GENERAL INFORMATION

ABOUT THE FUND

Your membership in the Management Benefits Fund ("Fund") entitles you and your eligible dependents to the financial protection afforded by its benefits programs. All coverages, with the exception of Group Universal Life Insurance, are fully paid for by the Fund.

The program 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 the Office of Labor Relations. A Fund Director is employed to provide day-to-day management of Fund operations and recommend appropriate improvements. Within economic limits, continuing efforts are made to assure that City contributions to the Fund provide responsive and meaningful benefits to members. The Fund's benefit plans are maintained for the exclusive benefit of the membership and are intended to be continued for an indefinite period. However, the City maintains the right to amend or terminate any program or plan as is deemed necessary.

ADVISORY BOARD

Mayor
Comptroller of the City of New York
Corporation Counsel
Director, Office of Management and Budget
Commissioner, Citywide Administrative Services
President, N.Y.C. Health and Hospitals Corporation
Commissioner, Office of Labor Relations (Chairman)

FUND OFFICE

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
Fax:	1-212-306-7353
TTY:	1-212-306-7629 (for the Hearing Impaired)
Web site:	http://nyc.gov/olr

MAILING ADDRESS

Management Benefits Fund
Bowling Green Station
P.O. Box 707
New York, NY 10274

If you have any questions about your Fund benefits that are not handled satisfactorily by the Fund's insurance carriers/ program administrators, you should contact the Management Benefits Fund.

IMPORTANT

Since benefits are frequently updated and enhanced, we suggest that you visit our Web site on a regular basis. The Fund's Web site is http://nyc.gov/html/olr.

Sections of this book can also be obtained by calling the Fund and requesting the sections through the telephone faxback system or by downloading them from the Fund's Web site.

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SECTION A

FUND ELIGIBILITY AND MEMBERSHIP

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A. FUND ELIGIBILITY AND MEMBERSHIP

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

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

WHO IS ELIGIBLE TO ENROLL

Active Employees

May enroll for coverage if your:

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

Retired Employees

May enroll for coverage if you:

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

WHEN COVERAGE BEGINS

Active Employees

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

Retired Employees

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

Deferred Retirees

On the effective date you become eligible for pension payments.

Eligible Dependents

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

Your Domestic Partner:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Your Unmarried Dependent Children age 26 through age 29:

Dependent coverage terminates at age 26. Coverage may be extended through age 29 under the Direct Pay Coverage Continuation (DPCC) Young Adult Dependent Program for the continuation of (1) Superimposed Major Medical Plan (SMMP), and Dental & Vision Care Programs, (2) Dental & Vision Care Programs only, or (3) SMMP only. MBF will charge a monthly premium based on the type of coverage that the Young Adult Dependent elects.

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

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

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

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

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

Dependents who are Employees

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

Changes in Dependent Status

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

HOW TO ENROLL

Active Employees

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

Retiring Employees

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

Deferred Retirees

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

WHEN COVERAGE TERMINATES

Active Employees or Retirees

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

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

Dependents

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

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

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

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA) RIGHTS

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

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

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

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

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

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

If you believe that your privacy rights have been violated or would like to request any of the information as previously specified, you may contact the Plan in care of the following officer: MBF HIPAA Compliance Officer, 40 Rector Street, 3rd Floor, New York, N.Y. 10006.

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

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2) You have a right to inspect and obtain a copy of your PHI contained in a "designated record set," for as long as the Plan maintains the PHI. "Designated Record Set" includes the medical records and billing records about individuals maintained by or for a covered health provider; enrollment, payment, billing, claims adjudication and case or medical management record systems maintained by or for a health plan; or other information used in whole or in part by or for the covered entity to make decisions about individuals. Information used for quality control or peer review analyses and not used to make decisions about individuals is not in the designated record set.
    - If access is denied, you or your personal representative will be provided with a written denial setting forth the basis for the denial, a description of how you may exercise those review rights and a description of how you may complain to the Secretary of the U.S. Department of Health and Human Services.
3) You have the right to request the Plan to amend your PHI or a record about you in a designated record set for as long as the PHI is maintained in the designated record set.
    - The Plan has 60 days after the request is made to act on the request. A single 30-day extension is allowed if the Plan is unable to comply with the deadline. If the request is denied in whole or in part, the Plan must provide you with a written denial that explains the basis for the denial. You or your personal representative may then submit a written statement disagreeing with the denial and have that statement included with any future disclosures of your PHI.
4) At your request, the Plan will also provide you with an accounting of disclosures by the Plan of your PHI during the six years prior to the date of your request. However, such accounting need not include PHI disclosures made: (1) to carry out treatment, payment or health care operations; (2) to individuals about their own PHI; (3) prior to the compliance date.
    - If the accounting cannot be provided within 60 days, an additional 30 days is allowed if the individual is given a written statement of the reasons for the delay and the date by which the accounting will be provided.
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    - 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
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SECTION B

BASIC LIFE INSURANCE AND ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE

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Conversion Privilege	B . 4
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B. BASIC LIFE INSURANCE AND ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE

The Fund provides members only (no coverage is provided for dependents) with Basic Life Insurance and Accidental Death & Dismemberment Insurance, which is fully paid for by the Fund. This coverage is underwritten by The Prudential Insurance Company of America, Prudential Plaza, Newark, N.J. 07102.

The purpose of this section of your Fund benefits booklet 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.

COVERAGE

Basic Life Insurance

For Active Members: Your life is insured for 1 times (1x) your annual salary (rounded to the next higher $1,000). Coverage amount is subject to a minimum of $15,000 and a maximum of $50,000 if you are under age 65. This amount of coverage is reduced to 66 2/3% of your annual salary at ages 65-69, coverage amount subject to a minimum of $10,000 and a maximum of $34,000, and is further reduced to 50% of your annual salary amount at age 70, coverage amount subject to a minimum of $7,500 and a maximum of $25,000.

For Retired Members: Your life is insured for $5,000, regardless of age.

If you are entitled to a benefit described under "Basic Life Insurance Protection While Disabled" and first became entitled to that 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.

Accidental Death & Dismemberment Insurance

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. At any time, you may change your beneficiary. To do so, contact MBF directly. After your death, your beneficiary may name a person or entity (such as a funeral home) to receive any amount payable to him or her.
- Accidental Death & Dismemberment 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 Accidental Death & Dismemberment 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. 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. To do so, you must give written notice to the Fund.

Table of Losses for Accidental Death & Dismemberment Insurance

The full amount of Accidental Death & Dismemberment 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;
- Total and permanent loss of hearing in both ears; or
- Quadriplegia (complete and irreversible paralysis of both upper and lower limbs).

Three-quarters of the amount of Accidental Death & Dismemberment Insurance is paid for:

- Paraplegia (complete and irreversible paralysis of both lower limbs).

One-half the amount of Accidental Death & Dismemberment Insurance is paid for loss of:

- One hand;
- One foot;
- Sight of one eye;
- Hearing;
- Speech; or
- Hemiplegia (complete and irreversible paralysis of the upper and lower limbs on one side of the body).

One-quarter of the amount of Accidental Death & Dismemberment Insurance is paid for:

- Loss of thumb and index finger of the same hand by severance at or above the metacarpophalageal joint.

An amount equal to the lesser of 10% or $10,000 of Accidental Death & Dismemberment 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% or $10,000 of Accidental Death and Dismemberment Insurance is paid for loss of life in a four-wheel vehicle while using a supplemental restraint system.

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.

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 (Accidental Death & Dismemberment Insurance)

Accidental Death & Dismemberment Insurance does not cover loss due to :

- Suicide or attempted suicide;
- Intentionally self-inflicted injuries;
- Sickness;
- Medical or surgical treatment of sickness;
- Certain infections;
- War or certain military duties;
- Travel or flight in an aircraft not intended to transport passengers;
- Commission of a felony;
- Legal intoxication or influence of any narcotic unless administered or consumed on the advice of a doctor; or
- Participation in certain hazardous sports.

Basic Life Insurance Protection While Disabled

If, while insured as an active employee, you become Totally Disabled before you reach age 60, the Fund 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.

Beneficiary

The "Beneficiary" for your insurance for loss of life means the person(s) chosen by you on the member application, Form 1060, to receive the insurance benefits. You may change your Beneficiary at any time by completing Form 1060. The beneficiary change is effective on the date the form is signed provided it is received before the claim is paid.
If there is a Beneficiary for the insurance, it is payable to the named Beneficiary. You may change your Beneficiary at any time by completing Form 1060 and sending it to the Fund Administrative Office without the consent of the present Beneficiary. This change will take effect upon actual receipt of such notice by the Fund. It is your responsibility to ensure that the change has been received by the Fund.

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 a part of your insurance for loss of life for which there is no named Beneficiary living at your death, that part will be paid in a lump sum to the survivors in the first surviving class of those that follow: (a) spouse; (b) children; (c) parents; or (d) brothers and sisters. If none survives, that part will be paid in a lump sum to your Estate.

If your insurance for loss of life under the Group Policy(ies) replaces another policy, the Beneficiary under the replaced will be in effect until you: (a) name a Beneficiary under the Group Policy(ies) or (b) change your Beneficiary as set forth above.

If you die after having applied to convert your Group 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 Policy.

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

Assignment of Basic Life Insurance and Accidental Death & Dismemberment Insurance

Please be advised that you have the option to assign your Basic Life Insurance and Accidental Death & Dismemberment Insurance. Keep in mind that when you assign your insurance policy, you perform an irrevocable transfer of all property rights, title, interests and incidents of ownership, both present and future, relating to the assigned group insurance coverage. Assignments can be made as gifts or viatical assignments, but not for collateral. Should you wish to assign your insurance coverage or receive additional information related to the assignment of benefits, please contact Prudential at 1-800-524-0542.

Filing of Claims for Basic Life Insurance and Accidental Death & Dismemberment Insurance

Claims for both the Basic Life Insurance and Accidental Death & Dismemberment Insurance should be submitted to the Fund Administrative Office at the following address:

Management Benefits Fund
Basic Life and Accidental Death & Dismemberment Claims
40 Rector Street, 3rd Fl., New York, N.Y. 10006

APPEAL OF DENIED CLAIMS

If you are not satisfied with the resolution of your claim and you feel your claim for benefits has been improperly denied, you (or in the event of your death, your Beneficiary or estate) may submit in writing the issues and comments relating to the claim denial that you are appealing. Send written appeals to Prudential at the following address:

Prudential Insurance Company of America
Group Life Claim Operations
P.O. Box 8517, Philadelphia, PA 19176
1-800-524-0542

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 30 day periods if necessary.

If you have any questions regarding your claims, Prudential's toll-free number is 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 Policy to an Individual Policy **without** proof of good health.

Of the two options listed, you may obtain a lower rate by providing evidence of good health and purchasing an Individual Policy. For information, please contact Prudential at 1-877-889-2070.

Please be advised that there are no conversion rights or individual policies available for Accidental Death & Dismemberment Insurance.

INSURER

Basic Life Insurance and Accidental Death & Dismemberment Insurance are underwritten by The Prudential Insurance Company of America, Prudential Plaza, Newark, N.J. 07102, contract series form 83500. If there is any discrepancy between this document and the Group Contract issued by Prudential, the terms of the Group Contract will govern. To obtain a copy of the Group Contract, please contact the Fund's Administrative Office at 1-212-306-7290 or at 1-888-4000 MBF(623), if outside New York City, or at (TTY) 1-212-306-7629 if hearing impaired. This Accidental Death & Dismemberment 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.

IMPORTANT NOTICE - THIS POLICY DOES NOT PROVIDE COVERAGE FOR SICKNESS.

SECTION C

GROUP UNIVERSAL LIFE INSURANCE

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C. GROUP UNIVERSAL LIFE INSURANCE

BACKGROUND

On May 1, 1990, the Management Benefits Fund introduced the Group Universal Life (GUL) Insurance program. This new program took the place of a prior group term Optional Supplemental Life Insurance plan which was terminated for active employees as of that date. Active employees as of May 1, 1990 were offered enrollment in the Group Universal Life (GUL) Insurance plan. The Plan has been underwritten by the Prudential Insurance Company of America (Prudential) since January 1, 1998.

Retired members who retired prior to May 1, 1990 and participated in the prior group term Optional Supplemental Life Insurance plan continue to be covered by the prior plan with direct billing for premium payments by Prudential. Such retired participants are issued a separate insurance certificate for this prior plan and are not eligible for enrollment in the GUL plan described herein.

The purpose of this section of your Fund benefits booklet is to provide a general description of the GUL insurance plan underwritten by the Prudential Insurance Company of America, Prudential Plaza, Newark, N.J. 07102. This description does not replace the Group Insurance Certificate issued by Prudential to GUL participants. 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.

ELIGIBILITY

Member

In order to enroll, you must be an active employee and an eligible member of the Management Benefits Fund. You must be actively at work, working at least 20 hours per week when your coverage takes effect under the group contract. 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, the member, must be enrolled to insure your spouse and dependent children.

Spouse/Domestic Partner

You may elect coverage for your spouse/domestic partner as long as you are enrolled in GUL. An eligible spouse is covered on the effective date as described in "WHEN COVERAGE BEGINS" (Page A1), if not confined for medical care or treatment at home or elsewhere on that date.

Unmarried Dependent Children

To be eligible, a child must be at least 15 days old and under under 26 years of age, and unmarried. Coverage for a child may be continued beyond the limiting age 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. An eligible dependent is covered on the effective date as described in "WHEN COVERAGE BEGINS" (Page A1), if not confined to a hospital on that date.

A dependent child who is not your natural child is covered at the earliest of the following dates:

- When the child starts living with you in a regular parent-child relationship and is primarily supported by you (the member); or
- 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.

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.

EFFECTIVE DATE OF COVERAGE

Coverage commences on the date a completed application for GUL coverage is received by the Management Benefits Fund:

(1) For amounts up to the guaranteed amounts, and

(2) If received within 31 days of the member and/or spouse/Domestic Partner/dependent satisfying eligibility requirements.

Coverage commences on the date Prudential approves the application:

(1) For amounts over the guaranteed amounts, and

(2) For all applications received after 31 days of the member and/or spouse/Domestic Partner/dependent satisfying eligibility requirements.

"Guaranteed amounts" refers to coverage that is offered without medical evidence of good health.

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 a Fund eligible position at a later date, the member is not treated as a new member for the purposes of the 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, so that coverage remained in effect. If premium payment is not continued during the leave and as a result the coverage lapses, the member will be subject to medical evidence of good health in order to reinstate coverage to the amount previously in effect. In either case, any requests for additional coverage amounts will be subject to medical evidence of good health.

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 evidence of good health 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 evidence of good health 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.

If you are eligible as a member for the first time and have enrolled within 31 days of becoming eligible, there are no medical evidence requirements for amounts of insurance up to the lesser of 3 times your annual salary* or $500,000. For coverage beyond that amount, you must satisfy the insurability requirements of Prudential.

If you enroll beyond 31 days after your initial eligibility date, you must provide medical evidence of good health to Prudential regardless of the amount of insurance being requested. Medical evidence of good health refers to the completion of a statement of health form, which is reviewed and approved by Prudential before coverage is issued at members' expense. In certain instances, additional medical information and/or medical exam may be required.

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

Accidental Death & Dismemberment Insurance

This feature is automatically included for active members under age 70 participating in the Group Universal Life program. It provides 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, the member would receive a certain percentage (depending on the injury) of the life 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.

Terminal Illness Benefit

This program has a terminal illness benefit that applies to member's coverage only. To qualify for this benefit, you must have a life expectancy of six months or less as certified by a licensed medical doctor. You may elect to receive an advance of up to 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 advance payment of up to $50,000. The death benefit would be reduced by the amount paid out in advance. Your cost of insurance would also reduce. If your coverage is assigned, this benefit is not available.

COVERAGE INCREASE OPPORTUNITY FOR THE MEMBER

If an increase in annual salary as of November 15 of the previous year makes you eligible for additional coverage, your coverage will automatically increase on January 1, subject to the program maximum. 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.

You will have an opportunity each year to increase your coverage by one times your annual salary without medical evidence of good health up to the guaranteed amount of the lesser of 3 times salary or $500,000. You must elect coverage as a multiple of annual salary, apply within 31 days of the increase opportunity, and be actively at work on the effective date of coverage.

If you are an active member, you may increase your coverage at any time up to the maximum allowable limit by completing Form 1060. This is subject to medical underwriting by Prudential.

COVERAGE 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.
- Maximum coverage: The spouse/domestic partner may elect coverage up to the lesser of 5 times member's salary or $250,000.
- A spouse/Domestic Partner age 64 or under can be covered for up to $30,000 without medical evidence of good health if enrolled within 31 days of the member's eligibility date or within 31 days of the date he/she becomes an eligible spouse/Domestic Partner.
- A spouse/Domestic Partner age 65 or older must submit medical evidence of good health regardless of the amount of coverage.
- The MBF member must be enrolled in GUL in order for the spouse/domestic partner to enroll.
- The MBF member is owner of the coverage.

COVERAGE FOR DEPENDENT CHILDREN

- Effective April 1, 2012, coverage is available in a flat amount of $10,000, $15,000, or $20,000 for each unmarried dependent child between the ages of 15 days and 26 years. No medical evidence of good health is required if this coverage is elected within 31 days of the member's eligibility date or within 31 days of the date the child becomes an eligible dependent.
- The cost is $0.0295 per month per $1,000 of coverage for $10,000, $15,000 or $20,000 of dependent child coverage, regardless of the number of children in the family.
- The MBF member must be enrolled in GUL in order for the dependent child to be enrolled.
- The MBF member is owner of the coverage.

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CASH ACCUMULATION FUND

If you enroll yourself or your spouse/Domestic Partner for Group Universal Life Insurance, you may contribute an additional amount of money, in addition to the cost of insurance coverage, toward a Cash Accumulation Fund (CAF) an element of your GUL coverage. This optional contribution to CAF, which is voluntary, allows savings through convenient payroll deductions on an after-tax basis. These additional savings earn tax-deferred interest and accumulate to provide for any future financial needs of members as such needs may arise. Key features of this option include:

- The amounts contributed to the CAF will earn competitive interest rates. New rates are declared each year. While new rates will reflect returns on investments in the marketplace, the rate is guaranteed never to be less than 4%.

- Earnings are income tax deferred until withdrawn from the CAF. Under current law, no federal income tax is due upon withdrawal, if the total amount of your contributions to the CAF plus the cumulative cost of insurance is greater than the amount you withdraw.
- The balance in the Cash Accumulation Fund (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 Cash Accumulation Fund can be borrowed against, once you have been contributing to the CAF for at least a year. The minimum amount that can be borrowed is $200. The maximum amount that can be borrowed is 90% of the Cash Accumulation Fund balance (less the amount of any outstanding loans and interest charged). The annual net interest charged is 1.5% of the amount borrowed.
- Members who cover their spouse/Domestic Partner for life insurance may also establish a Cash Accumulation Fund element for their spouse/Domestic Partner coverage.
- In addition to these amounts being available when a need arises during the member's lifetime, in the event of a member's death, the beneficiary may receive the benefits of the life insurance amount PLUS any balance in the Cash Accumulation Fund 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% state insurance premium tax (e.g., a $100 monthly contribution would be assessed a $2.00 premium tax. The remaining $98 would earn the current interest rate).

PREMIUM RATES –EFFECTIVE APRIL 1, 2012			
Monthly Rates for the Cost of Insurance			
Age of Insured as of prior January 1	Member Monthly Cost of Insurance/ $1,000 of Coverage		Spouse/Domestic Partner Monthly Cost of Insurance/$1,000 of Coverage
Age	Non-Smoker	Smoker	Spouse/Domestic Partner Rate
Under 30	$0.049	$0.056	$0.038
30-34	0.054	0.065	0.044
35-39	0.067	0.073	0.071
40-44	0.089	0.099	0.104
45-49	0.127	0.147	0.175
50-54	0.205	0.241	0.252
55-59	0.302	0.361	0.393
60-64	0.502	0.603	0.546
65-69	0.871	1.032	0.754
70-74	1.050	1.350	1.354
75-79	1.325	1.730	1.742
80-84	2.892	3.501	3.724
85-89	4.519	5.442	6.306
90-94	6.459	7.807	9.159
95-99	8.588	10.386	12.161
Dependent Child Coverage: $0.0295 per month per $1,000 of coverage for $10,000, $15,000 or $20,000. Rate covers all eligible children, regardless of number, up to age 26 for unmarried eligible children.			
For information on the maximum allowable contributions to the Cash Accumulation Fund, please call GUL customer service at 1-800-562-9874.			

Note:

1. Cost of Insurance

   The rates shown on Page C.4 are the premium contributions to cover the cost of life insurance protection only, exclusive contributions to the Cash Accumulation Fund. The cost of insurance indicated on Page C.4 reflects a 2% charge to cover taxes attributable to the state 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.

2. Cash Accumulation Fund

   The minimum optional contribution is $1.00 per month regardless of the amount of coverage selected. The maximum figures shown on Page C.4 are averages based on Internal Revenue Service guidelines. Prudential will review contribution levels to ensure contributions are within the Internal Revenue Service guidelines. Spouse/Domestic Partner maximums are determined by the age of the spouse, not that of the member. Contributions are subject to a 2% charge to cover taxes attributable to the state 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.

PORTABILITY

This program is portable: if you retire, terminate employment with the City of New York or are no longer an eligible member of the Management Benefits Fund, you can keep your entire coverage in force at group rates as long as you continue paying premiums and as long as the Group Contract is in force. If you have participated in the program for at least 12 months, your cost to continue coverage will be at the same group rates that apply to active members. Portable rates will be higher for members participating less than 12 months in the program.

ADMINISTRATION

This group plan made available to members of the Management Benefits Fund is underwritten by The Prudential Insurance Company of America, Prudential Plaza, 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 individual policy documents 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.

SECTION D

LONG TERM DISABILITY (LTD) INSURANCE

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D. LONG TERM DISABILITY (LTD) INSURANCE

The Management Benefits Fund provides eligible *active members* with Long Term Disability (LTD) Insurance fully paid for by the Fund. This benefit is intended to partially protect active employees against loss of income because of a total or partial disability that exceeds a period of six continuous months.

Fund eligibility and enrollment requirements for active employees are outlined in the "Fund Eligibility and Membership" section of this booklet. Retired members are not elegible to receive LTD coverage. However, any claims or benefit payments in progress for a disability which occurred prior to retirement will continue.

Please refer to page D.5 for definitions on the italicized words in this section.

WHEN COVERAGE BEGINS

Coverage begins on the date you are appointed to an approved title or on the date your title is approved for inclusion in the Fund and provided you are *actively at work*. 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;
- 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.

WHAT ARE THE BENEFITS

Long Term Disability 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 annual leave or sick leave (please refer to page D . 3). The amount of benefits is 66 2/3% of your *pre-disability Basic Monthly Earnings*, subject to a maximum benefit of $5,000 per month, and a minimum benefit of $150 per month. These benefits will be reduced by income from other sources. (See the General Provisions section.) The minimum benefit, however, is always payable.

Note: If you were approved for Long Term Disability benefits prior to January 1, 1999, your benefits will be continued at 50% of your basic monthly earnings. If you were approved for Long Term Disability 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, no benefit will be paid.

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. If, however, 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 percentage increase in the Consumer Price Index of the prior year 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 $5,000. 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, such as:

- 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.

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.

Often, LTD recipients are not immediately accepted as disabled when applying for Social Security disability benefits. Because 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. If you are receiving LTD benefits and Social Security has not accepted you as disabled, Prudential may assist you in pursuing your Social Security disability claim.

Because Social Security's definition of disability differs from the Fund's definition, many claimants entitled to benefits from the Fund 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 will receive full Social Security disability benefits if the Social Security benefit is as large or larger than the Fund's LTD benefits.
- You are able to maintain your pre-disability wage level for determining the amount of the Social Security retirement benefit payable at retirement.

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 paid to you, in which case no Long Term Disability benefits are payable; or (2) sick leave can be left unused with Long Term Disability 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 per period of disability 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 if you remain totally disabled.

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 on page D.2

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 full-time employment. Benefits may be available under this provision, with Prudential's approval, to pay some of the expenses associated with rehabilitation.

Recurrence

If you return to work full-time for **less than six months** and again become disabled for the **same** condition, benefits will be payable immediately. 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:

a. which is a result of war (declared or undeclared) or resistance to armed aggression;
b. arising from an intentional, self-inflicted injury or attempted suicide;
c. if you are not under the care of a legally licensed physician; or
d. that arises during the first year of the employee's LTD coverage due to a *pre-existing condition.*

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.

HOW OTHER FUND BENEFITS ARE AFFECTED BY DISABILITY

The table below summarizes the affect of total disability on your Fund benefits

Basic Life Insurance	Disability occurring before age 60: The Fund 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: The Fund 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), the Fund will extend benefits beyond the termination date. Full benefits coverage will continue under the Basic City Health Benefits Program and the Fund'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.
Fund Survivor Benefits	Once you are totally disabled, your dependents' eligibility for the Fund Survivor Benefits Program ceases unless you are receiving a disability or service pension and continue Fund membership as a retiree.

Note: To be eligible for extended Dental and Vision Care benefits, you must be (a) approved for LTD on or after January 1, 2004, or (b) covered for these benefits under COBRA prior to January 1, 2004.

DEFINITIONS

Active Member

A Management Benefits Fund member who is on active pay status.

Actively at Work

A requirement that you are actively at work on a full-time basis at the Employer's business, or at any other place that the Employer's business requires you to go, performing the regular duties of your position in an active pay status.

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 continues for a six-month period, or until disability ceases, whichever is earlier.

Pre-existing Condition

Accidental injury or sickness, which is diagnosed by a doctor or for which any charges were incurred for prescription drugs or treatment that was rendered during the 90 days immediately preceding your LTD coverage effective date.

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 the Fund Administrative Office at 1-212- 306-7290, TTY 1-212- 306-7629, if hearing impaired, 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 the Fund Administrative Office.

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.

FUTURE OF THE PLAN

It is hoped that the Group Long Term Disability Insurance will be continued indefinitely, but the Management Benefits Fund reserves the right to change or terminate the Plan in the future. Any such action would be taken only after careful consideration.

INSURER

The insurance briefly described in this booklet is insured by The Prudential Insurance Company of America, Prudential Plaza, Newark, NJ 07102 under group contract form series 83500 for the Management Benefits Fund. If there is any discrepancy between this document and the Group Contract issued by Prudential, the terms of the Group Contract will govern. To obtain a copy of the Group Contract, please contact the Fund at 1-212-306-7290, or 1-888-4000 MBF if outside New York City, or at (TTY) 1-212-306-7629 if hearing impaired. 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.

SECTION E

SUPERIMPOSED MAJOR MEDICAL PLAN (SMMP) BENEFITS

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E. SUPERIMPOSED MAJOR MEDICAL PLAN (SMMP) BENEFITS

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.

ADMINISTRATOR

The administrator for the SMMP is Administrative Services Only, Inc. (ASO), P.O. Box 9009, Lynbrook, NY 11563-9009.

ELIGIBILITY

Members and dependents are eligible for SMMP benefits by virtue of their meeting the eligibility and enrollment requirements outlined in the "Fund Eligibility and Membership" section of this booklet.

DEDUCTIBLE

The following summarizes individual and family deductibles based on participation in the City's basic (primary) plans with the 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 plan other than the member's basic medical coverage with the City may also fulfill the prescription drug rider requirement. However, those members with limited prescription drug coverage through a non-city health plan and/or discounted plans will be treated as not having any prescription drug coverage, and covered charges will be subject to deductibles (see above chart). Members who are not enrolled in a prescription drug plan offered by the City, must submit documentation of their prescription drug plan, in effect at the time the expense was incurred, to ASO.

IMPORTANT:

1) All claims are subject to review for medical necessity and appropriateness.
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.
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.
4) This plan does not cover long term care for which medical services given to a person 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. However, 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 page E.11 for additional information.

BENEFIT PAYMENT/CO-INSURANCE

Once you have satisfied your annual deductible, benefits are reimbursed at 90% of the Reasonable and Customary (R&C) allowance for medical services after benefit payments from all other health plans have been applied. Out-of-pocket costs for prescription drugs are reimbursed at 80%.

The remaining 10% of the R&C allowance for medical services (or 20% for prescription drugs) is accumulated towards your out-of-pocket maximum. You are responsible for paying any charges in excess of the R&C allowance. The R&C allowance is the amount paid for medical services in a geographic area based on what providers in the area usually charge for the same or similar medical services/supplies.

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 these expenses to the SMMP. Of the $10,000 incurred, $9,000 is considered the R&C allowed amount as determined by the 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 submitted	$10,000
R&C allowance	$9,000
Less: Amount paid by the primary health carrier	($3,000)
Covered 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,10% co-insurance 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 the amounts accumulating towards the out of pocket expense reach $2,500, the Plan pays 100% of the R&C allowance for Non-Reimbursed Covered Charges after benefit payments from all other health plans are applied. 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
- Amounts that are covered outside of the deductible (i.e., hearing aids, audiometric examinations and the Adult Wellness Benefit)

COMMON ACCIDENT DEDUCTIBLE

If two or more covered persons in a family are in the same accident, only one deductible will apply to all Covered Charges for all such covered family members due to the accident, for that calendar year and again in the next year.

If prior to the common accident, one or more of these persons incurred Covered Charges in the same calendar year as the common accident, the deductible for these charges will be applied in aggregate toward the common accident deductible.

If subsequent to the common accident, one of these persons incurs Covered Charges in the same calendar year that do not relate to the common accident, the deductible for these charges will be reduced by the charges for that person that were used toward the common accident deductible.

HEARING AID AND AUDIOMETRIC EXAM BENEFITS

The maximum benefits payable for a covered person are:

- Up to $1,500* per hearing aid (90% of allowable charges up to $1,667) and
- 90% of the R&C allowance per audiometric examination

* Hearing aid benefits are subject to the SMMP Coordination of Benefits provision as stated on page E.14. The 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 $1,500 per hearing aid between all plans. If the other plan(s) pay $1,500 or more in benefits for the hearing aid the SMMP will pay nothing.

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 deductible is waived for hearing aid(s) and/or audiometric examinations, even if you or your covered dependent are not enrolled in the City basic health care plan.

OUTPATIENT MENTAL HEALTH

Covered professional fees will only include those of a psychiatrist, psychologist or a clinical social worker, who is licensed pursuant to the Education Laws of the State of New York, or similar laws of another state, if those services are rendered in such other state.

Outpatient mental health services are subject to the same benefit payment/deductible schedule in effect for other Covered Charges under the SMMP.

ADULT WELLNESS BENEFIT

The Adult 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. The program is designed to encourage healthier lifestyles for members and their spouses/domestic partners.

Benefits are reimbursed at 100% of the Reasonable and Customary (R&C) allowances after offsetting benefit payments from all other health plans. Deductibles are not applied to charges submitted for Adult 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
Spiral CT
Sigmoidoscopy
Bone Densitometry
Chest X-Rays
Pulmonary Function Testing
Colonoscopy

Laboratory Tests

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

Gender Specific

Prostate Specific Antigen (PSA)
Mammography
Pap/Pelvic Exam

Immunization

Rubella Titer
Influenza
Hepatitis B
Tetanus-Diptheria
Pneumococcal

How to Submit Claims

Expenses incurred for the above listed Covered Procedures may be reimbursed under your basic City health plan or any other health plans under which you may be covered. Therefore, the current filing procedure for SMMP will be maintained for the Adult Wellness Benefit. Claims submitted for qualifying out-of-pocket wellness expenses which remain after all other health coverage has been applied should be submitted as they are incurred. You may obtain an MBF SMMP Claim Form from the Fund Web site at http://nyc.gov/html/olr, the Fund Office or the Plan Administrator's website at www.asonet.com.

1. Submit medical bills to your primary health plan for benefit determination.

   Note: If you are a participant in the Health Benefits Buy-Out Waiver Program, you are covered for primary health benefits either under your spouse's plan or through other current/former employment. In these cases, expenses must first be submitted to the other plans for benefit determination. If you are covered under both the City's Health Benefits Program and a spouse's plan (or a plan through other current/former employment), medical bills must be submitted to all other plans before the SMMP.
2. If you are covered under both the City's Employee Health Benefits Program and a spouse's plan (or a plan through other current/former employment), medical bills must be submitted to all other plans before the SMMP.
3. Compile all itemized bills generated from your health care provider related to this benefit.
4. Compile Explanation of Benefits (EOB) statements provided by all health plan(s) that correspond to the above-mentioned itemized bills.
5. Include proof of payment (cancelled check, receipt, etc.) for all out-of-pocket expenses. Computer generated forms from a provider may not be acceptable.
6. Complete the SMMP Claim Form and submit the claim form, with all documentation, including itemized bills, EOBs, and proof of payment of out-of-pocket expenses to:

MBF SMMP ADULT WELLNESS CLAIMS
Administrative Services Only (ASO), Inc.
P.O. Box 9009
Lynbrook, NY 11563-9009
Toll Free: 1-877-844-SMMP (7667)

Claim forms must be completely filled out each time a claim for services is submitted. Failure to complete the claim form properly may result in the pending of the claim. In order to be considered for payment, claims must be submitted within 24 months from the date of services.

For information on submitting all other SMMP claims, please refer to page E.13.

WHAT IS COVERED

The Plan covers the services and supplies described in this section. Exceptions and limitations are noted in each section and in the "What Is Not Covered" section. The following is not an exhaustive inventory of all coverages and limitations under the 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 are 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 in the office, home or hospital for diagnosis, treatment and surgery.

Durable Medical Equipment - Charges for the purchase or rental (at the SMMP's option) 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 that a doctor orders.

Hearing Aid and Testing - Charges for one audiometric examination and one hearing aid per ear within a 24-month period. Services must be rendered by an otolaryngologist, otologist or audiologist. Benefits are payable at 90% of R&C for the audiometric examinations and 90% of unreimbursed charges for the hearing aid, up to a maximum of $1,500 per hearing aid payable between primary and secondary plans, if applicable.

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 pages E.9, E.10, E.16 and E.17 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" on page E.11 and E.12.

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.

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.

Mental Health, Alcoholism and Substance Abuse Treatment – Charges for inpatient and outpatient care are subject to the Plan medical necessity and appropriateness provisions.

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 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 the Fund'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. Effective July 1, 2005, the categories of drugs under the PICA Plan include Injectables (including injectable fertility prescription drugs) and Chemotherapy. Members must follow guidelines established under their primary health plan regarding prescription drug coverage.

Charges for the 5% out-of-pocket coinsurance incurred once a Medicare-eligible member or the member's Medicare-eligible spouse/domestic partner reaches the catastrophic level of coverage under Medicare Part D. Refer to page E.1 for additional information.

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.

Extended Care Facility/Skilled Nursing Facility- Services are covered in a skilled nursing facility (SNF) or extended care facility up to 180 days per confinement. Care must be medically necessary and ordered by the primary physician. Refer to Page E.8 and E.9 for additional information.

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.

WHAT IS NOT COVERED

Covered Charges do not include charges for the following services and supplies:

- not ordered by a doctor, except as specified under the section "What is Covered."

- for preventive care, other than that specified for dependent children under “What is Covered” and adults under the “Adult 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 to the 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.
- which 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 a 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) toe nails, 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."
- for a procedure to reverse voluntary sterilization.
- provided by an Out-of-Network Provider if you or your eligible dependents are covered under a Health Maintenance Organization (HMO) plan or where the primary basic plan of coverage provides a benefit for services through a network of participating providers only.
- which a covered person incurs after his/her coverage 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 Section K of the MBF Benefits Booklet entitled "Consolidated Omnibus Budget Reconciliation Act (COBRA)."
- for charges or a portion of a charge, that are in excess of R&C as determined by the 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, except charges for the 5% out of pocket coinsurance incurred once a Medicare eligible member or the member's Medicare-eligible spouse/domestic partner reaches the catastrophic level of coverage under Medicare Part D .
- for ambulette and other services for which the primary purpose is to provide transportation to a health care professional for outpatient visits or treatment.
- Also, benefits will not be paid for, and the term "Covered Charges" will not include, charges incurred for or in connection with a procedure held to be experimental or investigational by the 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.

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

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;

   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.

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: The 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 Extended Care Facility charges 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" for other conditions that may affect this coverage. Also, see "What is not Covered."

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 (R.N.).
   (b) Licensed Practical Nurse (L.P.N.).
   (c) Licensed Public Health Nurse.
   (d) Licensed Vocational Nurse under the supervision of a Registered Nurse (R.N.).
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, skilled nursing facility 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, skilled nursing facility 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" for other conditions that may affect this coverage. Also, see "What is Not Covered."

ALCOHOLISM AND SUBSTANCE ABUSE BENEFITS

Benefits will be paid for charges incurred to diagnose or treat alcoholism, alcohol abuse, substance abuse or substance dependence. Benefits will also be paid for charges incurred for the counseling of Family Members (defined below) of the person in need of treatment. These charges must be incurred while the person or Family Member is covered for these benefits.

Outpatient Benefits

Benefits will be paid for charges incurred for outpatient visits:

1. for services to diagnose or treat alcoholism, alcohol abuse, substance abuse, or substance dependence; and
2. for services to counsel Family Members of the person receiving or in need of treatment.

Such person or family member must not be confined to a Hospital or Covered Facility where these services are received. Benefits will be paid at the rate of 90% of the R&C allowances made for each outpatient visit.

For the purpose of this benefit:

Covered Facility: This term means an institution:

1. certified by the Division of Alcoholism and Alcohol Abuse or the Division of Substance Abuse Services of the State of New York, with respect to facilities situated in New York; and
2. approved by the Joint Commission on Accreditation of Hospitals as alcoholism or substance abuse treatment programs, with respect to facilities situated in a state other than New York.

Family Member: This term means a person who is:

1. a member of the family of the person receiving or in need of treatment; and
2. covered under the SMMP.

Inpatient Benefits

The SMMP covers inpatient substance abuse treatment.

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

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

Infertility is the inability or diminished ability of an otherwise healthy individual to achieve pregnancy after more than 12 months of intercourse without the use of contraception. The condition may be present in one or both sexual partners.

For purposes of benefits under the SMMP, infertility is deemed present when the condition is diagnosed by a physician. Methods to bypass the infertile condition 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, replaces the resulting embryo into the woman's uterus.
- Gamete IntraFallopian 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 a covered person for the diagnosis or treatment of Infertility, including In-Vitro Fertilization and Artificial Insemination, up to specified plan maximums as indicated in the table below. Only treatment and services provided directly to individuals covered under this plan will be considered for payment. Any charges, costs, expenses, etc. that are incurred by or through a donor or result from the use of donor sperm or ovum donation are not covered expenses under this plan.

	Infertility	Artificial Insemination or Similar Procedure	In-vitro Fertilization or Similar Procedure
Covered Charges	• Diagnostic workup • Diagnostic testing • Drug therapy • Surgical correction	Same as Infertility as well as: • Insemination procedures • Screening/lab test	Same as Infertility/Artifical Insemination as well as: • Removal/fertilization of egg(s) • Implantation of egg(s)
Non-Covered Charges & Exclusions	• Experimental procedures • All donor costs, charges & expenses • Reversal of tubal ligation • Reversal of vasectomy • Surrogate motherhood	• Experimental procedures • All donor costs, charges & expenses • Reversal of tubal ligation • Reversal of vasectomy • Storage costs • Surrogate motherhood	• Experimental procedures • All donor costs, charges & expenses • Reversal of tubal ligation • Reversal of vasectomy • Storage costs • Surrogate motherhood • In-Vitro services for women who have undergone tubal ligation
Lifetime Maximums		• Surgical insemination for up to a total of 8 attempts per lifetime.	• Up to 4 attempts or cycles per lifetime • $15,000 maximum per attempt or per cycle

MEDICARE PART D CATASTROPHIC-LEVEL COINSURANCE

Under Medicare Part D, once a Medicare-eligible individual reaches the catastrophic level of coverage for prescription drugs, the Medicare Part D 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/or member's spouse/domestic partner must wait for this annual EOB before submitting a claim.

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 Fund 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 Fund 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.

EXTENDED BENEFITS

If a person becomes ineligible for SMMP benefits and that person is Totally Disabled (as defined below) on the date coverage ends, he/she 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, he/she is not able to: (a) in the case of a Fund member, do any work for compensation or gain; and (b) in the case of a dependent of a Fund 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.
IMPORTANT: See "Other Important Facts" for the conditions that may affect this coverage.

HOW TO SUBMIT CLAIMS

Out-of-pocket covered medical expenses should be submitted as they are incurred. In order to be considered for payment, claims must be submitted within 24 months from the dates of service. The following is a summary of claims procedures:

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

Please note: If you are a participant in the Health Benefits Buy-Out Waiver Program, you are covered for primary health benefits either under your spouse's plan or through a current/former employer. In this case, medical expenses must first be submitted to your primary health plan for payment.

2. If you are covered under both the City's Employee Health Benefits Program and a spouse's plan (or a plan through current/former other employment), medical bills must be submitted to both plans before you submit the bill under the SMMP.
3. Compile all itemized bills generated from your health care provider(s) related to claims.

   Please note:

   1. Your documents must include the diagnosis codes and CPT procedure codes. Section C of the MBF-SMMP claim form indicates all of the data 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 for Section C of the claim form to be completed. Claims received without this information will be pended until the information is received.
   2. Outpatient mental health claims also require all of the information requested in Section C - "Claim Information" on the claim form. Incomplete statements of rendered services submitted on provider letterhead are not acceptable and will be pended until the required information is received.
   3. Compile the Explanation of Benefits (EOB) statements provided by all health plans under which you have coverage in reference to the above itemized bills.
   4. If you have prescription drug coverage through one or more of the basic medical plans under which you are covered, please include a copy of each drug card. If you are not enrolled in a prescription drug plan/rider offered by the City, you must submit documentation of your prescription drug plan in effect at the time the expense was incurred.
   5. Include proof of payment (cancelled check, receipt, etc.) for out-of-pocket expenses. Computer generated forms from a provider may not be acceptable.
   6. Complete the SMMP claim forms. Under Section A of the SMMP Claim Form, entitled "Member Information," you must enter all applicable information regarding your other coverages under the heading "List All Other Coverages, Including Medicare Coverage." This also applies to coverage for your spouse/domestic partner and your dependents. If there is no other coverage, you must indicate "None." If this section is left blank, processing of the claim will be delayed.
   7. Submit all claims, as they are incurred, with the proper documentation to:

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

Payment will be made to you, the member, NOT to the provider.
Please note: Claim forms must be completely filled out 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.

Only actual remaining out-of-pocket expenses will be considered for payment. Proof of payment or verification of remaining out-of-pocket expenses is required.
For information on submitting Adult Wellness claims, please refer to page E.4

CLAIMS APPEAL PROCESS

If your claim for benefits is denied in part or in whole, you may call ASO to discuss the denial before requesting a formal appeal. If ASO cannot resolve the issue to your satisfaction over the phone, you have the right to file a written formal appeal. When filing the appeal, please provide ASO with the reason you believe the claim was improperly denied and submit documentation, questions or comments you deem appropriate to the above address.

ASO will conduct a full and fair review of your appeal. ASO has one hundred eighty (180) days to review the appeal, investigate, and make a determination, subject to information and HIPAA authorizations being received. If necessary, you will then have an additional thirty (30) days to appeal to the Fund regarding this decision.

OTHER IMPORTANT FACTS

Coordination of Benefits

If you or a dependent are covered by another plan in addition to the Fund 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 Fund's plan.

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 Fund's plan 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 this Plan will be subrogated. This means that the Plan 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 the Plan 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 the Fund's Plan pays benefits that should have been paid by another plan or organization, the Plan has the right to seek recovery from the other plan or organization. If the Fund's Plan 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 also eligible for Medicare benefits, the order of payment will be:

(a) Group Employer (Primary, Secondary etc.) health plan(s); and or

(b) SMMP; and

(c) 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.

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) apropriate 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 the Fund.

Non-Reimbursed Covered Charges

Covered Charges (See pages E.4 - E.6) 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 and 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 his/her 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

QUALIFIED MEDICAL CHILD SUPPORT ORDER

If a Qualified Medical Child Support Order is issued for your child, that child will be eligible for coverage as required by the order. You must notify the Fund and elect coverage for that child as soon as reasonably possible.

A Qualified Medical Child Support Order is a judgment, decree or order (including approval of a settlement agreement) issued by a court of competent jurisdiction or through an administrative process established under state law that satisfies all of the following requirements:

1. the order specifies your name and last known address and the child's name and last known address;
2. the order provides a description of the coverage to be provided or the manner in which the type of coverage is to be determined;
3. the order states the period to which it applies; and
4. the order specifies each plan to which it applies.

The Qualified Medical Child Support Order may not require the health plan to provide coverage for any type or form of benefit not otherwise provided under the plan.

ELIGIBILITY FOR COVERAGE FOR ADOPTED CHILDREN

Any child under the age of 26 who is adopted by you, including a child who is placed with you for adoption, will be eligible for dependent coverage upon the date of placement with you. A child will be considered placed for adoption when you become legally obligated to support that child, totally or partially, prior to that child's adoption.

If a child placed for adoption is not adopted, all health coverage ceases when the placement ends and will not be continued.

SPECIAL RIGHTS FOR MILITARY RESERVISTS AND THEIR DEPENDENTS

A. COBRA rights are available to your dependents while you are serving on active military duty as a Reservist, whether or not you have elected any continuation of group coverage.

   In the event of your death, your spouse will have COBRA rights. He/she will also have COBRA rights in the case of divorce or annulment. A child may exercise this right on his/her own behalf, upon reaching the age limit in the plan.

   See "Benefit Continuation Available Upon Coverage Termination" on page E.18 for conditions that may affect the rights of your dependents.

   "Reservist" means a member of a reserve component of the armed forces of the United States. The term includes a member of the National Guard whose active duty is extended at a time when the President is authorized to order:

(i) units of the ready reserve; or (ii) members of a reserve component to active duty. Such additional active duty must be at the request and for the convenience of the federal government. It does not include: (i) reservists entering active duty for the purpose of training or determining physical fitness; or (ii) reservists who have served more than four years of active duty.

B. If you return to employment with your employer as a member of the Fund when your active military duty as a Reservist ends, you are entitled to the reinstatement of SMMP coverage for yourself and your dependents. To reinstate your SMMP coverage, you must notify your employer and the Fund that you elect reinstatement within 90 days from your date of discharge. Such reinstatement will be retroactive to your date of discharge. The reinstatement will be without the application of:

   (a) a new waiting period. However, the remainder of a waiting period not satisfied before active military duty began may still be applied; and

   (b) the pre-existing conditions limitation to any condition that you or your dependent may have developed while coverage was interrupted due to active military duty. However, the limitation may still be applied to conditions resulting directly from military duty. There is no pre-existing provision in the plan.

C. If you do not return to employment with your employer as a member of the Fund when your active military duty as a Reservist ends, you and your dependents are entitled to COBRA Optional Continuance rights.

See “Benefit Continuation Available Upon Coverage Termination” for conditions that may affect your rights.

BENEFIT CONTINUATION AVAILABLE UPON COVERAGE TERMINATION

Upon termination of coverage (circumstances resulting in coverage termination are described in the “Fund 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 a 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 Section K of the Fund Benefits Booklet.

To receive a COBRA application, or for additional information, please contact the MBF Administrative Office at 1- 212-306-7290, or 1-888-4000 MBF if outside New York City, or (TTY) 1-212-306-7629 (for the hearing impaired).

SECTION F

DENTAL BENEFITS

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F. DENTAL BENEFITS

ELIGIBILITY

Members and dependents are eligible for dental benefits by virtue of their meeting the eligibility and enrollment requirements as outlined in the “Fund Eligibility and Membership” section of this booklet.

BENEFIT YEAR

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

WHAT IS COVERED

Benefits are payable for Covered Dental Charges incurred during a benefit year during which the member or 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 two applications in a benefit year for each covered person.
- Drugs prescribed by a provider for a dental condition. (Please note - if you utilize a PPO 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 amalgam or composite. (Limitation: replacement of inlays/onlays or crowns less than five years old, by another such restoration or bridge unit, will not be covered.)
- The localized delivery of antimicrobial agents is only covered if rendered by a periodontist.
- Oral surgery, and root canal therapy.
- Installing for the first time, or adding to, a denture or fixed bridge if:
  - the work is needed due to extraction of injured or diseased natural teeth or to the congenital absence of deciduous or permanent teeth; and
  - the work includes replacing the missing tooth (teeth).

  If such tooth (teeth) was missing before the date the person became covered for these benefits, such charges will be covered only if incurred at least twelve (12) months after the person became covered.

  A denture or bridge is considered to be installed for the first time if it does not replace any existing denture or bridge.
- Replacing or altering a denture or 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.
- Replacing a full or partial denture if needed due to a change in the structure of the mouth or the prosthetic device because of which the device cannot be made serviceable, if replaced five years after the date the bridge or denture was installed, which was covered under this plan.
- Replacing a fixed bridge that cannot be made serviceable, if replaced five years after the date the bridge was installed, which was covered under this plan.
- Repairing a denture or bridge.
- 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 for dependent children, 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 (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 the section “Important Limitations” on Page F.5 for information on limitations on 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.

Please also refer to F. 5, "Charges Not Covered."

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 Healthplex and SIDS PPO Networks of licensed providers and dental specialists who agree to provide care at a discounted price for covered services. By using a PPO provider, you maximize the value you derive from this plan and receive the highest level of benefit. In-network dentists file claim forms with Healthplex, 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 Healthplex or SIDS 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 and 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 services, up to scheduled maximum allowance for each type of service in a certain geographical area, as determined by Healthplex. 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 claim forms for you. Once services have been rendered, claim forms must be sent to Healthplex.

	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%	70%
Major Restorative (Crowns, dentures and bridges)	90%	70%
Implants	50%	50%
Annual Maximum (Per Individual)	$4,000***	
Lifetime Orthodontic Maximum**	$4,000***	

* 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).
*** For services completed prior to January 1, 2012, the annual maximum is $2,500 and lifetime orthodontic maximum is $2,500.

ORTHODONTIC TREATMENT

In addition to the annual dental benefit of $4,000, there is a separate $4,000 lifetime maximum for orthodontic treatment. The orthodontic benefit covers care for diagnosis, evaluation and pre/post installation of braces up to the lifetime maximum. In certain situations, orthodontic services may be covered for adults, but only if there is documented medical evidence that the malocclusion interferes with speech or breathing. For services completed prior to January 1, 2012, the lifetime orthodontic maximum is $2,500.

PROCEDURE FOR OBTAINING PPO SERVICES

Just follow these steps to select a PPO dentist:

1. Select a provider from the Fund's dental PPO directory, which is available on the Fund's Web site at http://nyc.gov/html/olr. Once you have entered the Web site, click on Dental PPO, and then "Healthplex." When the page loads, you can search providers by city, county, zip code or specialty. You can also click on MBF-SIDS Select. For members residing outside of NY, NJ or CT, you should click on CONNECTION Dental Provider Organization.

OR

2. Call Healthplex at 1-888-468-5179 or MBF-SIDS Select PPO at 1-718-204-7172 ext. 5501, 1-516-396-5501 or 1-800-537-1238 ext. 5501 (if outside of the 516 area code). For members residing outside of NY, NJ or CT, call the CONNECTION Dental Provider Organization at 1-877-277-6872.
3. Contact the Provider to arrange an appointment, identify yourself as an eligible member (or a dependent) of the Management Benefits Fund with coverage through Healthplex, and confirm that the Provider is a current PPO provider.
4. 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.
5. 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 Fund payment directly to the provider for services rendered.

If the dentist who submits the claim form (billing dentist) is a participating provider and the treating dentist is not a participating provider, the claim(s) will be paid to the billing dentist as an in-network claim. Tax identification numbers will be used to determine the participation status of the billing dentist.

Note: It is important to understand that the Management Benefits Fund does not recommend or endorse any provider. You are responsible for selecting the provider of your choice, participating or non-participating, and you should exercise the same care and apply the same criteria in selecting a participating provider that you would in selecting a non-participating provider. Because many providers may practice at a site which is listed as participating, you should verify the participation status of the dentist who is actually providing treatment.

PPO PERFORMANCE REVIEW

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

Healthplex systematically monitors and evaluates the delivery and appropriateness of dental care provided by its participating providers. In addition, all Healthplex providers have been fully credentialed according to the highest standards in the industry. Healthplex, as a Credentials Verification Organization, is certified by the National Committee for Quality Assurance (NCQA) in 10 out of 10 verification services. The National Committee for Quality Assurance is an independent, non-profit organization dedicated to measuring the quality of America's healthcare.

The Healthplex program, the CONNECTION Dental Provider Organization and the MBF-SIDS Select PPO program employs, among other means, patient satisfaction surveys, evaluation of treatment outcomes, and monitoring of disciplinary actions taken by official agencies.

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

PPO ADMINISTRATORS

The PPO Administrators for the Fund's Dental program are Healthplex, Inc., 333 Earle Ovington Blvd., Suite 300, Uniondale, NY 11553 and SIDS, P.O. BOX 9005, Lynbrook, N.Y. 11563-9005. For information regarding participating providers, please refer to the MBF PPO directories or call:

Healthplex, Inc.
1-800-468-0600
1-888-468-5179 (Dedicated customer service line for MBF members)

MBF-SIDS Select PPO Program
1-718-204-7172 ext. 5501
1-516-396-5501
1-800-537-1238 ext. 5501 (outside of New York City)

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

1. Out-of-Network providers should use a Management Benefits Fund claim form. To request a claim form, you may call 1-212-306-7290 or 1-800-4000-MBF (623) if outside New York State or download a claim form at www.nyc.gov/olr. Standard ADA dental claim forms will also be accepted by the Administrator.
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 the Management Benefits Fund's Claims Administrator:

HEALTHPLEX, INC.
333 EARLE OVINGTON BLVD., SUITE 300
UNIONDALE, NEW YORK 11553

In order to be considered for payment, claims must be submitted within 24 months from the date of services. If you have any questions regarding your claim, please call Customer Service at 1-888-468-5179.

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 Claims 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 the Fund, its consultants, and the Claims Administrator. For example, suppose your provider can restore a tooth with a filling (amalgam), and you request a more costly type of restoration, like a crown. In this case, the plan will pay a benefit equal to the amount normally paid to the provider for the 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. This 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. (See the "Alternate Treatment Provision" under "Important Limitations.")

The Claims 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.

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 Claims 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 scaling in the presence of inflammation.
- No payment will be made for crown build-ups.
- If payment for osseous surgery and gingival curettage or scaling of teeth is requested when performed on the same day, payment will be made for osseous surgery only. Payment for gingival curettage or scaling of teeth is not allowed when performed in conjunction with osseous surgery.
- 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.
- Preventive periodontal maintenance is 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 less than five years old will not be covered even if replacement is by a bridge unit or implant.

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.
- 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 hemisection(s).
- 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. These charges may be covered under the member's primary health insurance plan and the Fund'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.

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

EXTENDED DENTAL BENEFITS

If, at the time a person's coverage ends, he/she has 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:

- for up to one month after the date the person's coverage ends, if it ends because the plan ceases or coverage ends for the class of which the person is a member.
- for up to three months after the date the person's coverage ends, if it ends for any other reason.

COORDINATION OF BENEFITS (COB)

If you or a dependent is covered by another group dental plan in addition to the Fund dental plan, the Fund's plan will take into account benefits paid or payable by the other coverage(s) in determining if additional benefit payments can be made under the Fund dental plan. 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.

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.
- 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 insurance company or 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 of the parent 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 his or her dependent) will be secondary to a plan that covers the person (or his/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 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 Fund's plan is secondary, submit your claim to the primary plan first. After the primary plan has rendered a payment determination, submit your claim and primary plan's Explanation of Benefits (EOB) statement(s) to the Fund's plan. The Fund's 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 total payments from all plans (including the Fund's plan) will not exceed 100% of the Fund's allowable expense.

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 the Fund plan pays benefits that should have been paid by another plan or organization, the plan may get its money back from the other plan or organization. If the Fund plan 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.

If the dentist who submits the claim form (billing dentist) is a participating provider and the treating dentist is not a participating provider, the claim(s) will be paid to the billing dentist as an in-network claim. Tax identification numbers will be used to determine the participation status of the billing dentist.

CLAIMS APPEALS PROCESS

When appealing a determination made by the Dental Claims Administrator (Healthplex), state the reason you believe the claim was improperly denied and submit documentation, questions or comments you deem appropriate to the address on page F.4. Healthplex has thirty (30) days once all documentation has been received, to review the appeal, investigate and make a determination.

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. But 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;

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

(c) 1. as it applies to charges, fees or expenses of participating providers; more than that which is negotiated between the participating provider and Healthplex for covered services.

2. as it applies to all other charges, fees or expenses more than what is an R&C covered dental charge in the geographic area where the charge was incurred, as determined by Healthplex.

These amounts will be determined by Healthplex.

Preferred Provider
This term refers to a Provider that has an agreement with the Fund's PPO 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.

PROOF OF CLAIM

Written proof of claim must be given to Healthplex at the address noted on the Healthplex dental claim form(s) within six months after the date of service for which a claim is made. Itemized bills may be required as part of proof of claim. **Late proof will be accepted only if it is furnished as soon as is reasonably possible, but in no event will such proof be accepted if two years have elapsed from the date of service for which a claim is made.**

COBRA OPTIONAL CONTINUANCE

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 Optional Continuance). A notice of each person's rights under this option will be provided by your employer agency. Any person who has questions regarding COBRA Optional Continuance of dental benefits should refer to Section K in this benefits booklet or contact the Fund Administrative Office at 212-306-7290 or 1-888-4000 MBF(623) if outside New York City, or at (TTY) 1-212-306-7629 if hearing impaired.

CLAIMS ADMINISTRATOR

The Claims Administrator is the entity that reviews and determines whether to pay benefits to you. The Claims Administrator for the Fund's dental care program is Healthplex, Inc., 333 Earle Ovington Blvd., Suite 300, Uniondale, NY 11553.

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.

SECTION G

VISION CARE BENEFITS

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G. VISION CARE BENEFITS

ELIGIBILITY

Members and their dependents are eligible for Vision Care Benefits by virtue of their satisfying the eligibility and enrollment requirements as outlined in the "Fund 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 Fund vision care benefits:

- In-Network Preferred Provider Option (PPO): You utilize one of the Fund's PPO vision care providers for full service benefits, paid in full directly by the Fund to the provider and without incurring any out-of-pocket expense on your part for most services.
- Out-of-Network Indemnity Option: You select and directly pay the provider of your choice, file a claim with the Fund's Vision Care Administrator, and you are reimbursed up to the scheduled limits. The maximum benefit is $150 per covered person, per benefit year. In order to be considered for payment, claims must be submitted within 24 months from the date of services.

Once selected, only one of the above options (PPO or Indemnity) may be used for all services within a benefit year. (All in-network benefits must be obtained during a single visit.) However, individuals within a family unit may select different options.

Important: Please refer to the section on "Specific Details of Your Vision Care Benefit Options" (see page G.2) for complete information on the PPO Option and Indemnity Option.

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, optometrist or optician during the benefit entitlement 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 lenses (or conventional or disposable contact 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 Indemnity Option only) with reimbursement limited to the unused portion of the current benefit year maximum payment. If there is an accidental breakage of PPO spectacles, lenses and plan frames will be covered under the PPO Options warranty provisions for up to one year.
- Frames:
  Under the Preferred Provider Option (PPO): One pair of eligible frames is covered per person, per benefit year.

  Under the Indemnity Option: Charges for one pair of frames, per covered person, are covered once every two consecutive benefit years, except for children under age 14 who are covered for one pair of frames every benefit year.

Note: You will not be covered for frames in the same benefit year that 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 Program:

- 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 Indemnity Option. (See "Schedule of Benefits," page G . 1.)

- Replacement of lost lenses or frames, or replacement of scratched lenses not covered by the PPO Option's warranty provisions.
- Services or supplies for which the covered person incurred no expense.
- For frames in the same benefit year that coverage for contact lenses has been provided by the Vision Care Plan.

SPECIFIC DETAILS OF YOUR VISION CARE BENEFIT OPTIONS

Indemnity Option

The Indemnity Option reimburses eligible members and dependents 100% of the first $25 in eligible vision care expenses and 80% of additional eligible expenses, with a maximum benefit of $150 per person per benefit year. Coverage includes one eye examination and lenses each benefit year and frames once every two benefit years (except for children under age 14 who are covered for one pair of frames every benefit year). Members receive reimbursement under the Indemnity 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, which should then be mailed to:

DAVIS VISION
VISION CARE CLAIMS
P.O. Box 1525
Latham, N.Y. 12110

- Members are then reimbursed by mail 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. (Reimbursement for one pair of frames is every other January 1st.)
- In order to be considered for payment, claims must be submitted within 24 months from the date of services.

PPO Option

The Preferred Provider Option (PPO Option) is designed to provide eligible members and dependents with comprehensive services while maximizing value through reduction or elimination of out-of-pocket expenses. Listed below are key features of this option:

- Paid-in-full annual benefit for an eye examination, lenses and frames.
- No annual deductible.
- No fixed co-payments for selected high cost services. (See "Partially Paid Benefits" on Page G . 3.)
- 1300 optometrists and ophthalmologists currently participate in the PPO panel.

Paid-In-Full Benefits (PPO Option):

- Eye Exam
  - One eye examination, including a Dilated Fundus Evaluation when professionally indicated, is covered in full at a PPO provider.

- Lenses
  - Lenses available through the PPO 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)
    - Photochromic (glass) or photosensitive (plastic) transitions (lenses that darken when exposed to the ultra-violet 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

*Effective October 1, 2012, Premium ARC will be available with a co-pay of $13.00 and Ultra Arc will have a co-pay of $25.00.

- Frames

The Fund offers a selection of approximately 275 frames of both metal and plastic construction. This collection includes selected designer frames from Davis Vision's (the Plan Administrator's) exclusive "Premier Collection." Selecting frames from the Davis Vision Premier Collection results in maximum value as:

- No co-payment is required, and
- Unconditional one-year warranty against breakage is provided.

Partially Paid Benefits (PPO Option):

- Contact Lenses

Fund members and eligible dependents can obtain daily wear contact lenses, as well as certain disposable or frequent replacement contact lenses at no cost.

In the case of non-plan contact lenses, the Fund provides an allowance of $94 towards purchase. The member is responsible for paying the remaining amount to the provider.

- Non-Plan Lenses and Frames

Under the PPO Option, in the case of expenses for non-plan contact lenses, special lens designs and special designer frames, the Fund pays a specific allowance beyond which the member is responsible for full payment directly to the PPO Provider without reimbursement from the Fund.

Procedure for Obtaining PPO Vision Care Services:

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

1. Select a provider from the Fund's Vision Care PPO Directory, which is available from your Agency Personnel Office, the Fund Office, or by calling Davis Vision's toll-free number at 1-800-999-5431 to find a provider near you.

   OR

   Visit the Fund's Web site at http://nyc.gov/html/olr or visit www.davisvision.com.
2. Make an appointment with the PPO provider of your choice and identify yourself as a Management Benefits Fund member. (Verification of Fund and benefit usage eligibility will be conducted directly between the provider you have selected and Davis Vision.)
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 Service Record Form verifying your receipt of services and supplies. You do not have to pay the provider unless you select services or materials that are not covered by the plan or require a co-payment.

Note: All covered services (eye examination and eyewear) provided by a PPO provider must be scheduled as a single visit. The Fund will not, for example, pay for an eye examination on July 1, and eyeglasses on October 1 of the same benefit year under the PPO Option.

CONTACT LENS MAIL-ORDER PROGRAM

All members of the Fund and their eligible dependents are eligible to participate in a mail-order contact lens program, which offers savings on all contact lenses and solutions. The toll-free telephone number to place an order is: 1-800-LENS-123. You may also visit the Web site at www.lens123.com. You should know the brand and type of contact lenses you wear to receive a price quote. To purchase the lenses, you will be advised to mail or fax your prescription. Membership in this program is free, as long as you remain an eligible member/dependent of the Management Benefits Fund.

LASER VISION CORRECTION SERVICES

Through a network of surgeons, members and their eligible dependents can have access to laser vision correction services at savings of up to 25% off the selected provider's usual and customary fee or receive an additional 5% discount on any provider's advertised specials, whichever is less.

For more information regarding this benefit, or to receive information regarding providers in your area, please visit the Davis Vision Web site at:

www.davisvision.com
select "Laser Vision Correction"
and enter client code #7187

or you may call the Davis Vision Interactive Voice Response System, 24 hours a day, at 1-800-584-2866 and enter client code #7187. The member service hours are Monday – Friday from 8:00 a.m. to 8:00 p.m. and Saturday from 9:00 a.m. to 4:00 p.m. Eastern Time.

COBRA OPTIONAL COVERAGE

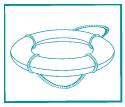
If coverage of a member or his/her dependent ends, that person has the right to continue coverage under the federal law known as the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). Notice of each person's rights under this option will be provided by the member's employing agency. Any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

CLAIMS ADMINISTRATOR

The Claims Administrator for the Fund's Vision Care Program is Davis Vision, 159 Express Street, Plainview, N.Y. 11803.

Please note that the Management Benefits Fund 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.

SECTION H



SURVIVOR BENEFITS

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What is Covered	H . 1
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Coordination of Benefits	H . 2
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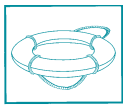
Filing Claims	H . 2

H. SURVIVOR BENEFITS

OVERVIEW



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

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

WHO IS COVERED

The Fund provides Survivor Benefits to the eligible:

- Surviving Spouse/Domestic Partner and
- Dependent Children

If the deceased member was eligible for Fund 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 Fund benefits, are eligible for Survivor Benefits.

Eligible dependent children are those who are not married and are under age 19, and those under age 23 who are full-time students attending a recognized college or university, trade or secondary school. Disabled dependent children are covered regardless of age if the disability occurred (1) before their 19th birthday and (2) while covered under the Fund's benefit plans. Refer to the "Fund Eligibility and Membership" section of this booklet for additional eligibility information. (See page A.2)

WHAT IS COVERED

City Health Insurance

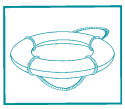
The surviving spouse/domestic partner and eligible dependent children will be provided coverage in the same City Health Insurance plan that they were enrolled in at the time of the member's death. In addition, should the health plan offer an Optional Benefits Rider, the Fund will also offer the same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

Fund Benefits

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

Please note:

1. If the deceased Fund member was an employee or retiree of the State of New York, his/her survivors are only eligible for the Fund's Superimposed Major Medical, Dental and Vision Care benefits.
2. If the surviving spouse/domestic partner of a deceased Fund member is an employee/retiree of the City of New York, the spouse/domestic partner and eligible dependents are only eligible for the Fund's SMMP, Dental and Vision Care benefits.



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. However, the City of New York Employee Health Benefits Program provides survivors with Health Insurance coverage during the month of the death of the deceased retired member.

- The Fund provides survivors with the Fund's SMMP, Dental and Vision Care benefits commencing on the day following the active/retired member's death.

Termination of Survivor Coverage

All Fund Survivor Benefits cease on the last day of the 36th month following the date of the member's death.

Upon termination of the Fund's survivor benefits coverage, survivors only have the right to convert their basic City health plan into an individual policy.

COORDINATION OF BENEFITS

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

HOW TO APPLY

After the Fund is notified of a member's death, the eligible surviving spouse/domestic partner or dependent children will be sent an application form to complete and return to the Fund Office. Coverage will be maintained retroactively to the date of the member's death, 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 Social Secuirty Number must be used.

Survivors	Social Security Number (SS#) 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.	SS# of the spouse/domestic partner 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 spouse/domestic partner for claims incurred from the first day of the month following the member's death.
Survivors of a deceased retired member.	SS# of the deceased member for claims incurred until the last day of the month of the member's death. SS# of the spouse/domestic partner 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 spouse/domestic partner for claims incurred from the first day of the month following the member's death.

SECTION I

RETIREE MEDICARE HMO DRUG BENEFITS

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Qualified Medicare HMO Plans	I . 1
Benefits	I . 1
Procedure for Obtaining Benefits	I . 1

I. RETIREE MEDICARE HMO DRUG BENEFITS

OVERVIEW

The Management Benefits Fund pays the drug option premium cost directly to Health Maintenance Organizations (HMOs) on behalf of Medicare-eligible retirees and their spouses/domestic partners who are enrolled in qualified Medicare HMOs.

ELIGIBILITY

Retired Fund members and/or their spouses/domestic partners who satisfy the Fund's eligibility and enrollment requirements, as outlined in the "Fund Eligibility and Membership" section of this booklet (See page A.1), are eligible for benefits under this program if:

1. their City health plan coverage is provided through a qualified Medicare HMO; and
2. they are enrolled in Medicare Parts A & B; and
3. they reside at their present address for at least nine months of the year.

QUALIFIED MEDICARE HMO PLANS

The City of New York Employee Health Benefits Program publishes a Summary Program Description (SPD) that provides detailed information on qualified Medicare HMO Plans. To request a copy of this SPD, please call (212) 513-0470 or write to the City of New York Office of Labor Relations Employee Health Benefits Program, 40 Rector Street, 3rd Floor, New York, NY 10006.

BENEFITS

The Fund will pay the premium cost of any drug option of qualified Medicare HMO Plans offered by the City of New York Employee Health Benefits Program, where such a cost would otherwise be paid by the member through pension deductions. The member, however, will be liable for any co-payments (if applicable).

Please Note: The Fund Retiree Medicare HMO Drug Benefits are only available to Medicare-eligible members and/or their Medicare-eligible spouses/domestic partners. Charges for a drug option for a non-Medicare-eligible person will not be assumed by the Fund and are the responsibility of the member.

PROCEDURE FOR OBTAINING BENEFITS

As long as a member and/or his/her spouse/domestic partner satisfies the eligibility criteria (specified earlier), and applies for drug option coverage under a qualified Medicare HMO Plan, which charges a separate premium payment for such coverage, he/she automatically receives benefits from this program. The Fund directly pays the premium cost to the HMO, without any further paperwork required on the member's part.

SECTION J

HEALTH CLUB REIMBURSEMENT PROGRAM

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Benefits	J . 1
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J. HEALTH CLUB REIMBURSEMENT PROGRAM

OVERVIEW

The Management Benefits Fund, recognizing the life-long benefits of exercise, is offering to Fund members and their spouse/domestic partner a Health Club Reimbursement Program, which provides reimbursement for membership fees at an MBF approved Health Club (see definition below).

WHO IS COVERED

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

Note: Other dependents are not eligible for this benefit.

TYPES OF FACILITIES COVERED

Your health club must meet the MBF definition of an approved Health Club to qualify for benefits under the Program.

An MBF approved Health Club is a facility designed to promote wellness and improve the health and physical condition of each member. Please refer to the exclusions listed on page J.2

BENEFITS

The program provides the following benefits:

Member	Spouse/Domestic Partner
$250 maximum ($500 annual maximum)	$250 maximum ($500 annual maximum)

You and your spouse/domestic partner are eligible for reimbursement after exercising a minimum of five times a month, for six consecutive months, in a health club.

We recommend that before you join a health club, you visit with your primary care physician to determine the appropriate cardiovascular fitness program for you.

CLAIMS PROCESS

- You must submit separate claim forms for your spouse/domestic partner and yourself and receipts of payment from the health club and include one of the following as proof of payment: (a) health club contract, (b) payment receipt, or (c) letter on company (health club) stationery or letterhead. The dates on the proof of payment must coincide with the dates of the claim period.
- You and your spouse/domestic partner are required to complete new claim forms after every six-month exercise period and must attach proof of payment.
- You and/or your spouse/domestic partner and a representative from the health club must complete appropriate sections of the claim form.
- All completed claim forms must be mailed, along with proof of payment, to the Management Benefits Fund, 40 Rector Street, Third Floor, New York, N.Y. 10006.
- Upon receipt and approval, you will receive a confirmation letter confirming the reimbursement amount.
- To obtain a claim form, call the Fund at 1-212-306-7290 or 1-888-400-0MBF (if outside New York City) or visit the Fund Web site at http://nyc.gov/olr.
- In order to be considered for payment, claims must be submitted within 24 months of the claim period ending date.

TAXABLE INCOME

Reimbursement for participation in the Health Club Reimbursement Program will be considered taxable income for the member in the calendar year in which it is paid.

REIMBURSEMENT

Active Employees and Employee's Spouse/Domestic Partner

You must submit a claim form (after six consecutive months of exercise) to the Management Benefits Fund Administrative Office by the last day of the month so that it may be processed for that month. You will receive reimbursement of approved expenses received during a particular month by the close of the following month.

Note: Employees of the Mayoralty, Housing Authority, Department of Education (H-Bank), Health & Hospitals Corporation, School Construction Authority, and Cultural Institutions and Libraries will receive reimbursement in their regular paychecks.

Note: Unified Court System employees will receive reimbursement directly from the Management Benefits Fund. Please be advised that this is a taxable benefit. Unified Court System employees will be responsible for paying all applicable taxes when filing an income tax return.

All reimbursements for participation in the program by a member's spouse/domestic partner will be issued in the member's name, for tax purposes. Reimbursements for membership will be issued directly to the member.

Please note: the Fund does not process claims for claim periods less than six months in duration.

Retired Employees

The retiree will receive a reimbursement check from the Management Benefits Fund with 7.65% FICA tax withheld. The retiree will receive a Form W-2 for the benefit amount from the retiree's retirement system. This reimbursement amount should be reported as earned income on the retiree's tax return. All reimbursements will be issued directly to the retiree.

LIMITATIONS AND EXCLUSIONS

1. Any establishment that does not have as one of its primary purposes or businesses the provision of health club services is not considered an MBF approved Health Club.
2. Memberships in dance studios, country/tennis clubs, weight loss clinics, spas or any other similar facilities are not considered approved Health Clubs under the MBF definition as stated above, and will not be reimbursed.
3. Coverage does not include any fitness activity, including swimming lessons, tennis lessons, dance, personal trainer programs and wellness center programs, if the activity takes place outside of a health club or is not included in the health club membership. In addition, coverage does not include additional classes not covered by the general health club membership fees.
4. Classes or programs provided by any nonprofit school, public school or private school, college or university are not covered.
5. Reimbursement for membership in a health club is limited to actual workout visits. The program does not reimburse you for expenses incurred for equipment, locker rentals, clothing, vitamins, or other services that might be offered by the facility for an additional fee (massages, personal trainers, etc.).
6. 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 that covers only the fee for the member and/or member's spouse/domestic partner (if he/she is also participating in the Health Club Reimbursement Program).
7. Rehabilitation programs and fitness centers in a hospital setting are not covered.
8. Payment of membership fees to the fitness center by gift certificate or by a third party other than a spouse/domestic partner is not eligible for reimbursement under the program.

SECTION K

CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT (COBRA)

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COBRA Continuation for Spouses/Domestic Partners	K . 1
COBRA Continuation for Dependent Children	K . 1
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K. 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 Fund 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 (or 150% of the group rate for the 19th through 29th months in case of total disability). You will be billed directly by Healthplex, the MBF COBRA administrator, for premiums on a monthly basis.

COBRA CONTINUATION FOR MEMBERS

- Fund members are eligible for COBRA continuation if their benefits terminate due to:
  - a reduction in hours of employment, or
  - termination of employment (including unpaid leave of absence) for reasons other than gross misconduct, or,
  - deferred retirement.
- The coverage period is 36 months from the date of coverage termination.

COBRA CONTINUATION FOR SPOUSES/DOMESTIC PARTNERS

- The spouse/domestic partner of a member has the right to choose COBRA continuation coverage if benefit coverage is lost due to any of the following reasons:
  - Death of the member. (Coverage is available at no premium cost through the MBF Survivor Benefit)
  - Termination of the member's employment for reasons other than gross misconduct.
  - Loss of benefit coverage due to the member's reduction in hours of employment.
  - Spouse divorce from the member.
  - Termination of domestic partnership with the member.
  - Deferred retirement of the member.
- The coverage period is 36 months from the date of coverage termination.

COBRA CONTINUATION FOR DEPENDENT CHILD(REN)

- Dependent child(ren) of members have the right to COBRA continuation coverage if benefit coverage is lost due to any of the following reasons:
  - Death of the Fund member parent. (Coverage is available at no premium cost through the MBF Survivor Benefit)
  - Termination of a Fund member parent's employment for reasons other than gross misconduct.
  - Loss of benefit coverage due to the Fund member parent's reduction in hours of employment.
  - The dependent ceases to qualify as a covered dependent child under the terms of the Fund's eligibility requirements.
  - Deferred retirement of the member.
- The coverage period is 36 months from the date of coverage termination.

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 Termination of member's employment (including unpaid leave of absence) for any reason other than gross misconduct Member's deferred retirement	Employee Spouse/Domestic Partner Dependent Children	36 months
Death of covered employee	Spouse/Domestic Partner Dependent Children	36 months
Divorce Legal separation Termination of domestic partnership	Spouse/Domestic Partner Dependent Children	36 months
Covered employee becomes eligible for Medicare	Spouse/Domestic Partner Dependent Children	36 months
Loss of eligible dependent child status	Dependent Children	36 months

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).

COBRA BENEFIT OPTIONS

COBRA benefit continuation options provided by the Fund are as follows:

(1) You are eligible to elect COBRA continuation of:

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.

HOW TO APPLY FOR COBRA

To elect Fund COBRA continuation coverage, the member or his/her spouse/domestic partner or dependent child should complete a Management Benefits Fund COBRA Application and submit it to the Fund within 60 days of the date of benefit coverage termination. The member may be eligible to receive full COBRA continuation coverage from your basic City health plan. Please contact your agency benefit manager or your health carrier directly within 60 days of your benefit coverage termination to apply for this coverage.

For current COBRA rates and an application, please visit the Fund's Web site at http://nyc.gov/olr or call the Fund Office at 1-212-306-7290, or at 1-888-4000MBF (1-888-400-0623) if outside New York City, or at (TTY) 1-212-306-7629 if hearing impaired. Please keep MBF informed of any address changes.

SECTION L

FAMILY AND MEDICAL LEAVE ACT (FMLA)

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How to Apply	L . 1
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Special Leave of Absence Coverage (SLOAC) Eligibility	L . 2
COBRA Optional Coverage	L . 2
Basic Life Insurance Conversion Privilege	L . 2
Group Universal Life (GUL) Insurance Coverage	L . 2
Long Term Disability (LTD) Insurance Coverage	L . 2

L. FAMILY AND MEDICAL LEAVE ACT (FMLA)

OVERVIEW

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 to care for an immediate family member or for the serious illness of the employee. Eligible and approved employees using this paid and/or unpaid leave can continue their basic City health coverage and the Fund benefits which are paid by the City and the Fund, respectively, for up to a maximum of 12 weeks.

EMPLOYEE ELIGIBILITY

An employee is eligible for leave under FMLA if he or she has 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 age 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

The Fund provides continuation of benefits to the eligible employee (member) and his/her eligible dependents (spouse/domestic partner and children).

BENEFITS COVERED

Benefits which are fully paid by the Fund include:

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

HOW TO APPLY

Contact the personnel office of your employer agency to request a leave under FMLA. If eligible and approved, the personnel office will provide to the Fund's Administrative Office the appropriate information for continuation of your Fund benefits.

EFFECTIVE DATE OF COVERAGE

The effective date for continuation of your Fund benefits under FMLA is the approved start date provided by your employer agency.

DURATION OF COVERAGE

The 12-month period in which the 12 weeks of leave entitlement occur is a "rolling" 12-month period measured backward from the date any leave under FMLA is taken. Under this method of leave calculation, each time an employee is to take any leave under FMLA, the leave entitlement would be the balance of the 12 weeks which has not been used during the previous 12-month period.

If you have exhausted the maximum leave period under FMLA, you will need to satisfy the eligibility and leave entitlement requirements once again before a request for an additional leave of absence under FMLA may be approved.

SPECIAL LEAVE OF ABSENCE COVERAGE (SLOAC) ELIGIBILITY

When the continuation of your basic City health coverage and Fund benefits ends under FMLA and you have exhausted all personal leaves (compensatory, annual, and sick), and your absence is due to your own serious illness, you may be eligible to extend your benefits under SLOAC. To find out if you are eligible to extend your City health coverage and Fund benefits, please contact the personnel office of your employer agency.

COBRA OPTIONAL COVERAGE

When the continuation of your basic City health coverage and Fund benefits ends under FMLA and you are not eligible or not approved for SLOAC, you and/or your eligible dependents may each have the right to continue basic City health coverage and certain Fund benefits (Superimposed Major Medical, Dental and Vision Care) under the federal law known as the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). Notice of each eligible covered person's rights under COBRA will be provided by the personnel office of your employer agency. If you have any questions regarding the continuation of basic City health coverage under COBRA, you should contact your health plan or the personnel office of your employer agency. If you have any questions about continuing your Fund benefits under COBRA, please contact the Fund's Administrative Office at 1-212-306-7290, 1-888-4000MBF (1-888-400-0623) if outside NYC, or (TTY) 1-212- 306-7629 if hearing impaired.

The period of leave under FMLA will not count towards the maximum COBRA coverage entitlement period.

BASIC LIFE INSURANCE CONVERSION PRIVILEGE

When the continuation of your Basic Life Insurance and Accidental Death & Dismemberment Insurance ends under FMLA and you are not eligible or not approved for SLOAC, your Basic Life Insurance coverage will continue for 31 days. During this 31-day period, you may convert your Basic Life Insurance group coverage to an individual policy without evidence of good health or purchase an individual policy at a lower rate with evidence of good health. For information, please contact The Prudential Insurance Company of America at 1-973-548-6061.

Please be advised that there is no conversion privilege available for the Accidental Death & Dismemberment Insurance.

GROUP UNIVERSAL LIFE (GUL) INSURANCE COVERAGE

If you are enrolled in the Group Universal Life Insurance Program, GUL payroll deductions will continue while you are on paid leave under FMLA.

If all of your leave is unpaid or you have exhausted your paid leave and your unpaid leave goes into effect under FMLA, payroll deductions for your GUL Insurance coverage will cease. You must continue your GUL Insurance on a direct-billing basis by paying premiums to the insurance carrier, The Prudential Insurance Company of America. If you have any questions or need additional information, please contact The Prudential Company of America at 1-800-562-9874

LONG TERM DISABILITY (LTD) INSURANCE COVERAGE

There is no continuation of LTD Insurance during a leave of absence under FMLA. If your leave of absence, however, is the result of a disabling condition, you may be eligible to apply for LTD insurance benefits.

For additional information about LTD Insurance, please refer to Section D of this benefits booklet or contact the Fund's Administrative Office at 1-212-306-7290, 1-888-4000MBF (1-888-400-0623) if outside NYC, or at (TTY) 1-212-306-7629 if hearing impaired.

SECTION M

SPECIAL LEAVE OF ABSENCE COVERAGE (SLOAC)

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Long Term Disability (LTD) Insurance Coverage	M . 2

M. SPECIAL LEAVE OF ABSENCE COVERAGE (SLOAC)

OVERVIEW

Special Leave Of Absence Coverage (SLOAC) entitles the City of New York employees (approved for leave) 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 Fund benefits, which are paid by the City and the Fund, respectively.

WHO IS COVERED

The Fund provides continuation of benefits to the eligible employee (member) and his/her eligible dependents (spouse/domestic partner and children).

BENEFITS COVERED

Benefits which are fully paid by the Fund include:

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

HOW TO APPLY

Contact the personnel office of your employer agency to request SLOAC coverage when taking an unpaid leave. If your request for unpaid leave is approved by your employer agency, the personnel office will provide to the Fund's Administrative Office the appropriate information for continuation of your Fund benefits.

EFFECTIVE DATE OF COVERAGE

The effective date for continuation of your Fund benefits under SLOAC is the day following the date all eligible leaves of absence (Family and Medical Leave Act, compensatory, annual and sick leave) have been exhausted.

DURATION OF COVERAGE

The 12-month period in which the 18 weeks or 4 months maximum of coverage (depending on your pay cycle) occur is a "rolling" 12-month period measured backward from the date any coverage is continued under SLOAC. The remaining SLOAC eligibility would be the balance of the 18 weeks or 4 months which has not been used during the previous 12-month period, less any coverage during unpaid leave under FMLA (as explained below).

FAMILY AND MEDICAL LEAVE ACT (FMLA) COVERAGE

An employee not satisfying the eligibility requirements under FMLA, or an employee who was on paid leave for all 12 weeks under FMLA, would have the maximum allowable coverage of 18 weeks or 4 months under SLOAC.

Please be advised that coverage previously received during an unpaid leave under FMLA serves to reduce the maximum allowable coverage period under SLOAC. For instance, one month unpaid leave coverage under FMLA results in a maximum of 3 months coverage allowable under SLOAC.

COBRA OPTIONAL COVERAGE

When the continuation of your basic City health coverage and Fund benefits ends under SLOAC, you and/or your eligible covered dependents may each have the right to continue basic City health coverage and certain Fund benefits (Superimposed Major Medical, Dental and Vision Care) under the federal law known as the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). Notice of each eligible covered person's rights under COBRA will be provided by the personnel office of your employer agency. If you have anyquestions regarding the continuation of basic City health coverage under COBRA, you should contact your health plan or the personnel office of your employer agency. Also, if you have any questions about continuing your Fund benefits under COBRA, please contact the Fund's Administrative Office at 1-212-306-7290, 1-888-4000MBF (1-888-400-0623) if outside NYC, or (TTY) 1-212-306-7629 if hearing impaired.

The period of coverage under SLOAC will not count towards the maximum COBRA coverage entitlement period.

BASIC LIFE INSURANCE CONVERSION PRIVILEGE

When the continuation of your Basic Life Insurance and Accidental Death & Dismemberment Insurance ends under SLOAC, your Basic Life Insurance coverage will continue for 31 days. During this 31-day period, you may convert your group coverage for Basic Life Insurance to an individual policy without evidence of good health or purchase an individual policy at a lower rate with evidence of good health. For information, please contact The Prudential Insurance Company of America at 1-973-548-6061.

Please be advised that there is no conversion privilege available for the Accidental Death & Dismemberment Insurance.

GROUP UNIVERSAL LIFE (GUL) INSURANCE COVERAGE

If you are enrolled in the Group Universal Life Insurance Program, GUL payroll deductions will cease while you are on unpaid leave. You must continue your GUL Insurance on a direct-billing basis by paying premiums directly to the insurance carrier, The Prudential Company of America. If you have any questions or need additional information, please contact The Prudential' Insurance Company of America 1-800-562-9874.

LONG TERM DISABILITY (LTD) INSURANCE COVERAGE

There is no continuation of LTD Insurance during a leave of absence under SLOAC. If your leave of absence, however, is the result of a disabling condition, you may be eligible to apply for LTD insurance benefits.

For additional information about LTD Insurance, please refer to Section D of this benefits booklet or contact the Fund's Administrative Office at 1-212-306-7290, 1-888-4000MBF (1-888-400-0623) if outside NYC, or (TTY) 1-212-306-7629 if hearing impaired.

SECTION N

GHI/EMPIRE BLUE CROSS BLUE SHIELD SENIOR CARE PROGRAM SUBSIDY BENEFIT

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N. GHI/EMPIRE BLUE CROSS BLUE SHIELD SENIOR CARE PROGRAM SUBSIDY BENEFIT

OVERVIEW

The GHI/Empire Blue Cross Blue Shield (EBCBS) Senior Care Program Subsidy Benefit is a payment made by the Management Benefits Fund directly to the Health Benefits Program on behalf of retired Fund members and their spouses/domestic partners covered under the GHI/EBCBS Senior Care Program.

ELIGIBILITY

Fund members and their spouses/domestic partners who satisfy the Fund's eligibility and enrollment requirements, as outlined in the "Fund Eligibility and Membership" section of this booklet, and are able to receive prescription drug coverage under Medicare, are eligible for benefits under the GHI/EBCBS Senior Care Program Subsidy Benefit.

GHI/ EBCBS SENIOR CARE PROGRAM

The New York City Employee Health Benefits Program publishes a Summary Program Description (SPD) that provides detailed information on the GHI/EBCBS Senior Care Program. To request a copy of this SPD, please call 1-212-513-0470 or write to the New York City Employee Health Benefits Program, Retiree Health Benefits Unit, 40 Rector Street, 3rd Floor, New York, N.Y. 10006.

BENEFITS

The Fund pays a $50.00 per person per month subsidy ($100.00 maximum) directly to GHI on behalf of Retired Fund members and their spouses/domestic partners who are covered under the GHI/EBCBS Senior Care Program.

Please Note: The GHI/EBCBS Senior Care Program Subsidy 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 drugs will not be subsidized by the Fund and are the responsibility of the member.

PROCEDURE FOR OBTAINING BENEFITS

The GHI/EBCBS Senior Care Program Subsidy Benefit provides those eligible members insured through the GHI/EBCBS Senior Care Program 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.