

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 the date of service and participation in the City’s basic (primary) plans.

Date of Service	Primary Group Health Coverage	Prescription Drug Plan/Rider	One Individual	Two Individuals	Three or More Individuals
On or after 1/1/08	Yes	Yes	\$500	\$1,000	\$1,500
On or after 1/1/08	Yes	No	\$2,500	\$5,000	\$7,500
All Dates	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 conditions for which medical services are given to a person due to age or mental or physical condition and 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 for Medicare-eligible members and/or their Medicare-eligible spouse/domestic partner for the 5% out-of-pocket co-insurance incurred once a member reaches the catastrophic level of coverage under Medicare Part D. Please refer to page E.13 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 providers in your geographic area typically charge for similar services or 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, only \$9,000 is considered R&C 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*	(\$250)
Benefit Payments Based on	\$5,750
SMMP reimbursement @ 90%:	\$5,175
Member co-insurance ** @ 10%:	\$575
*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 \$5,175 and the member would be responsible for \$1,825 (SMMP deductible, 10% co-insurance plus \$1,000 not included in R&C allowance). The \$575 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)
- Penalties due to failure to pre-certify hospital, mental health and substance abuse benefits.

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.16. 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 is not enrolled in the City basic health care plan.

OUT PATIENT MENTAL HEALTH

Covered professional fees will only include those of a psychiatrist, psychologist or a social worker who is certified and registered and whose name appears on the list of social workers who are qualified for payment under Chapter 893 of New York State laws (maintained by the New York Board of Social Work).

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

Claims for out patient mental health treatment are subject to review for medical necessity and appropriateness as determined by New York County Health Services Review Organization (NYCHSRO).

LIFETIME MAXIMUM BENEFIT

The lifetime maximum benefit payable under this plan for a covered person is \$1 million.

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.

The maximum annual benefits payable for a covered person is \$800 and 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	Chest X-Rays
Spiral CT	Pulmonary Function Testing
Sigmoidoscopy	Colonoscopy
Bone Densitometry	

Laboratory Tests

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

Gender Specific

Prostate Specific Antigen (PSA)	Pap/Pelvic Exam
Mammography	



Immunization

Rubella Titer
Influenza
Hepatitis B

Tetanus-Diphtheria
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. Obtain an MBF Adult Wellness 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 employment. In these cases, expenses must first be submitted to the other plans for benefit determination.
2. If you are covered under both the City's Employee Health Benefits Program and a spouse's plan (or a plan through other 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-Adult Wellness 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.

For information on submitting all other SMMP claims, please refer to page E.15.

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 out-patient 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 examination 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.11 and E.18 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.13.

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 mastopexy. 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 R&C 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. Covered charges for complications with respect to the newborn child, even if not covered, will be added to those of the mother in determining benefits.

Mental Health and Substance Abuse Treatment – Charges for inpatient and outpatient care may be limited based on medical necessity and plan provisions. See Section Alcoholism and Substance Abuse Benefits for coverage details.

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 Management Benefits Fund Dental Plan, but must be performed in order for dental procedures that are covered under the Management Benefits Fund 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' spouses 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, ordered by the primary physician and approved by NYCHSRO or IPRO. Refer to Page E.10 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 through age 19, 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.
- of the following types on account of mental, nervous or emotional conditions:
 - (a) educational testing or training on account of mental, nervous or emotional conditions;
 - (b) room and board and other services made by hospitals for confinement for more than 30 days in a calendar year or for a total of more than 365 days in the lifetime of an insured person on account of drug abuse, alcoholism or mental, nervous or emotional conditions.
- for more than 60 out patient visits in a calendar year for alcoholism and/ or substance abuse.



- 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 is 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.
- for ambulance and other services for which the primary purpose is to provide transportation to a health care professional for out patient 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.



HOSPITAL MENTAL HEALTH BENEFITS PRE-CERTIFICATION PROGRAM

The term “Pre-Certification” means review by the SMMP administrator’s designated review organization, to determine the number of days of inpatient hospital confinement, of at least 18 hours, for alcoholism, substance abuse or psychiatric treatment which will be deemed medically necessary for the care or treatment of the patient’s condition, not to exceed 30 days in a calendar year. Coverage may be extended beyond 30 days, if authorized by the review organization, based on review at the end of the initial certified period (see “Hospital Stay Extensions,” below). Coverage may not exceed a total of 365 days in a covered person’s lifetime. This pre-certification process only applies to mental health hospitalization for mental health, alcoholism and substance abuse.

Subject to deductibles and co-insurance, benefits will be paid for Covered Charges except as follows:

1. No benefits will be paid for, nor will the term Covered Charges include, any of the charges listed below made by a hospital that are incurred on any day of a patient’s in-patient hospital confinement which extends beyond the number of days determined by NYCHSRO to be medically necessary for the patient’s condition:
 - (a) charges for in-patient hospital room and board; and/or
 - (b) other charges for medical services and supplies furnished by the hospital.
2. If the required Pre-Certification is not obtained, the payment otherwise applicable to Covered Charges with respect to in-patient hospital confinement will be reduced as follows:
 - (a) paid at SMMP benefit less \$250 per day (up to a total penalty of \$500).
 - (b) a post-admission review will also be conducted by or on behalf of SMMP and all expenses not determined to be medically necessary for the patient’s condition will be excluded from Covered Charges.
3. Applicability: 1. and 2., above, apply to all Fund members and eligible dependents regardless of area of residence or eligibility for Medicare.
4. Pre-Certification Review Procedures:
 - (a) Non-Emergency Hospitalization: if already an in-patient receiving benefits under the New York City Health Benefits Program, NYCHSRO/IPRO must be contacted at least five days prior to the expiration of City primary health benefits to request continuation of benefits under the SMMP. If the City health benefits plan does not cover the category of in-patient hospital confinement, i.e., drug abuse/alcoholism rehabilitation, NYCHSRO must be contacted at least ten days prior to the proposed admission date to obtain Pre-Certification of a hospital admission.
 - (b) Emergency Hospitalization: if the admission is an emergency, NYCHSRO must be contacted within 24 hours of the start of the confinement or on the first business day after the weekend or legal holiday admission. Emergency Hospitalization means an in-patient hospital confinement for a condition which, unless treated at once on an in-patient basis, would: (a) jeopardize the patient’s life; or (b) cause serious impairment to the patient’s bodily functions.
 - (c) Hospital Stay Extensions: if the hospital stay must be extended beyond the days initially certified by NYCHSRO, NYCHSRO will obtain clinical data from the doctor and, if appropriate, process an extension-of-stay Pre-Certification through the Continued Stay Review Program. The doctor will be contacted 24 hours before the scheduled discharge date to confirm discharge or to certify additional days. The term “Continued Stay Review” means the SMMP’s review to determine if it is medically necessary to extend the in-patient hospital confinement beyond the number of days previously authorized.
5. The telephone number for NYCHSRO is 1-212-897-6042.

The following information must be supplied to NYCHSRO:

- name, address, date of birth and Social Security number of patient;
- name, Social Security number and employer of Fund member;
- identification of the member as a participant in the Management Benefits Fund SMMP;
- date of proposed admission;
- admitting diagnosis, procedure, and requested length of stay;
- name, address, and telephone number of hospital;
- name, address, and telephone number of attending doctor;
- primary coverage carrier and group policy number; and
- type of admission (Emergency vs. Non-Emergency).



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 medical 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 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 great extent. 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.

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 in which the deductible has been met.

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;

(For Covered Charges made by the Extended Care Facility incurred within 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.
- up to 180 days per period of confinement.)

AND

- 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.

(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.
- up to 60 days per period of confinement.)

Payment for all such Covered Charges made by an Extended Care Facility shall not be made for more than 365 days during the covered person's lifetime.

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 plan does not cover services that are provided for a person due to age or mental or physical condition and that 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, provided you have exceeded your deductible, 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. This benefit is subject to the limits and provisions of the plan and it is in place of all benefits to which the person is entitled under all other parts of the plan for the same amount of such charges.

Out-Patient Benefits

Benefits will be paid for charges incurred for out-patient 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 out-patient visit, up to 60 such visits in a calendar year. Benefits will be paid for up to 20 family member visits which when combined with the visits of the person receiving or in need of treatment will not exceed 60 out-patient visits in a calendar year.

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.

In-Patient Benefits

The SMMP covers inpatient substance abuse treatment that is pre-certified by the SMMP administrator’s designated review organization. Refer to the section on “Hospital Mental Health Benefits Pre-Certification Program.” (See page E.9.) If you fail to pre-certify the hospital stay, benefits will be reduced. The SMMP limits coverage for inpatient substance abuse to 30 days per calendar year and 365 days per lifetime.

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	<ul style="list-style-type: none"> • Diagnostic workup • Diagnostic testing • Drug therapy • Surgical correction 	Same as Infertility as well as: <ul style="list-style-type: none"> - Insemination procedures - Screening/lab test 	Same as Infertility/Artificial Insemination as well as: <ul style="list-style-type: none"> - Removal/fertilization of egg(s) - Implantation of egg(s)
Non-Covered Charges & Exclusions	<ul style="list-style-type: none"> • Experimental procedures • All donor costs, charges & expenses • Reversal of tubal ligation • Reversal of vasectomy • Surrogate motherhood 	<ul style="list-style-type: none"> • Experimental procedures • All donor costs, charges & expenses • Reversal of tubal ligation • Reversal of vasectomy • Storage costs • Surrogate motherhood 	<ul style="list-style-type: none"> • 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		<ul style="list-style-type: none"> • Surgical insemination for up to a total of 8 attempts per lifetime. 	<ul style="list-style-type: none"> • 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 member 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%.



Members are entitled to receive retroactive reimbursement for calendar years 2006 and 2007 (claims for these years must be submitted no later than June 30, 2010). For 2008, 2009, and future calendar years, the general SMMP 24-month limitation on claims submissions will apply.

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 plans, 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 plans. 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 plans; (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 (for reasons other than reaching plan maximums) 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 second 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 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) Out-patient 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.



4. Compile the Explanation of Benefits (EOB) statements provided by all health plans under which you have coverage in reference to the above itemized bills.
5. 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.
6. Include proof of payment (cancelled check, receipt, etc.) for out-of-pocket expenses.
7. 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.
8. 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
Toll Free: 1-877-844-SMMP(7667)

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.3.

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 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) Primary health plan(s); and or
- (b) Medicare; and
- (c) SMMP

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.

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 must 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) rehabilitative 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 in-patient 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) proper 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 is R&C in the locale where incurred, as determined by the SMMP and as elected by the Fund.
R&C amounts will be determined by the SMMP.

Non-Reimbursed Covered Charges

Covered Charges (See pages E.5 - E.7) 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 great extent. 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 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, 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 great extent.

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 18 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" (below) 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.

Please Note: If the qualified COBRA participant becomes disabled within the time specified above and the Social Security Administration determines that the participant is disabled, said participant must notify the Fund in order for coverage to be extended from 18 to 29 months.

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).

