

Winter 2003



Management Benefits Voice

A newsletter for Fund members

In this issue....

*New and Revised Sections
of the Management Benefits Fund
Benefits Booklet Available On-line
in the Spring*



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Management Benefits Fund is a division of the
Mayor's Office of Labor Relations'

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② **Benefit Enhancements**

- Vision Care
- Dental
- Superimposed Major Medical Plan (SMMP)
- Wellness (under SMMP)
- Health Club Reimbursement Program
- Survivor

③ **Benefit Information**

- Vision Care
- Dental
- SMMP
 - Positron Emission Tomography (PET) Scan
- Health Club Reimbursement Program

⑦ **FYI**

- Health Insurance Portability and Accountability Act (HIPAA) Rights

Benefit Enhancements

The Management Benefits Fund (MBF) is proud to announce benefit enhancements to Fund coverage. These benefits are effective for **services provided on or after January 1, 2003**.

Benefit Program	Current Coverage	Enhancements to Coverage, Effective January 1, 2003
Vision Care	<ul style="list-style-type: none"> The Indemnity Option (out-of-network) reimburses eligible members and dependents up to a maximum benefit of \$125 per person per benefit year. Participating Provider Option (PPO Option) in-network benefits include: photochromic lenses, progressive lenses, blended segment lenses. There is a co-payment for additional lens options and contact lenses for in-network providers. 	<ul style="list-style-type: none"> The Indemnity Option (out-of-network) reimburses eligible members and dependents up to a maximum benefit of \$150 per person, per benefit year. In addition to existing benefits, in-network benefits include: hi-index lenses, polaroid lenses, polycarbonate lenses, plastic photo-sensitive lenses, scratchguard coating, UV coating, and reflection-free coating (see detailed explanation on page 3) at no additional co-payment. Elimination of co-payments for contact lenses for in-network providers.
Dental	<ul style="list-style-type: none"> Orthodontic benefits are applied toward the \$2,500 benefit year dental maximum. 	<ul style="list-style-type: none"> There is a separate \$2,500 orthodontic lifetime maximum that is not included in the \$2,500 benefit year dental maximum.
Superimposed Major Medical Plan (SMMP)	<ul style="list-style-type: none"> The annual deductible for those with prescription drug riders is \$500 for one individual, \$1,000 for two individuals, and \$1,500 for three or more individuals. No more than one hearing aid and or audiometric examination per ear will be covered in a 36-month period. For in-vitro fertilization, there is a \$10,000 maximum per attempt, per cycle. Preventive and routine care services are reimbursed at 80% and subject to the Plan deductible. Annual limits and age limitations exist for well child visits and immunizations. Benefits are provided for the following immunizations: DPT, Polio, Hemophilus B, Measles, Mumps, Rubella, and Hepatitis B. 	<ul style="list-style-type: none"> The annual deductible for those with prescription drug riders is \$250 for one individual, \$500 for two individuals, and \$750 for three or more individuals. No more than one hearing aid and or audiometric examination per ear will be covered in a 24-month period. For in-vitro fertilization, there is a \$15,000 maximum per attempt, per cycle. The deductible is waived for preventive and routine care services for dependent children. No annual limits and age limitations for well child visits and immunizations. Benefits are provided for all immunizations covered under primary plans. The SMMP covers the Positron Emission Tomography (PET) Scan, provided that the physician refers you for the test.
Wellness (under SMMP)	<ul style="list-style-type: none"> Benefits are reimbursed at 80% of Reasonable and Customary (R&C) allowances. 	<ul style="list-style-type: none"> Benefits are reimbursed at 100% of Reasonable and Customary (R&C) allowances.
Health Club Reimbursement Program	<ul style="list-style-type: none"> The Health Club benefit is offered only to active and retired Fund members. 	<ul style="list-style-type: none"> The Health Club benefit is offered to active and retired Fund members, as well as a member's spouse/domestic partner.
Survivor	<ul style="list-style-type: none"> The Fund provides one year of basic health and MBF benefits (SMMP, Vision and Dental) to the member's surviving spouse/domestic partner and/or eligible dependent children. 	<ul style="list-style-type: none"> The Fund provides two years of basic health and MBF benefits (SMMP, Vision and Dental) to the member's surviving spouse/domestic partner and/or eligible dependent children.



Vision Care

Participating Provider Option (In-Network)

Effective January 1, 2003, the enhancements listed below are implemented for the New York City Management Benefits Fund Vision Care Program, administered by Davis Vision. The enhanced in-network benefit design can provide a comparable retail value of \$400-\$450. To locate an 'in-network' provider, dial **1-800-999-5431** or visit the Davis Vision Web site at **www.davisvision.com** and enter your member I.D. number.

New in-network benefits now available with no co-payments

Benefits are enhanced to include the following lenses and treatments:

High-Index Lenses: Type of lens with a higher index of refraction, meaning that light travels faster through the lens to reach the eye than in traditional glass or plastic. It is denser, so the same amount of visual correction occurs with less material (whether glass or plastic); therefore, the lens can be thinner and lighter for patients who require strong prescriptions.

Polarized Lenses (includes Polaroid Lenses): A laminated lens containing a layer of polarizing material which filters light waves coming at the wearer in a particular direction, thereby reducing glare from reflective surfaces.

Polycarbonate Lenses: A high-index, impact-resistant plastic lens.

Plastic Photosensitive Lenses: Plastic photosensitive lenses darken when exposed to the sun's ultraviolet rays. These lenses may have a photochromic substance mixed throughout the lens, or a color-changing coating.

Scratchguard Coating: A clear, hard coating applied to plastic lenses to increase their resistance to scratching.

Anti-Reflective Coating: A clear coating applied to a lens that limits light reflection (glare) on both the internal and external surfaces of the lenses.

Ultraviolet (UV) Coating: A lens coating that blocks the sun's ultraviolet rays. Overexposure to ultraviolet light is thought to be a cause of cataracts, retinal damage and other eye problems. An ultraviolet treatment is simple and quick to apply to most plastic eyeglass lenses, and it does not change the appearance of the lenses at all. (The exception is polycarbonate lenses, which don't need anti-UV treatment, as that is an inherent property of the material.)

Indemnity Option (Out-of-Network)

The annual maximum out-of-network benefit is increased from \$125 to \$150. You must pay the provider in full at the time of service and submit a claim form to Davis Vision for reimbursement.

Benefit Information

Enhancements to Dental Benefits - Dental Implants

Effective January 1, 2003, listed below are the only requirements that must be met in order for dental implants to be covered under the Dental Benefit Program.

The implant must be obtained:

- two years after the date you become covered for Fund dental coverage; and
- seven years after the date that a previous initial implant was installed, that was benefited under this plan.

Approval of all implants are subject to the dental claims administrator's discretion and will be reviewed by a dental consultant for considerations such as cost effectiveness, clinical appropriateness, and likelihood of success. In addition, pre-treatment authorization is required for all dental implants.

Superimposed Major Medical Plan (SMMP) -

Understanding the Positron Emission Tomography (PET) Scan

A Positron Emission Tomography (PET) Scan is an imaging technique by which physicians can accurately diagnose and manage various diseases, particularly cancer. It is a non-invasive procedure, usually performed in an outpatient facility, which uses radioactive positrons (positively charged particles) to detect metabolic and chemical changes in the body that signify the presence of disease. For example, in cancer cells there are increased rates of blood flow, amino acid flow, DNA synthesis and glucose transport compared to normal tissues. PET Scans can identify cancerous masses based on the presence of these particular behaviors in the body. Because the PET Scan is extremely sensitive and can detect smaller amounts of cancer cells than a CT Scan, MRI or X-Ray, it is becoming increasingly popular and widely used in the identification and assessment of malignant diseases. In addition to diagnosis, PET Scans are also used to determine if the course of treatment currently prescribed for an illness needs to be altered.

The following is meant for informational purposes only and is not meant to be a substitute for professional medical advice. Please be sure to contact your doctor for more information. This article is based on data gathered from various Web sites. Your doctor's and/or PET Scan technician's procedure may vary from the information provided below.

How is the PET Scan performed?

- During the PET Scan, you will receive a radioactive tracer in the form of an intravenous injection, or inhale it as a gas. Once it is in your body and reaches the target organ, this chemical will emit positrons that will ultimately be detected by the PET scanner. A computer will analyze the information and produce an image of the organ's function. Initial scans might be taken before the administration of the tracer.

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- You must remain very still on the scanning table. The table will glide through an opening in the scanner ring. You will be instructed not to move.
 - The PET Scan should take 30 minutes to 2 hours.

Will I experience any pain?

This exam should not cause you any discomfort. The only pain you may experience is a needle prick from the intravenous injection. However, if you have pain, redness or swelling at the injection site after the exam, be sure to contact your doctor.

How do I need to prepare for the PET Scan?

- Take prescription medication with water. You should also bring your medication and a snack to the exam if you wish to eat afterwards.
- Do not perform any strenuous exercise the day before the exam.
- Wear comfortable clothing.
- Bring previous imaging studies such as CT Scans, MRI Scans or plain film radiographs so that the PET Scan can be compared to these studies.
- Notify the staff prior to the exam if you are pregnant or breast-feeding.

Is there anything I need to do after the PET Scan is over?

After the exam, you can go home and resume your normal activities. Please remember to ask personnel at the PET Scan facility about when you should contact your doctor for the official PET Scan report.

How safe are PET Scans?

The minimal radiation exposure level from the scan itself is similar to what you would receive from chest X-rays. The radioactive tracer used in PET Scans is also considered to be safe, since it is a chemical that is normally found in the body that has merely been altered to allow it to emit positrons. Because the radioactive tracers are short-lived, they are quickly cleared from the body.

What types of illnesses can be evaluated using the PET Scan?

- **Cancer** — PET Scans can be used to detect cancerous tumors, to determine cancer stage (extent of spread) and to judge the effectiveness of cancer treatment. They are most often used in patients with brain cancer, colorectal cancer, lymphoma, melanoma or lung cancer.
- **Brain diseases** — PET Scans can be used to evaluate neurologic illnesses, especially epilepsy, and Alzheimer's disease and other dementias.
- **Cardiac illnesses** — PET Scans can be used to evaluate heart muscle function in patients with coronary artery disease or cardiomyopathy. Additionally, PET Scans are used for research in other areas, including drug addiction, psychiatric illnesses and stroke.

Please Note: The SMMP provides *supplemental* coverage for qualifying out-of-pocket medical expenses that remain *after all other health coverage has been applied*. The current claim filing procedure for the SMMP will be maintained for expenses incurred for a PET Scan. In addition, please note that you must be referred by a physician in order for your PET Scan to be covered under the SMMP.

Reminders:

About the Health Club Reimbursement Program

- If you have a family membership at a health club that includes dependents (other than your spouse/domestic partner if he/she is also participating in the Health Club Reimbursement Program), please be sure that the membership is pro-rated to cover **ONLY** the cost for yourself and/or your spouse/domestic partner.
- The Health Club Reimbursement payment for both a member and a member's spouse/domestic partner will be paid directly to the member and will be included as taxable income to the member, regardless of who is the claimant. The MBF member's and/or spouse/domestic partner's payment information will be included on the MBF member's Form W-2.
- Please note that the Management Benefits Fund is **NOT** accepting photocopied checks, bank statements or credit card statements as proof of payment. The only items you may submit for proof of payment are:
 - health club contracts,
 - payment receipts, or
 - letters on company (health club) stationery or letterhead.

Please use the enclosed revised Health Club Reimbursement Program claim form for future claim submissions.

Health Insurance Portability and Accountability Act (HIPAA)

Rights

THIS INFORMATION DESCRIBES HOW PERSONAL 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 “Fund”) is required by law to take reasonable steps to ensure the privacy of your personally identifiable health information and to inform you about:

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

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

- 1) You may request the Fund to 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 Fund is not required to agree to your request.
- 2) You have a right to obtain and inspect a copy of your PHI contained in a “Designated Record Set,” for as long as the Fund 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 your 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 Fund 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.

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- The Fund has 60 days after the request is made to act on the request. A single 30-day extension is allowed if the Fund is unable to comply with the deadline. If the request is denied in whole or in part, the Fund 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 Fund will also provide you with an accounting of disclosures by the Fund of your PHI during the six years prior to the date of your request. However, such accounting need not include PHI disclosures made: (i) to carry out treatment, payment or health care operations; (ii) to individuals about their own PHI; (iii) 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 Fund 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 listed above, you may contact the Fund in care of the following officer: HIPAA Compliance Officer, 40 Rector Street, 3rd Floor, New York, NY 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.