or retiree MBF member, or their spouse or domestic partner, is genetically related to the child; OR (b) the child will be or is a legal dependent of the MBF member AND the child will or does live in the household of the MBF member.

Surrogacy Eligible Expenses

- Agency fees associated with the surrogacy
- Attorney fees and Court costs related to the surrogacy
- Screening and surrogate fees
- Consultant/specialist fees
- Expenses related to an unsuccessful surrogacy attempt not resulting in a live birth
- Reasonable and necessary out-of-pocket medical costs incurred by the surrogate related to pregnancy and delivery including the expenses listed below, provided that such medical expenses are incurred after the date a valid surrogacy contract is executed, and provided further that such medial claims are incurred no later than one month after delivery and provided further that the expenses are not otherwise covered by the City of New York Health Benefits Program
    - Screening costs for gestational carrier/surrogate
    - Egg or sperm retrieval fees, IVF and medical costs, if not covered by another plan or source
    - The cost of transfer of the embryo to the gestational carrier/surrogate
    - Egg or sperm shipping and transport fees
    - Pregnancy medical expenses related to surrogacy not covered by another plan or source
    - Reasonable and necessary lodging and travel expenses of the eligible active/retired MBF member and/or their spouse/domestic partner, or the surrogate, provided that such travel: (1) is within the U.S., (2) is associated with the U.S. based surrogacy, (3) occurs on or after the date a valid surrogacy contract is executed and (4) is completed within one month after delivery.

EXAMPLE	ELIGIBLE EXPENSES FOR REIMBURSEMENT
Same-sex male couple seeks to have a child through the use of a surrogate/gestational carrier.	In addition to the above referenced fees, treatments and procedures for a surrogate/gestational carrier, including, but not limited to, the costs of any treatment associated with oocyte retrieval from a donor, sperm donation, and the costs of embryo transfer to a surrogate/gestational carrier.

Surrogacy Non-Reimbursable Expenses

- Expenses associated with a surrogacy contract/agreement outside the U.S. or expenses associated with a surrogate who does not reside in the U.S.
- Expenses for surrogacy arrangements that are not legally recognized
- Cost of living expenses and/or personal items such as: transportation to doctor's appointments, special food, maternity clothing, rent, utilities, toys, furniture, etc.

- Voluntary contributions such as donations (monetary gifts provided to the MBF member for surrogacy purposes) Guardianship or custody costs that are not associated with the legal surrogacy of the child
- Expenses incurred prior to active employee/retiree enrollment in MBF
- Charges that are in violation of federal or state law
- Loss of income of MBF member and/or surrogate due to complications of pregnancy such as bed rest
- Any fees, expenses or costs associated with a dispute of custody and/or legal parenting rights
- Any costs associated with transferring and/or terminating a surrogacy arrangement
- Expenses reimbursed, paid or funded under any state, local or federal program
- Expenses reimbursed under another employer-sponsored surrogacy assistance plan
- Any federal and/or state taxes incurred by the surrogate related to the surrogacy arrangement between the MBF member and the surrogate
- Storage of blood, umbilical cord, reproductive materials, etc.
- Costs associated with destroying any eggs, sperm or embryos
- Any expenses not expressly stated as included shall be deemed excluded.

Purchase of Donor Tissue

This benefit applies to costs associated with the procurement of donor material tissue through a Food & Drug Administration (FDA) regulated egg/sperm bank, agency or provider's office for the purpose of having a child where (a) the child will be or is a legal dependent of the MBF member; AND (b) the child that will or does live in the household of the MBF member.

Purchase of Donor Tissue Eligible Expenses

Donor-related expenses are reasonably and directly related to the costs for the procurement of donor egg(s) and donor sperm through FDA regulated egg/sperm banks, agencies or providers offices. Donor-related expenses include:

- One year of storage for donor egg(s) and donor sperm
- Subscription fees
- Shipping fees
- Reasonable and necessary travel expenses for the donor (including amounts spent for meals and lodging away from home)
- Agency fees
- Donor fertility costs including medications, office visits to fertility clinic, bloodwork, ultrasounds, injection training, egg retrieval costs and anesthesia
- Legal costs and attorney's fees
- Screening costs for donor including psychological clearance, genetic carrier screening, FDA infectious disease screening and fertility screening examples

EXAMPLE	ELIGIBLE EXPENSES FOR REIMBURSEMENT
A single female seeks to have a child through the use of the City's IVF program.	The purchase of donor egg or sperm, as part of a fertility treatment plan of the MBF member.

Purchase of Donor Tissue Non-Reimbursable Expenses

- Fees associated with adoption or purchase of donor embryos
- Costs associated with the active/ retired member's psychological clearance
- Compensation to egg/sperm donor
- Voluntary contributions such as donations (monetary gifts provided to the MBF member for purchase of donor material purposes)
- Expenses incurred prior to active employee/retiree enrollment in MBF
- Charges that are in violation of federal or state law
- Loss of income of MBF member due to complications with regards to the purchase of donor material.
- Expenses reimbursed, paid or funded under any state, local or federal program
- Expenses reimbursed under another employer-sponsored donor assistance plan
- Any expenses not expressly stated as included shall be deemed to be excluded

Tax Treatment

- Adoption. Reimbursement benefits may be excluded from taxable income for certain adoption-related expenses. Please contact your tax advisor.
- Surrogacy Assistance. Reimbursement benefits for surrogacy-related expenses are not excluded from taxable income under IRS regulations. Please contact your tax advisor.
- Purchase of Donor Tissue Assistance. Reimbursement benefits for the purchase of donor material-related expenses are not excluded from taxable income under IRS regulations. Please contact your tax advisor.

Reimbursement Procedures

To obtain reimbursement for the eligible reimbursement expenses outlined in this Family Building Benefit, the active/retired MBF member must submit the following information to ASO, SMMP Administrator:

- Submit a completed and signed Family Building Benefit Reimbursement form
- Submit supporting documentation as noted below:
    - Eligible Adoption required documentation:
        - Documentation of all fees, costs and other expenses paid and incurred in connection with the adoption of Eligible Child along with proof of payment (including detailed receipts, itemized bills/ invoices, cancelled checks, credit card statements, paid stamped invoices confirming payment, etc.)
        - For successful adoptions:

        - Documentation that indicates whether the Eligible Child is a citizen or resident of the U.S.
        - If the Eligible Child is not a citizen or resident of the U.S. a final decree of adoption by a competent authority of the foreign-sending country, as well as evidence that the child has been issued the appropriate visa from the State Department of the U.S. (e.g., proof the child legally resides in the U.S. with the active/ retired MBF member)
        - For an adoption of an Eligible Child who is a citizen of the U.S., a final decree of adoption
    - For unsuccessful or disrupted adoptions:
        - A home study completed by an authorized placement agency
        - A placement agreement with an authorized placement agency
        - Notarized letter from the adoption agency indicating an unsuccessful /disrupted adoption, detailing the amount paid, when the unsuccessful adoption(s) occurred, reason(s) for unsuccessful adoption, etc.
- Eligible Surrogacy required documentation:
    - Documentation of all fees, costs and other expenses paid and incurred in connection with a surrogacy parenting arrangement along with proof of payment (including detailed receipts, itemized bills/ invoices, cancelled checks, credit card statements, paid stamped invoices confirming payment, etc.)
    - Copy of the surrogacy agency contract
    - Copy of birth certificate naming the MBF member as the legal parent for successful surrogacy
- Eligible Purchase of Donor Tissue required documentation:
    - Documentation of all fees, costs and other expenses paid and incurred in connection with the procurement of donor tissue along with proof of payment (including detailed receipts, itemized bills/ invoices, cancelled checks, credit card statements, paid stamped invoices confirming payment, etc.)

All eligible reimbursement expenses incurred on or after November 1, 2024, the Family Building Benefit effective date, for which reimbursement is requested, must be submitted within two years of:

1) the issuance of the final decree of adoption,
2) the date the unsuccessful adoption occurred, and
3) the date donor tissues were procured.

Surrogacy claims may be submitted three (3) times in the surrogacy process. All surrogacy reimbursement requests for expenses must be submitted no later than two years from the date the surrogacy was finalized.

1) After first non-refundable payment is made to the surrogacy agency
2) After final non-refundable payment is made to the surrogacy agency
3) When the surrogacy is finalized (e.g., once the child is born and the MBF member has a copy of the birth certificate naming the MBF member as the legal parent)

Eligible expenses must be incurred on or after the later of 1) enrollment in MBF and 2) the effective date of November 1, 2024.

If the submitted documentation requires additional substantiation and/or proof of payment, you will be contacted by ASO, SMMP Administrator.

MBF will only provide reimbursement to the MBF member and will not pay any eligible expenses directly. MBF will not pay for/reimburse any expenses for legal disputes (or related Court costs).

- Note: The SMMP deductible is waived for the Family Building Benefit. Reimbursement under the Family Building Benefit is not considered toward the SMMP out-of-pocket maximum.

EXPENSES FOR WHICH A THIRD-PARTY MAY BE LIABLE

This policy does not cover expenses for which another party may be responsible as a result of having caused or contributed to the injury or sickness. If you incur a Covered Charge for which, in the opinion of the SMMP, another party may be liable:

1. The SMMP shall, to the extent permitted by law, be subrogated to all rights, claims or interests which you may have against such party and shall automatically have a lien upon the proceeds of any recovery by you from such party to the extent of any benefits paid under the plan. You or your representative shall execute such documents as may be required to secure the SMMP's subrogation rights.
2. Alternatively, the SMMP may, at its sole discretion, pay the benefits otherwise payable under the plan. However, you must first agree in writing to refund to the SMMP the lesser of:
    a. the amount actually paid for such Covered Charges by the SMMP; or
    b. the amount you actually receive from the third party for such Covered Charges
    c. at the time that the third party's liability for medical expenses is determined and satisfied, whether by settlement, judgment, arbitration, award or otherwise.

The SMMP will only exercise its subrogation rights if the amount received by you is specifically identified in the settlement or judgment as amounts paid for medical expenses.

HOW TO SUBMIT CLAIMS

Claims submitted for qualifying out-of-pocket covered medical expenses, as well as SMMP Wellness expenses and hearing aid/audiometric exam expenses, should be submitted as they are incurred after all other health coverage has been applied. To be considered for payment, claims must be submitted within 24 months from the dates of service. You may obtain an MBF SMMP Claim Form from the MBF website at http://nyc.gov/mbf, the MBF Office, or the SMMP Administrator's website at https://www.asonet.com/.

Note: For reimbursement for Family Building Benefits please use the Family Building Benefit Reimbursement form.

The following is a summary of claims procedures:

1. Submit medical bills to your primary health plan for benefit determination (or to apply charges toward a deductible or coinsurance).

Please note: If you are covered under the City's Employee Health Benefits Program and/or a spouse's plan (or a plan through current/former other employment), medical bills must be submitted to each health plan before submitting them to SMMP.

2. Compile all itemized bills generated from your health care provider(s) related to claims and corresponding Explanation of Benefits (EOB) statements provided by all health plans under which you have coverage.

   Please note: Your documents must include the diagnosis codes and CPT procedure codes. Section C of the MBF SMMP claim form indicates all of the information that must be included to properly identify the services provided. If the documents you submit include all of the required information for each service provided, it is not necessary to complete Section C. Claims received without this information will be pended until the required information is received.

3. Include proof of payment (cancelled check, receipt, etc.) for out-of-pocket expenses.

4. Complete the SMMP claim form in its entirety. You must enter all applicable information regarding other coverages for yourself and your eligible dependent. If there is no other coverage, you must indicate "None." If this section is left blank, processing of the claim will be delayed. Please include a copy of your City and/or non-City prescription drug cards.

5. Submit all claims, as they are incurred, with the proper documentation either electronically by visiting and registering on asonet.com or via mail at the following address:

   MBF SMMP Claims
   Administrative Services Only (ASO), Inc.
   P.O. Box 9009, Lynbrook, NY 11563-9009

   Toll Free: 1-877-844-SMMP (7667)

Payment will be made to the MBF member, and not to the provider.

Please note: Claim forms must be fully completed each time a claim for services is submitted. Failure to complete the claim form properly may result in pending or denying the claim. In addition, if the claim is pended, you have 180 days from the date the claim was pended to provide the requested documentation. If you fail to provide the documentation within this time period, the claim will be denied. This 180-day requirement does not apply if you are legally incapacitated.

CLAIMS APPEAL PROCESS

If your claim is denied in part or in whole, you may call ASO to discuss the denial before requesting a formal appeal. You also 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 to the above address documentation, questions, or comments you deem appropriate.

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.

OTHER IMPORTANT FACTS

COORDINATION OF BENEFITS

If you or a dependent are covered by another plan in addition to MBF SMMP, the two plans will coordinate benefits. Coordination of Benefits (COB) allows both plans, and in some cases a third plan, to share expenses. One plan will be considered the "primary plan" and pay its benefits first, without regard to any other plan. Then, the "secondary plan" will adjust its benefits based on the amount paid by the primary plan. As a result, your benefits from this plan may be reduced by any other benefits you are eligible to receive. Other plans include:

- Group policies or plans, whether insured or self-insured (this does not include school accident-type coverage),
- Medicare,
- Government or tax-supported programs other than Medicaid, and
- Motor vehicle insurance programs.

ORDER OF PAYMENT

When two or more plans provide benefits for the same covered person, the plans will pay benefits in the following order:

1. A plan without a Coordination of Benefits feature is always the primary plan.
2. The plan covering the patient directly, rather than as a dependent, is the primary plan.
3. If a dependent child is covered under both parents' plans and the parents are not separated or divorced, the plan of the parent whose birthday (using month and day only) falls earlier in the year is the primary plan. If both parents have the same birthday, the plan that has covered a parent longer is the primary plan. However, if the other plan does not have this "birthday" rule and as a result, the plans do not agree on the order of benefits, the plan without the birthday rule will determine which plan will be primary.
4. If a child is covered under both parents' plans and the parents are separated or divorced, the plans pay benefits in this order:
    a. If the court has established one parent as financially responsible for the child's health care, the plan of the parent with that responsibility is the primary plan. The insurance company or the Plan Administrator must be informed of the court decree.
    b. The plan of the parent with custody of the child
    c. The plan of the spouse of the parent with custody of the child
    d. The plan of the parent who does not have custody of the child
5. If the court decree states that the parents have joint custody, without mentioning which parent is responsible for the child's health care expenses, the plans covering the child will follow the order of the benefit determination rules that apply to dependents of parents who are not separated or divorced.

6. A plan covering a person as a laid-off or retired employee member (or his or her dependent) will be secondary to a plan that covers the person (or his or her dependent) as an active employee or member who is not laid-off or retired.

If none of the rules above apply, the plan that has covered the claimant for the longer period of time is the primary plan.

The claimant's length of time covered under a plan is measured from the claimant's first date of coverage under that Plan. If that date is not readily available, then it is measured from the date the claimant first became a member of the group.

HOW BENEFITS ARE COORDINATED

Submit the claim to the individual's primary (basic) plan first. After the primary plan determines benefits, then the claim should be submitted to the secondary plan if applicable, i.e. coverage through a spouse's plan. After the secondary plan determines benefits, then submit your claim and all necessary documents including Explanation of Benefits (EOBs) statements to the SMMP administrator.

As each claim is submitted, the plan determines the Allowable Expense, deducts what has been paid by the primary (and in some cases the secondary) plan and applies any deductible or co-payment against the remaining amount. At no time will the SMMP administrator pay more than what would have been paid if you did not have other coverage.

PLAN'S RIGHT TO RECOVER BENEFITS PAID (SUBROGATION)

If someone causes you to be injured or ill, the benefits under SMMP will be subrogated. This means that SMMP has the right to recover expenses from the party who caused the harm, or from any insurance company or other party.

If you recover money, you must reimburse SMMP from any monies you recover from a third party up to the amount of the benefit payments that it has made, even if you do not recover the total amount of your claim against the other person(s). If SMMP pays benefits that should have been paid by another plan or organization, SMMP has the right to seek recovery from the other plan or organization. If SMMP paid too much, it may recover the excess payment.

MEMBERS IN THE NYC HEALTH BENEFITS BUY-OUT WAIVER PROGRAM

If you have waived basic health benefit coverage under the New York City Health Benefits Buy-Out Waiver Program, you still have SMMP coverage. However, keep in mind that this coverage was designed to supplement benefits typically provided under your basic group health coverage.

ACTIVE EMPLOYEES AND THEIR DEPENDENTS ELIGIBLE FOR MEDICARE

If a person covered under the SMMP for medical benefits is actively working and is also eligible for Medicare benefits, the order of payment will be:

1) Group Employer (Primary, Secondary etc.) health plan(s)
2) SMMP
3) Medicare

In the case of end-stage renal disease (permanent kidney failure being treated with dialysis or a transplant), Medicare will become primary and the SMMP will be last in the Order of Payment determination. Medicare will not become primary for active employees until approximately 30 months after onset of end-stage renal disease.

RETIREES AND SPOUSES OVER AGE 65

Medicare-eligible individuals must be enrolled in Medicare. Medicare is the primary payor for retired members and covered spouses who are age 65 and older.

BENEFIT CONTINUATION AVAILABLE UPON COVERAGE TERMINATION

Upon termination of coverage (circumstances resulting in coverage termination are described in the "MBF Eligibility and Membership" section of this booklet) under the MBF SMMP, you may extend coverage by applying for COBRA Optional Continuance.

COBRA OPTIONAL CONTINUANCE

If your coverage or that of an eligible dependent ends, you and your dependent may each have the right to continue health expense coverage under the federal law known as the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). A notice of each person's rights under this option will be provided by your employing Agency. For additional information, refer to the COBRA section of this booklet.

To download the COBRA application, please visit the MBF website at nyc.gov/mbf. If you require additional information, email MBF by visiting the MBF website. You can also contact MBF at 1- 212-306-7290, or 1-888-4000 MBF if outside New York City.

DENTAL BENEFITS

Current administrator: Administrative Services Only (ASO), Inc., PO Box 9005, Lynbrook, NY 11563.

For information regarding in-network providers, visit asombf.com or call ASO at 1-877-844-7667 (dedicated MBF customer service line).

ELIGIBILITY

Members and dependents are eligible for dental benefits as long as they satisfy the eligibility and enrollment requirements as outlined in the "MBF Eligibility and Membership" section of this booklet.

BENEFIT YEAR

The dental benefit year runs from January 1st through December 31st.

WHAT IS COVERED

Benefits are payable for Covered Dental Charges incurred during a benefit year during which the member or eligible dependent is eligible for these benefits. Covered Dental Charges include charges for:

- Routine oral exams (including diagnosis) and prophylaxis (including scaling and polishing) but not more than once in any consecutive six-month period for each covered person.
- X-rays (limitation: charges for full-mouth x-rays series or panoramic x-rays will be covered once every 36-month period).
- Topical application of fluoride for covered persons who have not reached age 16, but not more than one application in any consecutive 6-month period for each covered person.
- Drugs prescribed by a provider for a dental condition. (Please note - if you utilize an in-network provider, medication(s) prescribed by such provider is covered through the Out-of-Network benefits - subject to deductible and co-payment.)
- Extractions, fillings, inlays, onlays and crowns.
    - Inlays, onlays and crowns are limited for replacement due to decay, fracture or loss of natural tooth structure beyond the point of restoring with an amalgam or composite. (Limitation: replacement of inlays/onlays or crowns less than three years old, by another such restoration or bridge unit, will not be covered.)
- Localized delivery of antimicrobial agents is only covered if clinically approved and rendered by a periodontist.
- Oral surgery and root canal therapy.
- A denture or bridge (Note: It is considered to be installed for the first time if it does not replace any existing denture or bridge).
- Repairing a denture or bridge.
- Replacing or altering a denture if the change is needed due to oral surgery which involves changing the position of muscle attachment or removal of a tumor, cyst, torus, or excess tissue.

- Replacing a full or partial denture if needed due to a change in the structure of the mouth or the prosthetic device as long as the device cannot be made serviceable, if replaced three years after the date the bridge or denture was installed, which was covered under this plan. Replacing or altering a fixed bridge if:
  - the change is needed due to oral surgery which involves changing the position of muscle attachment or removal of a tumor, cyst, torus, or excess tissue, or
  - it cannot be made serviceable, if replaced three years after the date the bridge was installed, which was covered under this plan.
- Application of pit and fissure sealants on unrestored permanent molars (limited to one treatment per tooth in a 24-month period and only for covered dependents up to age 16).
- Orthodontic appliances and treatment, if incurred during a course of orthodontic treatment. This term means that period which

  begins when the first orthodontic appliance is installed, and ends when the last appliance is removed.
- Implants - Approval of all implant cases will be subject to the dental claims administrator's discretion based on such issues as cost effectiveness, clinical appropriateness and likelihood of success. In addition, pre-treatment authorization is required for all dental implants. (Limitation: Replacement of implant less than seven years old after the date the previous initial implant was installed will not be covered).

Please refer to section "Charges Not Covered" below.

HIGHLIGHTS OF THE PROGRAM

The MBF Dental Plan pays a benefit for covered expenses. The amount of your benefit depends on whether you go to an in-network or out-of-network provider.

IN-NETWORK BENEFITS (PREFERRED PROVIDER ORGANIZATION (PPO) PLAN)

The Dental Plan provides quality dental coverage through the Administrative Services Only, Inc. (ASO), the Careington, and Metrodent Select networks of licensed providers and dental specialists who agree to provide care at a discounted price for covered services. By using an in-network provider, you maximize the value of your benefits. In-network dentists file claims with ASO, and receive reimbursement directly from them. In-network dentists accept what the plan pays (less any deductibles or co-insurance or amounts over the benefit maximum) as payment in full. Covered preventive and diagnostic services are reimbursed at 100% of the discount price and are not subject to the deductible. They are subject to the annual benefit maximum.

OUT-OF-NETWORK BENEFITS

Out-of-network dentists are those who have not entered into an agreement with ASO, Careington, or Metrodent Select to provide covered services at a discounted price. If you receive dental services from an out-of-network dentist during a benefit year, Covered Dental Charges are subject to a deductible, co-insurance and the benefit maximum. The deductible is waived for preventive and diagnostic expenses such as oral exams, cleanings, and X-rays.

After satisfying the deductible amount, benefits are paid based on the charges submitted for Covered Dental Charges, up to the scheduled maximum allowance for each type of service in a certain geographical area, as determined by ASO. Out-of-network dentists may accept an assignment of benefits and may bill you for the difference between what the plan pays as a benefit and what their actual charge is. Therefore, you are responsible for paying any charges in excess of that amount. Additionally, they may or may not file a claim for you. Once services have been rendered, claim forms must be sent to ASO.

SERVICE	IN-NETWORK	OUT-OF-NETWORK
Annual Deductible (Amount you must pay out-of-pocket to a provider before MBF will issue reimbursement)	$50/Individual $150/Family	$100/Individual $300/Family
Preventive/Diagnostic*	100%	80%
Basic Restorative (Extractions, fillings, root canals and periodontal treatment)	90%	80%
Major Restorative (Crowns, dentures and bridges)	90%	80%
Implants	80%	80%
Annual Maximum (Per Individual)	$5,000	
Lifetime Orthodontic Maximum** (Per Individual)	$6,000	

* Not subject to deductible

** Separate deductible ($50 in-network and $100 out-of-network per individual) and payment (100% of the discounted price for in-network services and 80% up to the maximum fee allowance for out-of-network services, up to the lifetime benefit maximum amount).

ORTHODONTIC TREATMENT

In addition to the annual dental benefit of $5,000, there is a separate $6,000 lifetime maximum for orthodontic treatment. The orthodontic benefit covers care for diagnosis, evaluation and pre/post installation of braces up to the lifetime maximum, for members and dependents.

PROCEDURE FOR OBTAINING IN-NETWORK SERVICES

Just follow these steps to select an In-Network dentist:

1. Select a provider from MBF's dental in-network directory, which is available on the ASO website at asombf.com. On the website, click "Search Participating Dentists." You can search providers by

name, city, county, zip code or specialty. You may also view your costs by choosing "your expected out-of-pocket expense" by each provider. You may also call ASO at 1-877-844-7667.

2. Contact the provider to arrange an appointment, identify yourself as an eligible member (or a dependent) of the with coverage through ASO, and confirm that the provider is a current in-network provider through Metrodent Select or Careington Networks.
3. At the time of the appointment, complete the member statement section of the claim form provided by the dentist. Participating and non-participating providers may use any standard ADA type claim form.
4. Sign the claim form allowing the provider to submit a pre-treatment estimate (when necessary) for confirmation from the Claims Administrator of the covered benefits or sign the form upon completion of services authorizing payment directly to the provider for services rendered.

Note: It is important to understand that MBF does not recommend or endorse any provider. It is recommended that you exercise the same care and apply the same criteria in selecting an in-network provider that you would in selecting an out-of-network, provider. Because many providers may practice at a site which is listed as in-network, you should verify the participation status of the dentist who is actually providing treatment.

IN-NETWORK PERFORMANCE REVIEW

The performance of the in-network panel is reviewed on a continuing basis to monitor for quality dental services.

ASO systematically monitors and evaluates the delivery and appropriateness of dental care provided by its in-network providers. In addition, all ASO providers have been fully credentialed. ASO, Careington, and Metrodent Select programs employ, among other means, patient satisfaction surveys, evaluation of treatment outcomes, and monitoring of disciplinary actions taken by official agencies.

MBF members are encouraged to notify the MBF Administrative Office as well as the administrator immediately, by telephone or mail, of any complaint involving services received.

HOW AND WHERE TO FILE AN OUT-OF-NETWORK CLAIM

1. Out-of-Network providers should use an MBF claim form or file the claims electronically. ASO payor ID # is CX076. To request a claim form, you may call ASO at 1-877-844-7667 or MBF at 1-212-306-7290 or 1-800-4000-MBF (623) if outside New York State or download a claim form at www.nyc.gov/mbf or asombf.com. Standard ADA dental claim forms will also be accepted by ASO.
2. Complete the employee's portion of the claim form for dental expense benefits. Use a separate form for each member of your family. Follow the instructions given on the form.
3. Have your provider complete the provider's portion of the claim form.
4. Send the completed form to:

   ADMINISTRATIVE SERVICES ONLY (ASO), Inc.
   PO Box 9005
   Lynbrook, New York 11563

Or have your dentist electronically file your claim with ASO, payor ID # CX076

To be considered for payment, claims must be submitted within 24 months from the date of service. Itemized bills may be required. If you have any questions regarding your claim, please call ASO Customer Service at 1-877-844-7667.

WHEN A CHARGE IS INCURRED

A charge is incurred on the date dental services are provided, on the date of insertion for dentures, bridges and crowns, and on the date of completion for root canal therapy.

ALTERNATE TREATMENT PROVISION

The administrator currently applies the Alternate Treatment Provision in determining coverage for certain services. This means that, in certain instances where there is more than one course of treatment available that can provide a professionally acceptable result, payment is based on the least costly treatment option. Guidelines for applying the Alternate Treatment Provision are established by MBF, its consultants, and the administrator. For example, suppose your provider can restore a posterior tooth with an amalgam filling, and you request a more costly type of restoration, like a composite filling. As the less costly amalgam would produce the same result, the plan will pay a benefit equal to the amount normally paid to the provider for the amalgam filling. You do not have to accept the less expensive procedure. You must pay any additional charges if you choose the more expensive procedure.

BENEFITS PRE-CERTIFICATION

A treatment plan is required for orthodontic treatment and prosthetic procedures including crowns, laminates, inlays, onlays, implants, dentures, bridgework, partials, and periodontal surgery. The treatment plan is a provider's written report giving the results of his/her exam of the covered person and the suggested treatment and charges. A treatment plan can be submitted for other courses of treatment where it would be useful to know in advance the amount of reimbursement prior to starting the course of treatment.

The administrator will estimate the benefits to be paid. Alternate procedures, services or courses of treatment will be considered in determining the benefits. As previously stated, Covered Dental Charges will be limited to the charge for the least costly method of treatment that will produce a professionally acceptable result. This includes the allowance of a removable partial denture in lieu of fixed bridgework when a member is bilaterally edentulous.

Pre-certification helps you make an informed decision before treatment begins by letting you know in advance the level of benefits available for certain services. Pre-certification is required for orthodontic treatment and prosthetic procedures including crowns, laminates, inlays and onlays, dentures, bridgework, partials, implants and periodontal surgery. The pre-certification process requires your provider to complete a claim form noting the entire treatment plan before treatment begins. To reduce processing time, please ask your provider to submit a copy of your x-rays for treatment involving such services as single crowns, inlays, onlays, implants, bridges, dentures, periodontics, and orthodontics.

The administrator will process the treatment plan and send both the provider and the member pre-certification statements identifying covered and non-covered services as well as the amount of benefits available under the plan.

IMPORTANT LIMITATIONS

The following list contains important limitations of your dental coverage:

- Prophylaxis (cleaning) and scaling/root planning cannot be performed on the same day. Payment will be made only for the scaling.
- If payment for osseous surgery and gingivectomy or periodontal scaling of teeth is requested when performed on the same day, payment will be made for osseous surgery only. Payment for gingivectomy or periodontal scaling of teeth are included in the osseous surgery payment when performed on the same day.
- Payment will be allowed for post and core only if there is root canal history for that specific tooth or an x-ray demonstrates that root canal therapy has been successfully performed.
- Periodontal maintenance procedures are limited to four visits per benefit year and each date of service must be separated by at least three full calendar months.
- Replacement of a crown for a specific tooth or implant, less than three years old will not be covered.

CHARGES NOT COVERED

Covered Dental Charges do not include charges for services and supplies:

- not ordered by a licensed provider.
- that are in excess of those that are reasonable and customary Covered Dental Charges.
- performed or furnished by a member of the covered person's immediate family (his includes mother, father, sister, brother, niece, nephew, son, daughter or spouse).
- in a Veterans' Administration Hospital.
- due to loss or theft of an appliance.
- which a covered person would not legally have to pay if there were no coverage.
- due to war, declared or not.
- from a health department maintained by an employer, a union, a trustee or a similar type of entity.
- which are payable by a government agency, local or otherwise.
- for cosmetic reasons, including altering or extracting and replacing sound teeth to change appearance.
- for chairside labial veneers.
- for dental work or dentures or bridges except as Covered Dental Charges previously specified.
- for an injury or sickness due to employment with any employer or self-employment.
- for dental charges due to an accidental injury to teeth (Note: These charges may be covered under the member's primary health insurance plan and MBF's Superimposed Major Medical Plan).
- for diagnosing or treating conditions or dysfunctions of the temporomandibular joint.
- for multiple bridge abutments.

- for stabilizing periodontally involved teeth.
- for broken appointments.
- for bone grafts after extractions (may be eligible under Superimposed Major Medical Plan as a medical service).

IMPORTANT: See "Other Important Facts" below for other conditions that may affect this coverage.

EXTENDED DENTAL BENEFITS

If, at the time a person's coverage ends, they have not completed a dental procedure which began while covered, benefits will be paid for Covered Dental Charges incurred for the unfinished dental work as if coverage had not ended, but only for the following Covered Dental Charges:

- fixed bridgework and full or partial dentures
- crowns, inlays or onlays
- root canal therapy
- orthodontic treatment
- implants

Such coverage under this extended dental benefits provision is provided for the following time periods if pre-certification is received while covered and treatment has commenced:

- for up to one month after the date the person's coverage ends, if it ends because the plan terminates.
- for up to three months after the date the person's coverage ends or the person's title moves to a collective bargaining title and that title is no longer eligible under MBF.

COORDINATION OF BENEFITS (COB)

If any member or dependent is eligible for MBF benefits as an employee or retiree, that person is not eligible for coverage as a dependent. If you or a dependent is covered by another group dental plan in addition to the MBF dental plan, MBF's plan will take into account benefits paid or payable by the other coverage(s) in determining if additional benefit payments can be made by MBF. Coordination of Benefits (COB) allows both plans, and in some cases a third plan, to share expenses. One plan will be considered the "primary plan" and pay its benefits first, without regard to any other plan. Then, the "secondary plan" will adjust its benefits based on the amount paid by the primary plan. As a result, your benefits from this plan may be reduced by any other benefits you are eligible to receive. If you or a dependent uses a provider participating with your primary insurance and no out-of-pocket expense is incurred, no further benefits will be allowed.

Order of Payment

When two or more plans provide benefits for the same covered persons, the plans will pay benefits in the following order:

A plan without a Coordination of Benefits feature is always the primary plan.

The plan covering the patient directly, rather than as a dependent, is the primary plan.

For active members only covered by more than one plan, the coverage whose effective date is older will be the primary plan.

If a dependent child is covered under both parents' plans and the parents are not separated or divorced, the plan of the parent whose birthday (using month and day only) falls earlier in the year is the primary plan. If both parents have the same birthday, the plan that has covered a parent longer is the primary plan. However, if the other plan does not have this "birthday" rule and as a result, the plans do not agree on the order of benefits, the plan without the birthday rule will determine which plan will be primary.

If a child is covered under both parents' plans and the parents are separated or divorced, the plans pay benefits in this order:

1. If the court has established one parent as financially responsible for the child's health care, the plan of the parent with that responsibility is the primary plan. The Plan Administrator must be informed of the court decree.
2. The plan of the parent with custody of the child.
3. The plan of the spouse with custody of the child.
4. The plan of the parent who does not have custody of the child.

If the court decree states that the parents have joint custody, without mentioning which parent is responsible for the child's health care expenses, the plans covering the child will follow the order of the benefit determination rules that apply to dependents of parents who are not separated or divorced.

A plan covering a person as a laid-off or retired employee member (or their dependent) will be secondary to a plan that covers the person (or their dependent) as an active employee or member who is not laid-off or retired.

If a member is insured under COBRA, the other insurance carrier is the primary plan.

If none of the rules above apply, the plan that has covered the claimant for the longer period of time is the primary plan.

The person's length of time covered under a plan is measured from the person's first date of coverage under that plan. If that date is not readily available, then it is measured from the date the person first became a member of the group.

How Benefits are Coordinated

When the MBF plan is secondary, submit your claim to the primary plan first. After the primary plan has rendered a payment determination, submit your claim and the primary plan's Explanation of Benefits (EOB) statement(s) to the MBF dental plan. The MBF plan will determine the allowable expense for each service, deduct what has been paid by the primary (and any other group plan) and apply any applicable deductible against the remaining balance. When coordinating benefits, the MBF payment will not exceed the member's out-of-pocket expense remaining after the primary payment.

PLAN'S RIGHT TO RECOVER BENEFITS PAID (SUBROGATION)

If someone causes you to be injured or ill, the plan has the right to recover expenses from the party in question or that party's insurer. If MBF pays benefits that should have been paid by another plan or organization, the MBF plan may get its money back from the other plan or organization. If MBF paid too much, it may recover the excess payment.

ASSIGNMENT OF BENEFITS

All payments for in-network care will be paid automatically to the participating providers. Benefits for services provided by an out-of-network provider will be payable to the member or provider. To allow assignment of benefits to the provider, the member must sign the appropriate section of the dental claim form prior to submission.

CLAIMS APPEALS PROCESS

Your dental plan benefit provides for a two-level appeals process for benefit determinations. When appealing a determination made by the administrator, state the reason you believe the claim was improperly denied and submit documentation, questions and comments you deem appropriate to ASO, Inc. P.O. Box 9005, Lynbrook, NY 11563, Attention: Grievances and Appeals. Your appeal must be filed within 180 days after you receive notice of the adverse benefit determination. ASO will conduct a full and fair review of your appeal. ASO has thirty (30) days once all documentation has been received, to review the appeal, investigate and make a determination. If necessary, you will then have an additional thirty (30) days to appeal to MBF regarding this decision.

COBRA

If your coverage, or that of a dependent ends, you and your dependent may each have the right to continue coverage under the federal law known as the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). A notice of each person's rights under this option will be provided by your employer agency. Any person who has questions regarding COBRA of dental benefits should refer to Section K in this benefits booklet or contact MBF at 212-306-7290 or 1-888-4000 MBF(623) if outside New York City. You can also email MBF by visiting nyc.gov/mbf.

OTHER IMPORTANT FACTS

Allowable Expense. This term means any necessary item of expense within the maximum allowable fee schedule for in-network claims and reasonable and customary allowance for out-of-network claims, which is covered by (a) this plan, or (b) another plan, except Medicare or a "no-fault" motor vehicle plan. When a plan provides benefits in the form of services, the reasonable cash value of each service will be considered as both an Allowable Expense and a benefit paid.

Claim Determination Period. This term means the time during any one calendar year when a person is covered and incurs charges for one or more items of expenses covered under this plan and under at least one other plan.

As each claim is submitted, each plan is to determine its liability and pay or provide benefits based upon Allowable Expenses incurred to that point in the Claim Determination Period. That determination is subject to adjustment as later Allowable Expenses are incurred in the same Claim Determination Period.

Plan. This term means any plan that provides dental care coverage written on an expense-incurred basis with which coordination is allowed.

"Plan" may include:

(a) any group insurance or any other method of coverage of persons in a group.

(b) an uninsured arrangement of group coverage.

(c) group coverage through HMOs and other prepayment, group practice and individual practice plans.

(d) any governmental plan, but not including a state plan under Medicaid.

(e) any plan required by law, but shall not include a plan when, by law, its benefits are in excess to those of any private insurance plan or other non-governmental plan.

(f) the medical benefits coverage in group and individual mandatory automobile "no-fault" and traditional mandatory automobile "fault" type contracts.

(g) Medicare.

"Plan" shall not include:

(a) blanket school accident coverage; or

(b) hospital indemnity coverage.

DEFINITIONS

Charges/Fees/Expenses

The terms "charges," "fees," or "expenses," as they relate to dental care, will not include any amount:

(a) for a service or supply not generally accepted in dental care practice as necessary for the diagnosis or treatment of the patient, even if ordered by a provider, and which is not medically necessary;

Services will be deemed "Medically Necessary" if:

i. they are clinically appropriate in terms of type, frequency, extent, site, and duration, and considered effective for the illness, injury, or disease;

ii. they are required for the direct care and treatment or management of that condition;

iii. the condition would be adversely affected if the services were not provided;

iv. they are provided in accordance with generally-accepted standards of dental practice;

v. they are not primarily for the convenience of you, your family, or your provider;

vi. they are not more costly than an alternative service or sequence of services that is at least as likely to produce equivalent therapeutic or diagnostic results.

(b) for repeated tests which are not needed, even if ordered by a provider;

i. as it applies to charges, fees or expenses of participating providers; more than that which is negotiated between the participating provider and ASO, Careington, or Metrodent Select for covered services.

ii. as it applies to all other charges, fees or expenses more than what is a reasonable and customary covered dental charge in the geographic area where the charge was incurred, as determined by ASO.

These amounts will be determined by ASO.

Preferred Provider

This term refers to a Provider that has an agreement with MBF's In-Network Administrators to provide covered services at a pre-negotiated rate. This arrangement does not limit a covered person to the use of services provided only by a Preferred Provider.

Please note that the Management Benefits Fund does not recommend or guarantee any of the dental services covered by the Dental Program and does not endorse or recommend any of the providers offering those services. You should exercise independent judgment in screening and selecting an appropriate service provider. Your decision to receive services and your selection of a particular provider are solely your responsibility.

VISION CARE BENEFITS

VISION ADMINISTRATOR

The Administrator for the MBF Vision Care Program is General Vision Services (GVS), 520 Eighth Avenue, 9th Floor, New York, NY, 10018.

ELIGIBILITY

Members and their dependents are eligible for Vision Care Benefits as long as they satisfy the eligibility and enrollment requirements as outlined in the "MBF Eligibility and Membership" section of this booklet.

BENEFIT YEAR

The Vision Care Benefit year runs from January 1st through December 31st.

BENEFIT OPTIONS

There are two options for obtaining vision care benefits through the Vision administrator, GVS:

- In-Network (PPO) Benefit: You utilize one of GVS's in-network participating vision care providers for full-service benefits, paid directly by MBF to the provider, without incurring any out-of-pocket expense for most services, subject to annual benefit limitations.
- Out-of-Network Option: You select and directly pay the provider of your choice, file a claim with the MBF Vision Care Administrator, and you are reimbursed up to the scheduled limits. The maximum benefit is $150 per covered person, per benefit year. To be considered for payment, all claims must be submitted within 24 months from the date of services. Claim form can be requested by e-mailing the vision care provider directly at mbfmembers@gvsbenefits.com

Once selected, only one of the above options (In-Network or Out-of-Network) may be used for all services within a benefit year. (In-network/out-of-network benefits do not need to be obtained during a single visit.)

Important: Please refer to the section "Specific Details of Your Vision Care Benefit Options" below for complete information on the in-network (PPO) and out-of-network options.

SCHEDULE OF BENEFITS

Covered Charges

Covered charges are the usual and customary charges for the services and supplies recommended and made by a legally qualified ophthalmologist(s), optometrist(s), or optician(s) during the benefit year. Covered charges include:

- Eye Examinations: One eye examination, including a Dilated Fundus Evaluation (DFE) when professionally indicated, is covered each benefit year, per covered individual.
- Lenses (including contact lenses and prescription sunglasses): One pair of glass or plastic spectacle lenses is covered each benefit year, per covered individual. However, if there is a prescription change or accidental breakage

during the benefit year, the spectacle lenses (not contact lenses) may be replaced under the out-of-network option only with reimbursement limited to the unused portion of the current benefit year maximum payment. There is a one-year breakage warranty for collection (plan) frames at in-network locations. In lieu of eyeglasses and at select GVS locations, conventional or disposable (2 week) contact lenses will be offered as plan contacts. An allowance will be offered for contact lenses deemed non-plan (outside the plan contact lenses) at all GVS in-network locations.

- Frames: One pair of eligible frames is covered per person, per benefit year. At locations where there is a GVS Frame Collection, any collection frame up to a retail value of $300 is included at no charge. For members choosing a frame from the provider's own selection of frames, a $200 credit will be applied. If you choose to utilize your benefit at a Costco Optical location, please note that the frame allowance will be $80.

Note: You will not be covered for frames in the same benefit year for which coverage for contact lenses has been provided by the Vision Care Plan.

Charges Not covered

- The following charges are not covered under the Vision Care Plan:
- Services or supplies that are not provided by a licensed and qualified ophthalmologist, optometrist or optician.
- Sunglasses or other spectacle lenses that do not require a prescription.
- Expenses incurred due to an injury or sickness connected with any employment, or for services which are compensated under Workers' Compensation or similar legislation.
- Repair or replacement of damaged frames or spectacle lenses except under the PPO Option's warranty provisions or under the accidental breakage allowance of the out-of-network option. (See section "Schedule of Benefits")
- Replacement of lost lenses or frames, or replacement of scratched lenses not covered by the in-network plans warranty provisions.
- Services or supplies for which the covered person incurred no expense.
- For frames in the same benefit year for which coverage for contact lenses has been provided by the Vision Care Plan.
- Medical treatment of eye disease or injury.
- Vision therapy.
- Lasik Surgery (However, discounts are available, see Laser Vision Correction Services section).
- Non-prescription (plano) lenses.

SPECIFIC DETAILS OF YOUR VISION CARE BENEFIT OPTIONS

Out-of-Network Option

The Out-of-Network Option reimburses eligible members and dependents up to $150 per person per benefit year. Up to $25 can be submitted for the examination and up to $125 for materials (eyeglasses or contact lenses).

Members receive reimbursement under the Out-of-Network Option as follows:

Select any qualified provider and pay the provider directly for services rendered.

The provider and the member should complete the appropriate sections of the Vision Care Direct Reimbursement Claim Form (located on the MBF website at nyc.gov/mbf), which should then be mailed to:

General Vision Services
520 Eighth Avenue
9th Floor – Attention Out-of-Network Department
New York, NY 10018

Out-of-Network forms can also be requested from GVS and then e-mailed to: mbfmembers@gvsbenefits.com

Members are then reimbursed via regular mail by GVS for vision care expenses according to plan guidelines.

Members may only submit one claim for each covered person during a single benefit year to receive the maximum out-of-network reimbursement amount.

In order to be considered for payment, claims must be submitted within 24 months of the date of service.

In-Network (PPO) Option

The in-network option is designed to provide eligible members and dependents with comprehensive services while maximizing value through reduction or elimination of out-of-pocket expenses, subject to benefit limitations. Listed below are key features of this option:

Annual benefit for an eye examination, lenses, and frames.

No annual deductible.

For a full listing of in-network providers, please visit www.generalvision.com or call the MBF concierge line at GVS at 888-906-0393. When searching on the GVS app or the website, please use the MBF group number #6054.

Plan Benefits

- Eye Exam
  - One eye examination, including a Dilated Fundus Evaluation when professionally indicated, is covered in full when done by an in-network provider.
- Lenses
  - Lenses available through the in-network option at no out-of-pocket member cost include:
    - All prescription ranges in glass or plastic lenses, including prescription sunglasses
    - Polycarbonate lenses
    - Single vision, bifocal, trifocal and cataract lenses
    - Blended Bifocals

- Progressive addition (no-line) multifocals
- Oversized lenses (larger than standard size) for larger frame styles
- Fashion and gradient tints (available for plastic lenses only)
- Photosensitive (plastic) transitions (lenses that darken when exposed to the ultraviolet rays of the sun)
- High-Index lenses (thinner and lighter lenses)
- Polarized lenses
- UV coating
- Reflection-free standard coating - Anti-Reflective Coating (ARC)
- Scratch-resistant coating
- Premium ARC is available with a $13.00 copayment
- Ultra ARC is available with a $25.00 copayment
- Ultra Progressive Lenses are available with a $50.00 copayment
- Blue Light Filtering Coating is available with a $25.00 copayment

- Frames
  - GVS offers a selection of approximately 200 frames of both metal and plastic construction. This collection includes selected designer frames from GVS' exclusive Frame Collection. Any frame up to a retail value of $300 is included at no additional cost.
  - No co-payment is required, and
  - Unconditional one-year warranty against breakage is provided.

In lieu of Eyeglasses (In-Network PPO Option)

- Contact Lenses

  MBF members and eligible dependents can obtain specified plan disposable or frequent replacement contact lenses at no cost. For members prescribed Plan Collection Lenses, up to a 12-month supply is included at no additional cost.

- Non-Plan Contact Lenses and Frames

  Under the in-network benefit, MBF provides a specific allowance ($200) for non-plan frames (i.e. special designer frames) or specialty contact lenses. After this designated allowance is applied, the member is responsible for the difference and will be responsible for any additional cost, paid directly to the participating provider, without reimbursement from MBF. In the case of non-plan contact lenses, MBF provides the same allowance (in lieu of eyeglasses) towards purchase. The evaluation, fitting, and follow-up cost has been fixed at a $50.00 co-payment.

  Benefits and participation may vary by retailer location. Costco locations will provide a wholesale equivalent of $80 for frame selections.

Procedure for Obtaining In-Network Vision Care Services

MBF uses a "paperless" voucher system; no paper claim forms or vouchers are needed when utilizing vision care services from an MBF in-network provider. Just follow these steps to obtain your benefits:

1. Select a provider from the MBF Vision Care In-Network PPO Directory, which is available by visiting the GVS App, www.generalvision.com, or by calling GVS directly on the MBF concierge line at 888-906-0393.
2. Make an appointment with the in-network provider of your choice and identify yourself as an MBF member. (Verification of MBF and benefit usage eligibility will be conducted directly between the provider you have selected and GVS.) For members using one of the national retailers, please identify yourself as a VBA member having the GVS/MBF benefit. Please have your virtual ID card available as you will be asked for your ID and plan number when visiting the location. You will be asked to provide the last 4 digits of your Social Security Number for verification.
3. Go to your scheduled appointment, receive your examination, and select your eyewear.
4. Pick up your eyewear when it is ready and sign a Member Record Form verifying your receipt of services and supplies. You do not have to pay the provider unless you selected services or materials that are not covered by the plan or require a co-payment.

CONTACT LENS MAIL-ORDER PROGRAM (FOR REPLACEMENT CONTACTS ONLY AFTER THE BENEFIT HAS BEEN USED)

All members of MBF and their eligible dependents are eligible to participate in a mail-order contact lens program, which offers savings on all contact lenses and solutions. Replacement contacts (after initial benefit) through 1-800-AnyLens mail-order service ensures easy, convenient, purchasing online and quick, direct shipping to your door. They can be reached directly at 1-800-ANY-LENS or visit https://www.1800anylens.com/.

LASER VISION CORRECTION SERVICES

GVS provides you and your eligible dependents with the opportunity to receive Laser Vision Correction Services at discounts. All Lasik Benefits are administered by QualSight. Members with questions or who are looking for a participating provider should call 1-888-568-0308 and identify themselves as a GVS member.

COBRA OPTIONAL COVERAGE

If coverage of a member or their dependent ends, that person has the right to continue coverage under the federal law known as the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). Notice of each person's rights under this option will be provided by the member's employing agency. Any person who has questions on COBRA optional continuance should contact their Agency personnel officer or the MBF administrative office.

Please note that MBF does not endorse or guarantee any of the vision care services covered by the Vision Care Program and does not endorse or guarantee any of the providers offering those services. You should exercise independent judgment in screening and selecting an appropriate service provider. Your decision to receive services and your selection of a particular provider are solely your responsibility.

HEALTH AND FITNESS REIMBURSEMENT PROGRAM

OVERVIEW

MBF offers members and their spouse/domestic partner a Health and Fitness Reimbursement Program, which provides reimbursement for participation at a health club/gym and other physical fitness programs.

WHO IS COVERED

- Active/Retiree MBF member
- Active/Retiree MBF member's spouse/domestic partner

NOTE: Dependent children are not eligible for this benefit.

TYPES OF FACILITIES/FITNESS PROGRAMS COVERED

Your health club/gym or physical fitness program must be a facility in which you participate in health fitness activity or physical exercise, designed to improve the health and physical condition of each member (examples: health club/gym membership, Citibike (fitness purposes only), yoga, ClassPass, SoulCycle, etc.) A physical fitness program includes at-home virtual/on-line fitness programs or regular subscriptions. An example of an eligible virtual physical fitness program is Peloton. Please refer to the exclusions listed below under "Limitations and Exclusions."

BENEFITS

The program provides the following benefits:

For any claim periods before March 1, 2024:

MEMBER	SPOUSE/DOMESTIC PARTNER
$250 maximum per six-month period ($500 annual maximum)	$250 maximum per six-month period ($500 annual maximum)

For any claim periods on or after March 1, 2024, or after:

MEMBER	SPOUSE/DOMESTIC PARTNER
$500 maximum per six-month period ($1,000 annual maximum)	$500 maximum per six-month period ($1,000 annual maximum)

Note: If your claim period includes dates both prior to and after March 1, 2024, then your reimbursement will be a maximum reimbursement of $500 for the 6-month claim period.

Effective for claims submitted on or after July 1, 2024:

Claims are eligible for reimbursement as long as the MBF member and/or spouse/domestic partner submits the following:

- Health and Fitness claim form indicating a six-month consecutive period, and
- Proof of payment for any eligible Health and Fitness expenses, such as those at a health club/gym/fitness program, that were incurred within the six-month consecutive claim period. You do not need to have reimbursable expenses during every month of the 6-month period. However, reimbursement will only be issued for months in which payment receipts are provided.

Example: Claim period of January 2025-June 2025. Member incurred CitiBike expenses in January, March, April, May, and June. Member may submit for the January-June period and will be eligible for reimbursement for expenses incurred during those 5 months.

CLAIMS PROCESS

Claims may be submitted for yourself and your spouse/domestic partner for each six-month period and must include one of the following as proof of payment:

- health club/gym contract,
- payment receipt,
- credit card statement, or
- letter on company (health club/gym) stationery or letterhead.

To be considered for payment, claims must be submitted within 24 months of the claim period ending date. To obtain a claim form, visit the MBF website at nyc.gov/mbf.

All completed claim forms must be submitted, along with proof of payment, to MBF at the following link:

https://nyc-mbf.leapfile.net

REIMBURSEMENT/TAXABLE INCOME

Active Employees and Employee's Spouse/Domestic Partner

Active employees will receive reimbursement of approved claims in the month following the month the claim was processed. All reimbursements for a member's spouse/domestic partner will be issued directly to the member.

Employees of the Mayoralty, Housing Authority, Department of Education (H-Bank), NYC H+H, School Construction Authority, and Cultural Institutions/Libraries will receive reimbursement in their regular paychecks and appropriate taxes will be withheld.

Note: Unified Court System (UCS) employees will receive reimbursement directly from MBF. Since this is a taxable benefit, UCS employees will be responsible for paying all applicable taxes when filing an income tax return.

Retired Employees and Retiree's Spouse/Domestic Partner

MBF retirees will receive reimbursement of approved claims directly from MBF, minus 7.65% FICA, via direct deposit. Reimbursement for participation in the Health and Fitness Reimbursement Program is considered taxable income for the member in the calendar year in which it is paid. They will receive a Form W-2 for the reimbursement amount. This reimbursement amount should be reported as earned income on the retiree's tax return.

HEALTH AND FITNESS REIMBURSEMENT CERTIFICATION

By participating in this benefit, the MBF member and/or spouse/domestic partner acknowledge that MBF has not given any medical advice nor has recommended participation in and bears no liability resulting from any injuries or damages arising from use of this benefit. Prior to participating in this benefit, it is recommended that the claimant consults with their own physician.

The MBF member and/or spouse/domestic partner affirm and verify that all claim information submitted to MBF is complete, true, and accurate to the best of their knowledge. If any information or documentation submitted to MBF is fraudulent, the claim will be denied and may be referred to the City of New York Department of Investigations.

LIMITATIONS AND EXCLUSIONS

1. MBF does not process claims for claim periods less than six consecutive months in duration.
2. Any establishment that does not have health club/gym/fitness services as one of its primary purposes or businesses, such as weight loss clinics, spas, medical facilities, rehabilitative programs, or other similar facilities, is not eligible.
3. Coverage does not include the purchase or rental of exercise equipment or expenses incurred for equipment, locker rentals, clothing, vitamins, or other services offered by the health club/gym facility for an additional fee (e.g. massages).
4. Classes or programs provided by any nonprofit school, public school or private school, college or university that are part of a degree program are not covered.
5. Registration fees for events, such as marathons, are not eligible.
6. Payment of membership fees to the fitness center by gift certificate or by a non-MBF member/spouse/domestic partner is not eligible for reimbursement.
7. Maintenance fees and/or common charges that include fitness center fees are not included.

If the member and/or member's spouse/domestic partner has a family membership at a health club that includes dependent children, the member or member's spouse/domestic partner must submit the pro-rated cost of a membership, covering only the fee for the member and/or member's spouse/domestic partner.

RETIREE MEDICARE HMO AND MEDICARE ADVANTAGE PLAN DRUG BENEFITS

OVERVIEW

MBF pays the drug option premium cost directly to Health Maintenance Organizations (HMOs) and Medicare Advantage (MA) Plans on behalf of Medicare-eligible retirees and their spouses/domestic partners who are enrolled in qualified Medicare HMOs and MAs.

ELIGIBILITY

Retired MBF members and/or their spouses/domestic partners who satisfy MBF's eligibility and enrollment requirements, as outlined in the "MBF Eligibility and Membership" section of this booklet, are eligible for benefits under this program if:

1. their Retiree City health plan coverage is provided through a Medicare HMO or MA with the optional rider (prescription drug coverage);
2. they are receiving a City pension;
3. they are enrolled in Medicare Parts A & B; and
4. they reside at their present address for at least nine months of the year.

QUALIFIED MEDICARE HMO PLANS AND MA PLANS

The City of New York Employee Health Benefits Program (HBP) publishes a Summary Program Description (SPD) that provides detailed information on qualified Medicare HMO Plans and MA Plans. The SPD can be viewed and downloaded from the Health Benefits Program website at nyc.gov/hbp.

BENEFITS

MBF will pay the premium cost of any optional prescription drug rider of Medicare HMO Plans and MA Plans offered by HBP directly to the health plan, where such a cost would otherwise be paid by the member through pension deductions. Therefore, no premium will be deducted from the member's pension check. The member, however, will be liable for any deductibles or co-payments (if applicable).

PLEASE NOTE: MBF Retiree Medicare HMO/MA prescription drug rider is only available to Medicare-eligible members and/or their Medicare-eligible spouses/domestic partners. Charges for a prescription drug rider for a non-Medicare-eligible person will not be assumed by MBF and are the responsibility of the member.

PROCEDURE FOR OBTAINING BENEFITS

As long as a member and/or their spouse/domestic partner satisfies the MBF eligibility criteria, and applies for prescription drug rider coverage under a Medicare HMO Plan or MA Plan offered by the City, which charges a separate premium payment for such coverage, they automatically receive the subsidy. MBF pays the premium cost directly to the HMO or MA, without any further paperwork required on the member's part.

SUBSIDY BENEFIT FOR MEDICARE SUPPLEMENTAL PLANS

OVERVIEW

The Medicare Supplemental Subsidy Benefit is a payment made by MBF directly to the Health Benefits Program on behalf of retired MBF members and their spouses/domestic partners covered under an optional prescription drug rider of a Medicare Supplemental Plan offered by the City.

ELIGIBILITY

Retired MBF members and/or their spouses/domestic partners who satisfy the MBF eligibility and enrollment requirements, as outlined in the "MBF Eligibility and Membership" section of this booklet, are eligible for benefits under this program if:

1. their City health plan coverage is provided through a Medicare supplemental plan offered by the City with the optional rider (prescription drug coverage);
2. they are receiving a City pension; and
3. they are enrolled in Medicare Parts A & B.

ELIGIBLE MEDICARE SUPPLEMENTAL PLANS

The New York City Employee Health Benefits Program publishes a Summary Program Description (SPD) that provides detailed information about the Medicare supplemental plans currently offered:

1. GHI/AnthemBCBS Senior Care Program, and
2. Anthem Medicare-Related Program

To view or download this SPD visit the Health Benefits Program website at nyc.gov/hbp.

BENEFITS

MBF pays a $50.00 per person per month subsidy ($100.00 maximum) directly to the health plan on behalf of retired members and their spouses/domestic partners who are covered under an optional prescription drug rider of a Medicare Supplemental Plan offered by the City. Therefore, the monthly health plan optional rider premium on the retiree's monthly pension check will be reduced by the amount of the subsidy and the remainder of the premium will be deducted from their pension check.

Please note: The GHI/AnthemBCBS Senior Care Program Subsidy Benefit is only available to Medicare-eligible members and/or their Medicare-eligible spouses/domestic partners. Charges for optional riders for a non-Medicare-eligible person or for charges other than prescription drug riders will not be subsidized by MBF and are the responsibility of the member.

PROCEDURE FOR OBTAINING BENEFITS

This benefit provides those eligible members insured through one of the above Medicare Supplemental Plans with a $50.00 per person ($100.00 maximum) monthly subsidy. This subsidy is automatically reflected in the member's pension check according to the member's coverage status and effective as of the coverage begin date.

SURVIVOR BENEFITS

OVERVIEW

MBF provides Survivor Benefits to the spouse/domestic partner and eligible dependent children of deceased MBF members. Survivor Benefits are provided for a 36-month period. These benefits, which are fully paid for by MBF, include:

- Basic City Health Insurance with the Optional Benefit Rider, if applicable
- Superimposed Major Medical Plan (SMMP) Benefits
- Dental Benefits
- Vision Care Benefits

WHO IS COVERED

MBF provides Survivor Benefits to the eligible:

Surviving Spouse/Domestic Partner, and

Dependent Children up to age 26 or disabled children regardless of age.

If the deceased member was eligible for MBF benefits either as an employee or retiree at the time of his/her death, the surviving spouse/domestic partner and dependent children, who were previously eligible for MBF benefits, are eligible for Survivor Benefits.

WHAT IS COVERED

City Health Insurance

The surviving spouse/domestic partner and eligible dependent children will be provided coverage in the same City Health Insurance Plan that they were enrolled in at the time of the member's death. In addition, should the health plan offer an Optional Benefits Rider, MBF will also offer the same Optional Rider to the survivor(s) free of charge for the specified 36-month period.

MBF Benefits

Survivors are provided with coverage under MBF's SMMP, Dental and Vision Care plans.

Please note:

If the deceased MBF member was an employee or retiree of the State of New York, his/her survivors are only eligible for MBF's SMMP, Dental, and Vision Care Benefits.

If the surviving spouse/domestic partner of a deceased MBF member is an employee/retiree of the City of New York, the spouse/domestic partner and eligible dependents are only eligible for MBF SMMP, Dental, and Vision Care Benefits. Note: If the surviving spouse/domestic partner is also an MBF member, double coverage is not allowed.

EFFECTIVE DATES OF COVERAGE

Commencement of Survivor Coverage

The commencement of City Health Insurance coverage for survivors is based on the deceased member's status (active or retired) at the time of death. Coverage commences as follows:

DECEASED MEMBER STATUS	COMMENCEMENT OF COVERAGE
Active	The day following the member's death.
Retired	The first day of the month following the month of the member's death. Please note, the City of New York, Health Benefits Program provides survivors with Health Insurance coverage during the month of the death of the deceased retired member.

MBF provides survivors with MBF's SMMP, Dental, and Vision Care Benefits commencing on the day following the active/retired member's death.

Termination of Survivor Coverage

All MBF Survivor Benefits cease on the last day of the 36-month period following the date of the member's death. Please note that survivors should obtain their own individual policy prior to the expiration of the 36-month period.

COORDINATION OF BENEFITS

Established rules for Coordination of Benefits still apply with regard to Basic City Health Benefits and other MBF Benefits.

HOW TO APPLY

After MBF is notified of a member's death, the eligible surviving spouse/domestic partner or dependent children will be sent an application form via email to complete and return to MBF electronically. Coverage will be maintained retroactive to the date of the member's loss of coverage, pending receipt and approval of the application document(s).

FILING CLAIMS

The surviving spouse/domestic partner and eligible dependent children should file claims for SMMP, Dental and Vision Care benefits as outlined in the individual benefit sections of this booklet.

Important: When filing a claim for Survivor Benefits, please refer to the table below for information on which number must be used.

SURVIVORS	HEALTH PLAN I.D. NUMBER TO BE USED WHEN FILING CITY HEALTH INSURANCE CLAIMS	SOCIAL SECURITY NUMBER (SS#) TO BE USED WHEN FILING SMMP, DENTAL AND VISION CARE CLAIMS
Survivors of a deceased active member	• New Health Plan I.D. Number of the survivor(s) for claims incurred after the member's death.	• SS# of the deceased member for claims incurred until the last day of the month of the member's death. • SS# of the main survivor for claims incurred from the first day of the month following the member's death.
Survivors of a deceased retired member	• Health Plan I.D. Number of the deceased member for claims incurred until the last day of the month of the member's death. • New Health Plan I.D. Number of the survivor(s) for claims incurred from the first day of the month following the member's death.	• SS# of the deceased member for claims incurred until the last day of the month of the member's death. • SS# of the main survivor for claims incurred from the first day of the month following the member's death.

CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT (COBRA)

The Federal Consolidated Omnibus Budget Reconciliation Act of 1985 (called COBRA) requires the City of New York to offer employees, retirees, their covered dependents, and any child(ren) born or adopted during the COBRA continuation period, the opportunity to continue MBF coverage in certain instances when the coverage would otherwise terminate. As per New York State Law, the coverage continuation period is 36 months. The monthly premium is 102% of the group rate.

Current administrator: Administrative Services Only (ASO), Inc., PO Box 9005, Lynbrook, NY 11563.

For information regarding COBRA benefits, visit asombf.com or call ASO at 1-877-844-7667 (dedicated MBF customer service line).

COBRA participants will be billed directly by ASO for premiums on a monthly basis.

WHEN IS COBRA COVERAGE OFFERED? (QUALIFYING EVENT)	TO WHOM IS COBRA COVERAGE OFFERED? (QUALIFIED BENEFICIARY)	FOR HOW LONG IS COBRA COVERAGE OFFERED?
Reduction in hours of member's employment resulting in loss of benefit coverage Termination of member's employment (including unpaid leave of absence, i.e. FMLA and SLOAC) for any reason other than gross misconduct Member's deferred retirement	Employee Spouse/Domestic Partner Dependent Children	36 months
Death of MBF member	Spouse/Domestic Partner Dependent Children	36 months
Divorce Termination of domestic partnership	Spouse/Domestic Partner Dependent Children	36 months
Loss of eligible dependent child status	Dependent Children	36 months
When a dependent child reaches age 26 (Young Adult Dependent, YAD)*	Dependent Children age 26	36 months (until age 29)

* MBF also offers Direct Pay Coverage Continuation (DPCC) for eligible dependent children of MBF members through age 29.

To be eligible for MBF DPCC coverage, the YAD does not have to live with an MBF Member, be financially dependent on an MBF Member, or be a student. However, the YAD 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 for their YAD to be eligible for DPCC.

COBRA BENEFIT OPTIONS

COBRA benefit continuation options provided by MBF are as follows:

1. Superimposed Major Medical Plan (SMMP), Dental, and Vision Care Benefits; **or**
2. Only Dental and Vision Care Benefits; **or**,
3. Only SMMP Benefits.*

- *The $10,000 individual/$30,000 family deductible under the SMMP for COBRA is based on not having any primary health coverage whether through a City health plan or other group health plan.

WHEN WILL COBRA CONTINUATION TERMINATE

Continuation coverage will be terminated after 36 months from the MBF member's date of death, or upon a dependent reaching age 29, if YAD coverage is elected.

Continuation coverage will be terminated before the end of the maximum period if:

Any required premium is not paid in full on time, or

MBF ceases to provide SMMP, Dental or Vision Care benefits for its members.

Continuation coverage may also be terminated for any reason that MBF would terminate coverage of a member or eligible dependent receiving coverage as an active member (e.g., due to discontinuation of any group coverage).

HOW TO APPLY FOR COBRA

To elect MBF COBRA continuation coverage, the member or spouse/domestic partner or dependent child should complete an MBF COBRA Application and submit it to MBF within 60 days of the date of benefit coverage termination. If YAD coverage is being elected, the YAD application should be completed and returned to MBF.

The member may be eligible to receive COBRA continuation coverage from their primary City health plan. Please contact your agency benefit manager or health carrier directly within 60 days of your benefit coverage termination to apply for this coverage.

For updates to COBRA regulations, rates and an application, please visit the MBF website at nyc.gov/mbf or call MBF at 1-212-306-7290, or at 1-888-4000MBF (1-888-400-0623) if outside New York City. Please keep MBF informed of any address changes.

MBF BENEFITS DURING CITY APPROVED LEAVE

FAMILY MEDICAL LEAVE ACT (FMLA)

The Family and Medical Leave Act of 1993 (FMLA), which became effective February 5, 1994, entitles eligible and approved employees up to a maximum of 12 weeks of paid and/or unpaid leave in a 12-month period for the serious illness of the employee or to care for an immediate family member. Eligible and approved employees using this paid and/or unpaid leave can continue their primary City health coverage and MBF benefits which are paid by the City and MBF, respectively, for up to a maximum of 12 weeks.

EMPLOYEE ELIGIBILITY

An employee is eligible for leave under FMLA if they have worked:

- For the City of New York for at least 12 months; and
- At least 1,250 hours during the 12-month period prior to the start of the FMLA leave.

LEAVE ENTITLEMENT

An eligible employee may apply for leave under FMLA for one or more of the following reasons:

- For the care of the employee's newly born child, newly adopted child or newly placed foster child.
- For the care of an immediate family member (spouse, child under age 18, child aged 18 or older but incapable of self-care because of a physical or mental disorder, or parent) with a serious illness. Please note that parents of spouses are not included in this provision.
- When the employee is unable to work because of a serious illness.

WHO IS COVERED

MBF provides continuation of benefits to the MBF member and their eligible dependents (spouse/domestic partner and children).

BENEFITS COVERED

Benefits which are fully paid by MBF include:

- Basic Life Insurance and Accidental Death & Dismemberment Insurance (member only),
- Superimposed Major Medical Plan,
- Dental, and
- Vision Care

HOW TO APPLY

Contact the personnel office of your employer agency to request a leave under FMLA.

PAID FAMILY LEAVE (PFL)

Starting January 1, 2018, Paid Family Leave (PFL) will provide paid time off so an employee can: bond with a newly born, adopted, or fostered child, care for a family member with a serious health condition, or assist loved ones when a family member is deployed abroad on active military duty. Employees may be eligible to take up to 12 weeks of Paid Family Leave at 67 percent of their pay, up to a cap.

EMPLOYEE ELIGIBILITY

An employee is eligible for leave under PFL if they have worked:

- 20 or more hours a week for 26 weeks (6 months)
- At least 1,250 hours during the 12-month period prior to the start of the FMLA leave

LEAVE ENTITLEMENT

An eligible employee may apply for leave under PFL for one or more of the following reasons:

- For the care of the employee's newly born child, newly adopted child or newly placed foster child.
- For the care of an immediate family member (spouse, child under age 18, child aged 18 or older but incapable of self-care because of a physical or mental disorder, or parent) with a serious illness.
- For assisting loved ones when a family member is deployed abroad on active military service.

WHO IS COVERED

MBF provides continuation of benefits to the MBF member and their eligible dependents (spouse/domestic partner and children).

BENEFITS COVERED

Benefits which are fully paid by MBF include:

- Basic Life Insurance and Accidental Death & Dismemberment Insurance (member only),
- Superimposed Major Medical Plan,
- Dental, and
- Vision Care

HOW TO APPLY

Contact the personnel office of your employer agency to request a leave under PFL.

SPECIAL LEAVE OF ABSENCE COVERAGE (SLOAC)

Special Leave of Absence Coverage (SLOAC) entitles City of New York employees with civil service titles approved for leave up to a maximum of 18 weeks or 4 months of benefits coverage in a 12-month period, during unpaid leave resulting from a disability or serious illness of the employee. Approved employees taking unpaid leave can continue basic City health coverage and MBF benefits.

WHO IS COVERED

MBF provides continuation of benefits to the eligible employee (member) and their eligible dependents (spouse/domestic partner and children).

BENEFITS COVERED

Benefits which are fully paid by MBF include:

- Basic Life Insurance and Accidental Death & Dismemberment Insurance (member only),
- Superimposed Major Medical Plan,
- Dental, and
- Vision Care

HOW TO APPLY

Contact the personnel office of your employer agency to request SLOAC coverage when taking an unpaid leave.

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 ("MBF") 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.

The person or office to contact for further information about the Plan's privacy practices.

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

Your Rights:

1. Get a copy of your health and claims records: You can ask to see or get a copy of your health and claims records and other health information MBF has about you. MBF will provide a copy or a summary of your health and claims records, usually within 30 days of your request. MBF may charge a reasonable, cost-based fee.
2. Ask MBF to correct health and claims records if you think they are incorrect or incomplete: However, MBF is not required to agree to your request, and will send an explanation in writing within 60 days.
3. 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.
4. Request confidential communications: You can ask MBF to contact you in a specific way (for example, home or office phone) or to send mail to a different address. MBF will consider all reasonable requests and must say "yes" if you tell MBF that you would be in danger if we do not. MBF 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.
5. Ask MBF to limit what it uses or shares: You can ask MBF not to use or share certain health information for treatment, payment, or our operations. MBF is not required to agree to your request, and MBF may say "no" if it would affect your care.
6. Get a list of those with whom MBF shared information: You can ask for a list (accounting) of the times MBF shared your health information for six years prior to the date you ask, who MBF

shared it with, and why. MBF will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked MBF to make). MBF will provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

7. Get a copy of this privacy notice: You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. MBF will provide you with a paper copy promptly. You may exercise your rights through a personal representative. Your personal representative will be required to produce evidence of their authority to act on your behalf before that person will be given access to your PHI or be 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.

Your Choices:

For certain health information, you can tell us your choices about what we share.

1. In these cases, you have both the right and choice to tell MBF to: Share information with your family, close friends, or others involved in payment for your care or share information in a disaster relief situation. If you are not able to tell MBF your preference, for example, if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.
2. In these cases, MBF never shares your information unless you give MBF written permission: Marketing purposes or sale of your information.

Our Uses and Disclosures:

MBF typically uses or shares your health information in the following ways:

1. Help manage the health care treatment you receive: MBF can use your health information and share it with professionals who are treating you.
2. Run our organization: MBF can use and disclose your information to run our organization and contact you when necessary. MBF is not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage.
3. Pay for your health services: MBF can use and disclose your health information as we pay for your health services.
4. Administer your plan: MBF may disclose your health information to your health plan sponsor for plan administration.

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: https://www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

1. Help with public health and safety issues: MBF can share health information about you for certain situations such as:
   • Preventing disease • Helping with product recalls • Reporting adverse reactions to medications • Reporting suspected abuse, neglect, or domestic violence • Preventing or reducing a serious threat to anyone's health or safety.
2. Do research: MBF can use or share your information for health research.
3. Comply with the law: MBF will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
4. Respond to organ and tissue donation requests and work with a medical examiner or funeral director: MBF can share health information about you with organ procurement organizations. MBF can share health information with a coroner, medical examiner, or funeral director when an individual dies.
5. Address workers' compensation, law enforcement, and other government requests: MBF can use or share health information about you:
   • For workers' compensation claims • For law enforcement purposes or with a law enforcement official • With health oversight agencies for activities authorized by law • For special government functions such as military, national security, and presidential protective services.
6. Respond to lawsuits and legal actions: MBF can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities:

MBF is required by law to maintain the privacy and security of your protected health information.

MBF will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.

MBF must follow the duties and privacy practices described in this notice and give you a copy of it.

MBF will not use or share your information other than as described here unless you tell MBF that it is allowed to do so in writing. If you tell MBF it can be used, you may change your mind at any time. Advise MBF in writing if you change your mind.

For more information see: https://www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html

Changes to the Terms of This Notice: MBF can change the terms of this notice, and the changes will apply to all information MBF has about you. The new notice will be available upon request and on our website.

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 MBF in care of the MBF HIPAA Compliance Officer via email through the MBF website at nyc.gov/mbf.

You may also file a complaint with the U.S. Department of Health and Human Services Office for Cicil Rights by sending a letter to 200 Independence Avenue S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting https://www.hhs.gov/ocr/privacy/hipaa/complaints/