EFFECTIVE DATE OF COVERAGE UNDER SPECIAL ENROLLMENT PROVISION

If an eligible person properly applies for coverage during this special enrollment period, the coverage will become effective as follows:

- In the case of marriage, as of the date of marriage; or
- In the case of a dependent's birth, on the date of such birth; otherwise, coverage begins on the date on which we receive the notice; or
- In the case of a dependent's adoption, the date of such adoption or placement for adoption if you take physical custody of the infant as soon as the infant is released from the hospital after birth and you file a petition pursuant to Section 115-c of the New York Domestic Relations Law within thirty (30) days of the infant's birth; and provided further that no notice of revocation to the adoption has been filed pursuant to Section 115-b of the New York Domestic Relations Law, and consent to the adoption has not been revoked. However, we will not provide hospital benefits for the adopted newborn's initial hospital stay if one of the infant's natural parents has coverage for the newborn's initial hospital stay.
- If you have individual coverage, you must switch to family coverage within thirty (30) days of the birth or adoption in order for coverage to start at the moment of birth. Otherwise, coverage begins on the date on which we receive notice, or
- In the case of eligibility for premium assistance under a state's Medicaid plan or state child health plan, on the first day of the month following an approved request for coverage; or
- In the case of loss of coverage, the first day of the month following the date the completed enrollment form is received by the Health Benefits Program.

RELATION TO SECTION 125 CAFETERIA PLAN

Additional changes to enrollment due to changes in status events under the employer's Section 125 Cafeteria Plan may be allowed under Section 125 Cafeteria Plan. Refer to the employer's Section 125 Cafeteria Plan for more information.

SECTION VI – COORDINATION OF BENEFITS (COB)

You may be covered by two or more group health plans that may provide similar benefits. If you have coverage through more than one plan, your City health plan will coordinate benefit payments with the other plan. One plan will pay its full benefit as a primary insurer, and the other plan will pay secondary benefits. This prevents duplicate payments and overpayments. The plan covering you as an employee is primary before a plan covering you as dependent. In no event shall payments exceed 100% of a charge. Please refer to the coordination of benefits section of your health plan certificate of coverage or health plan summary plan description.

SECTION VII – TRANSGENDER INCLUSIVE HEALTH BENEFITS COVERAGE

WHAT'S COVERED, OTHER SERVICES? (AFFIRMATIVELY COVERING TRANSGENDER-RELATED SERVICES, AS WITH OTHER SERVICES.)

New York City Health Benefits Program covers medically necessary treatments and procedures, such as those defined by the World Professional Association for Transgender Health's Standards of Care for Gender Identity Disorders (www.wpath.org) to the same extent they are covered for illness, injury and other health conditions.

GENDER TRANSITION

All of the health plans offered through the New York City Health Benefits Program provide benefits for covered services associated with gender transition when ordered by a health professional. The treatment plan must conform to World Professional Association for Transgender Health's standards.

- Psychotherapy – See applicable health plan's Summary of Benefits and Coverage (SBC) mental health and substance abuse benefit section for coverage details. For Medicare plans, please contact the applicable health plan directly.

- Pre- and post-surgical hormone therapy – If you selected a health plan optional prescription drug rider, see applicable health plan's Summary of Benefits and Coverage (SBC) pharmacy benefit section for coverage details. If you have prescription drug coverage through your union, contact their pharmacy benefits manager directly. For Medicare plans, please contact the applicable health plan directly.

- Gender-affirmation surgery/Sex reassignment surgery/ies. See applicable health plan's Summary of Benefits and Coverage (SBC) hospital/physician benefit section for coverage details. Surgery must be performed by a qualified provider. You or your physician must pre-certify the surgery with your selected health plan. If you do not, the surgery may not be covered. For Medicare plans, please contact the applicable health plan directly.

There is no payroll/pension deduction for basic coverage under some of the health plans offered through the City Health Benefits Program, but others require a deduction. Additional benefits (e.g., prescription drug coverage) may also be available through an optional rider with a payroll/pension deduction. Some plans require copayments for certain services. Some plans require you to pay a yearly deductible and coinsurance before the plans will reimburse you for the use of non-participating providers, so you must consider the out-of-pocket cost. Please refer to the Section VII – Summary of Health Plans, the applicable health plan's Summary of Benefits and Coverage (SBC) available on the Health Benefits Program Website at nyc.gov/hbp and the applicable health plan's website for more cost information.

SECTION VIII – IN-VITRO FERTILIZATION (IVF) AND FERTILITY PRESERVATION

IN-VITRO FERTILIZATION (IVF) AND FERTILITY PRESERVATION HEALTH BENEFITS COVERAGE FOR EMPLOYEES AND NON-MEDICARE RETIREES AND THEIR DEPENDENTS

WHO IS ELIGIBLE FOR IVF COVERAGE?

Employees and non-Medicare retirees and their dependents covered by the New York City Health Benefits Program seeking IVF coverage must meet the coverage provisions under applicable New York State Insurance Laws and regulations, and guidance issued by the New York State Department of Financial Services. Individuals may be eligible for IVF coverage if they are diagnosed with infertility, which is defined as a disease or condition characterized by the incapacity to impregnate another person or to conceive, due to the failure to establish a clinical pregnancy after 12 months of regular, unprotected sexual intercourse or therapeutic donor insemination, or after six months of regular unprotected sexual intercourse or therapeutic donor insemination for a female 35 years of age or older. An individual may also be eligible for IVF coverage if they are unable to conceive due to their sexual orientation or gender identity. Earlier evaluation and treatment may be warranted based on an individual's medical history or physical findings.

WHAT'S COVERED, OTHER SERVICES?

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

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

Any treatments completed prior to July 1, 2020 will not count toward the IVF three-cycle per lifetime limit.

Medications, including prescription drugs, are covered under the IVF coverage. Injectable medications used to treat IVF are available through the PICA Program. Please refer to the PICA Program under Section XII – Summary of Health Plans.

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

Age restrictions are not permitted for any covered infertility services.

There is no payroll deduction for basic coverage under some of the health plans offered through the City Health Benefits Program, but others require a deduction. Additional benefits (e.g., prescription drug coverage) may also be available through an optional rider with a payroll deduction or a union welfare fund. Some plans, including the PICA Program, require copayments for certain services. Some plans require you to pay a yearly deductible and coinsurance before the plans will reimburse you for services, so you must consider the out-of-pocket cost. Please refer to Section IX – Summary of Health Plans, the applicable health plan's Summary of Benefits and Coverage (SBC) available on the Health Benefits Program Website at nyc.gov/hbp and the applicable health plan's website for more cost information.

SECTION IX – ANTIRETROVIRAL PRE-EXPOSURE PROPHYLAXIZ ("PrEP"), EFFECTIVE JULY 1, 2020

ANTIRETROVIRAL PRE-EXPOSURE PROPHYLAXIZ ("PREP") HEALTH BENEFITS COVERAGE TO REDUCE THE RISK OF CONTRACTING HUMAN IMMUNODEFICIENCY VIRUS ("HIV) INFECTION FOR EMPLOYEES AND NON-MEDICARE RETIREES AND THEIR DEPENDENTS, EFFECTIVE JULY 1, 2020

WHO IS ELIGIBLE FOR PREP COVERAGE?

Employees and non-Medicare retirees and their dependents covered by non-grandfathered health plans, as defined in Section IX, of the New York City Health Benefits Program.

WHAT'S COVERED, OTHER SERVICES?

New York City Health Benefits Program shall cover the cost of health care services and medicines for the detection and prevention of HIV, including screenings and PrEP.

Coverage for PrEP for the prevention of HIV infection and coverage for screening for HIV infection shall be provided with no cost-sharing, including copays, coinsurance, or deductibles.

There is no payroll deduction for basic coverage under some of the non-grandfathered health plans offered through the City Health Benefits Program, but others require a deduction. Please refer to Section XII – Summary of Health Plans, the applicable non-grandfathered health plan's Summary of Benefits and Coverage (SBC) available on the Health Benefits Program website at nyc.gov/hbp and the applicable health plan's website for more cost information.

SECTION X – SURPRISE BILLING PROTECTIONS (EFFECTIVE JANUARY 1, 2026)

Starting January 1, 2026, health plans provided by the New York City Health Benefits Program include new protections to help you avoid unexpected medical bills. These protections apply in the following situations:

- Emergency care at an out-of-network hospital or facility
- Non-emergency care from an out-of-network provider at an in-network/participating facility

In these cases, you'll only be responsible for your usual in-network/participating costs — such as copays, coinsurance, or your deductible. You won't be charged extra just because the provider is out-of-network.