MPA PERIODIC HEALTH EXAMINATIONS

Eligibility: **All non-represented management, professional and administrative (MPA) employees in addition to those employees who receive MPA benefits as stipulated in their respective collective bargaining agreement.**

Frequency: The frequency of a covered examination is based on the following age groups:

Under age 40 = one every 5 years
Age 40-49 = one every 3 years
Age 50-59 = one every 2 years
Age 60 and over = yearly

A pre-employment physical counts toward the frequency of a covered examination.

Reimbursement of Expenses

Each employee is encouraged to utilize the services of his/her own physician for a periodic health examination. The employee will submit the applicable charges for these services to his/her health insurance carrier.

If an employee is covered under a Health Maintenance Organization (HMO) or utilizes a Participating Provider under the Empire Plan, any co-payment will be reimbursed by the LIRR, up to a maximum of $200.

If an employee utilizes a non-Participating Provider under the Empire Plan and is age 50 or older, the Empire Plan will reimburse expenses (not subject to the deductible) up to a maximum of $250 annually. The balance will be reimbursed by the LIRR up to a maximum of $200. (For Employees 60 or older, the LIRR will reimburse expenses up to a maximum of $200 each year.)

If an employee is under age 50 and utilizes a non-Participating Provider under the Empire Plan or a physician not affiliated with the Health Maintenance Organization chosen by the employee, there will be no reimbursement from the applicable insurance company. The LIRR will reimburse the employee up to a maximum of $200 in expenses.

Time Away From Work

Time away from work used for a periodic health examination is to be charged either to the employee's sick leave or other available leave balances.

Attachments Required

In order for your claim to be processed the following documents must be attached:

1. Statement from examining physician(s) and laboratory(ies) indicating date, itemized costs or co-payments, if applicable, and that the purpose of the visit was for a physical examination.
2. Statement of reimbursment or denial of benefits from applicable insurance company.

Claim Submission

To claim reimbursement, complete the following section of the form, attach the required statements, and submit to the Benefits Office, Mail Code 1158.

Employee Information
Please complete in entirety

Name_____Employee No._____

Dept. Name_ __Dept .Cost Center._____

Date of Exam _____Total Cost of Exam $_____

Total reimbursement from insurance carrier $_____

Total reimbursement requested from LIRR $_____

I hereby certify that the above information is true in all respects.

Signature_____Date_____

For Benefits Use Only

Accounts Payable: Please reimburse the above employee for the following incurred for a periodic health exam.

Reimbursement requested $_____

Cost Center No._____Dept. _____Account No._____1511_____

Signature-Benefits Costs Manager_____

Signature-Director-Employee Services_____

Submit original to Accounts Payable. Keep copy for Benefits