United Nations ST/IC/2002/27

Secretariat

8 May 2002

Information circular*

To: Members of the staff at Headquarters

From: The Controller

Subject: **Renewal of the Headquarters medical and dental insurance plans effective 1 July 2002, and annual enrolment campaign, 3-7 June 2002**

General

1. The purpose of the present circular is to announce:

(a) Changes in the premium and contribution rates for the medical and dental plans offered at Headquarters (Aetna preferred provider organization (PPO), Empire Blue Cross preferred provider organization (PPO), HIP Health Plan of New York (HIP) and CIGNA dental preferred provider organization (PPO)), which will come into effect on 1 July 2002 (see chart on p. 2, and annexes I-IV);

(b) A one-month premium rebate for participants in both the Aetna and BlueCross plans (for details regarding administration of the rebate, see paras. 8-9);

(c) Modifications in plan benefits are as follows: With effect from 1 July 2002, the $1 million lifetime benefit maximum currently in place for out-of-network benefits (though not in-network benefits) under the BlueCross plan is eliminated. At the same time, an annual maximum benefit of $1,000 per calendar year will come into effect for chiropractic care. Also with effect from 1 July 2002, the BlueCross annual deductibles will be decreased from $200 to $150 for an individual and from $500 to $450 for a family of three or more persons. With respect to the Aetna "Open Choice" PPO plan, the current twice-in-a-lifetime limit for in-patient alcohol/substance abuse coverage is eliminated. Therefore, in-patient alcohol/substance abuse treatment will be covered for 60 days per calendar year with no lifetime limit. In addition, a new benefit has been added to the Aetna prescription drug programme, i.e. coverage, of prescription smoking-cessation aids for two 60-day periods per calendar year. Benefits under the HIP/HMO and Cigna dental plans will be unchanged.

2. Annexes I to VIII to the present circular set out plan outlines and benefit summaries. They are listed in paragraph 26.

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* Expiration date of the present information circular: 30 June 2003.

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Headquarters medical and dental insurance schedule of monthly premiums[a] and contribution rates[b]
(Effective 1 July 2002)

	Aetna Open Choice		*Empire Blue Cross PPO*		*HIP*		*CIGNA Dental with Medical Plan*		*CIGNA Dental alone*
Type of coverage	*2001 rates*	*2002 rates*	*2001 rates*	*2002 rates*	*2001 rates*	*2002 rates*	*2001 rates*	*2002 rates*	*2002 rates*
Staff member only									
Premium rate ($)	395.57	472.71	244.14	272.22	264.18	289.52	49.40	46.23	46.23
Contribution rate (per cent)	3.16	3.70	1.95	2.14	2.12	2.27	0.36	0.33	0.44
Staff member and one child									
Premium rate ($)	789.32	943.24	487.16	543.18	482.31	528.65	98.80	92.46	92.46
Contribution rate (per cent)	5.52	6.47	3.45	3.77	3.23	3.47	0.65	0.59	0.78
Staff member and spouse									
Premium rate ($)	789.32	943.24	487.16	543.18	482.31	528.65	98.80	92.46	92.46
Contribution rate (per cent)	5.52	6.47	3.45	3.77	3.23	3.47	0.65	0.59	0.78
Staff member and two or more eligible family members									
Premium rate ($)	987.68	1 180.28	707.31	788.65	767.91	841.63	159.54	149.30	149.30
Contribution rate (per cent)	6.16	7.21	4.43	4.84	4.53	4.86	0.98	0.90	0.84

[a] The cost of the medical/dental insurance plans at Headquarters is shared between the participants and the Organization. Staff members may determine their exact contribution by multiplying their “medical net” salary (see below) by the applicable contribution rate (per cent) above.

[b] “Medical net” salary for insurance contribution purposes is calculated as gross salary, less staff assessment, plus language allowance, non-resident’s allowance, post adjustment or the variable element of monthly subsistence allowance, as applicable. Actual contributions are capped at 85 per cent of the corresponding premium.

Annual enrolment campaign

3. The annual enrolment campaign at Headquarters will be held from 3 to 7 June 2002 in the Insurance Service of the Office of Programme Planning, Budget and Accounts, room S-2765, between the hours of 10 a.m. and 5 p.m. **Staff members at Headquarters must come in person to the Insurance Service to complete the application form and other forms as necessary.** The staff of the Insurance Service will be available during the designated dates and hours to provide information and answer specific questions regarding the health plans being offered to staff. In addition, representatives of the insurance companies will be on hand on 3 and 4 June to provide information about the various insurance plans offered. The insurance company desks will be located in the staff activities area near the Secretariat cafeteria entrance.

4. Staff members are reminded that this will be the **only** opportunity until the month of June 2003 to enrol in the United Nations medical and dental insurance plans, aside from the specific circumstances, such as marriage, birth or adoption of a child, regarding which special provisions for enrolment between campaigns are established (see annex VII, paras. 6-8). This is also an opportunity to review current health insurance coverages within or outside the Organization and either enrol in one of the United Nations plans or apply for changes within these plans. **Staff members who are satisfied with their coverage do not need to take any action at this time**.

5. The medical and dental plans being offered during the June campaign and the pages on which plan outlines may be found are as follows:

(a) Empire Blue Cross PPO (p. 11);

(b) Aetna “Open Choice” Plan (p. 22);

(c) HIP Health Plan of New York (HIP) (p. 34);

(d) CIGNA Dental PPO Plan (CIGNA) (p. 37).

6. The effective date of insurance coverage for all campaign applications, whether for enrolment, change of plan or change of family coverage, will be 1 July 2002.

7. Heretofore, a decision to switch from one health insurance plan to another during the campaign obliged the participant to meet the annual out-of-network deductible under the new plan regardless of the amount of deductible reached under the old plan. With effect from 1 July 2002, a new regime will be implemented whereby staff members who switch coverage between the Aetna and BlueCross plans and who have met the annual deductible or any portion thereof under either of these plans during the first six months of 2002, may be credited with such deductible payment(s) under the new plan for the second six months of 2002 under certain conditions. The deductible credit will not occur automatically and can be implemented only if the staff member takes the following actions: (a) formally requests the deductible credit on the special form designed for that purpose; and (b) attaches the original explanation of benefit (EOB) statements attesting to the level of deductibles met for the staff member and/or each eligible covered dependent. The deductible credit application form, which will be available at the office of the Insurance Service during the enrolment campaign, must be submitted to

the Insurance Service (**not to Aetna or BlueCross**) together with the relevant EOB statements **no later than 31 August 2002** in order to receive such deductible credit.

Premium rebate for Aetna and Blue Cross subscribers

8. Owing to the relatively favourable claims experience of the Aetna and BlueCross plans in prior years, it has been decided to effect a one-month premium rebate to participants. The rebate will be implemented in the month of August 2002. The amount of the rebate for each participant will equal the premium contribution which normally would be due for coverage in August, and will be reflected in the end-of-month payroll statement.

9. The criterion for eligibility to receive a premium rebate is that the participant must be enrolled in the health insurance plan concerned in the month in which the rebate is given and must also have been in the plan one year previously. In view of the fact that the rebate covers both Aetna and BlueCross participants, the distribution criterion will take account of those staff members who switch from Aetna to BlueCross, or vice versa, during the 2002 enrolment campaign. Accordingly, staff members who were enrolled in Aetna or BlueCross in August 2001 and who continue to be in either plan in August 2002 will receive a rebate.

Health insurance costs in the United States

10. The key element underlying this year's renewal of the Headquarters health insurance plans is the overall adverse state of the health insurance marketplace in the United States, driven principally by significant increases in prescription drug costs. As New York-based United Nations staff members and their dependants incur medical expenses for hospitalization, surgery, office visits and prescription drugs predominantly in the Headquarters area, the level of these expenses is directly dependent on costs in the medical market. For the past several years, the UN Headquarters plans generally outperformed national trends, particularly in the second half of the 1990s. Unfortunately, this is no longer the case. Medical costs (hospitals, doctors, etc., but not prescription drugs) increased by an average of about 9 per cent per annum in the mid-1990s, rose to 12 per cent per annum in the late 1990s, jumped to over 20 per cent in 2000, and currently cost increases are in the range of 15 to 20 per cent nationally. In contrast with the national trends, the UN Aetna PPO plan maintained an unchanged premium level for three successive years in the mid-1990s, while in 2000 Aetna premiums rose 10 per cent over the prior year (compared to over 20 per cent for comparable plans nationally), and last year the increase was 6.5 per cent. For the policy year 2000-2001, the BlueCross PPO premium did not increase over the prior year, and last year rose by a relatively favourable 5.9 per cent. For this year, however, the underlying medical cost inflation and utilization trends have caught up with the favourable experience of the past, with prescription drug costs leading the way.

11. The prescription drug cost trend nationally for the forthcoming 12-month period is approximately 30 per cent, one third of which is attributable to price increases and two thirds of which is attributable to increases in utilization as more and more prescription drugs, particularly expensive new drugs, are being prescribed. The adverse trend is exacerbated by the fact that prescription drug manufacturers increasingly are marketing their products directly to consumers through television and print advertising. The intended outcome of this strategy is becoming evident as patients all too frequently insist that their doctor prescribe the brand name

prescription drug rather than the generic version, which in many cases, though not in all, is every bit as efficacious.

Renewal premiums and effect of the one-month rebate

12. As a result of the adverse developments in health insurance trends outlined above, the renewal premium rates for the Headquarters medical plans will increase substantially by comparison with the developments of recent years. The Aetna premium rates will increase by 19.5 per cent, reflecting the underwriting calculation of the premium increase required if the plan is to break even at the end of the forthcoming 12-month policy period. On the same calculation basis, the premium increase required for the BlueCross plan is 11.5 per cent, while the overall premium increase under the HIP/HMO plan is 9.5 per cent. Only the Cigna dental plan is evidencing any favourable trend in that, following a premium increase of 10.2 per cent last year, premiums for the policy period commencing on 1 July 2002 will decrease by 6.42 per cent.

13. The one-month rebate to be distributed in August means that participants will be contributing towards the cost of the plan for 11 months which, in effect, brings the premium increase for the Aetna plan down to 9.4 per cent for the full 12-month renewal period, and brings the BlueCross premium increase down to an effective 2.2 per cent rate increase.

Eligibility and enrolment rules and procedures

14. By Secretary-General's bulletins ST/SGB/1997/1 and ST/SGB/1997/2, dated 28 May 1997, the Secretary-General introduced a new system for the promulgation of administrative issuances and information circulars. A separate administrative instruction will be issued in due course which will set out the eligibility criteria and enrolment rules and procedures governing all United Nations contributory health insurance plans. However, until the new administrative instruction is issued, the eligibility criteria and enrolment rules pertaining to the Headquarters medical and dental health insurance plans as set out in annex VII to the present circular will remain in effect.

Mailing address

15. Effective 1 July 2002, participants in the health insurance plans administered at Headquarters will be required to provide a mailing address in order to implement enrolment in a selected plan or a change in coverage (e.g., adding an eligible dependant). Current participants in the Headquarters plans and new enrollees alike are advised that the insurance carriers will only recognize mailing address data that are electronically transmitted to them. While the mailing addresses of many staff members already exist in IMIS, it is important that they be updated as necessary. Staff members should contact their personnel or executive offices in order to provide or update their mailing address. In this regard, staff members are advised that the Insurance Service cannot act as a forwarder of communications from insurance companies, such as insurance ID cards, reimbursement cheques and explanation of benefits statements.

Effective date of health insurance coverage

16. Provided that application is made within the prescribed 31-day time frame, new coverage for a staff member newly enrolled in a health insurance plan commences on the first day of a qualifying contract (minimum of 3 months for medical insurance and 6 months for dental insurance). If the first day of a qualifying contract occurs later than the first day of the month, the participant may opt for coverage to commence on the first day of the following month. In no event, however, can coverage commence prior to the first day of the qualifying contract. On the other hand, if a contract terminates before the last day of a month, coverage will remain in place until the end of the month in question.

Movement between organizations at Headquarters and breaks in appointment

17. Under IMIS, insured staff members who transfer between the UN, UNDP or UNICEF must be sure to reapply for health insurance coverage after a Personnel Action has been generated by the receiving organization. Such reapplication for health insurance coverage must be made within 31 days of separation from the releasing organization. Strict attention to this requirement is necessary to ensure continuity of health insurance coverage as termination from an organization results in the automatic termination of insurance coverage at the end of the month. Staff members who transfer between organizations should also ensure that the receiving organization establishes the staff member's household members and mailing address in its IMIS database so that coverage can be reinstated under the receiving organization.

18. Staff members should also be aware that under IMIS if there is a separation from service, no matter how short (e.g., three days), insurance coverage will be terminated. Therefore, upon reappointment, the staff member will be obliged to re-apply at the offices of the Insurance Services in order to reinstate health and life insurance coverage and to be sure that there will be no break in continuity of coverage.

Cessation of coverage of staff member and/or family members

19. The Insurance Service should be notified immediately of changes in the staff member's family that result in a family member ceasing to be eligible, for example, a spouse upon divorce or a child marrying or taking up full-time employment. The Insurance Service has initiated a procedure by which covered children who reach the age of 25 will be automatically dropped from the staff member's coverage at the end of the year in which they reach the age of 25. Other than with respect to the children reaching 25, **the responsibility for initiating the resulting change in coverage (e.g., from "staff member and spouse" to "staff member only" or from "family" to "staff member and spouse") rests with the staff member**. Staff members who wish to discontinue their coverage, or that of an eligible family member under a United Nations plan for any other reason, may do so at any time, although this is strongly discouraged. Such terminations of coverage should be communicated to the Insurance Service directly, in writing. It is in the interest of staff members to notify the Insurance Service promptly whenever changes in coverage occur, in order to benefit from any reduction in premium contribution which may result. Any such change will be implemented on the first of the month following receipt of

notification. No retroactive adjustments can be made as a result of failure to provide timely notification of any change to the Insurance Service.

Insurance enrolment resulting from loss of employment of spouse

20. Heretofore, a staff member whose health insurance coverage was provided by the employer of his or her spouse was ineligible to apply for United Nations health insurance coverage in the event of the loss of employment of the spouse, except on the occasion of the annual enrolment campaign. In line with the practice of employers in the United States, loss of coverage under a spouse's health insurance by virtue of the spouse's loss of employment is considered to constitute a qualifying event for the purpose of enrolment in a United Nations Headquarters plan, provided that the staff member holds a qualifying contract with the United Nations. Application for enrolment in a UN plan under these circumstances must be made within 31 days of the qualifying event. In addition, application for coverage under this provision must be accompanied by an official letter from the spouse's employer, certifying the termination of employment and its effective date.

After-service health insurance

21. Staff members are reminded that, among the eligibility requirements for after-service health insurance coverage, the applicant must be enrolled in a United Nations scheme at the time of separation from service. A minimum of five years of prior coverage in a United Nations health insurance scheme is necessary to qualify for unsubsidized after-service health insurance participation and 10 years of prior coverage for subsidized participation. In both cases, the staff member must be 55 years of age or over as of the date of separation. It should also be noted that only family members enrolled with the after-service health insurance staff member at the time of separation are eligible for continued coverage under the programme. **Enrolment in the after-service health insurance programme is not automatic. Application for enrolment must be made within 31 days following the date of separation.** Full details on the eligibility requirements and administrative procedures relating to after-service health insurance coverage are set out in administrative instruction ST/AI/394, dated 19 May 1994.

Conversion privilege

22. Participants who cease employment with the United Nations and are not eligible for after-service benefits may arrange for medical coverage under an individual contract. This provision applies to all medical plans currently offered. The conversion privilege means that the insurer cannot refuse to insure an applicant and that no certification of medical eligibility is required. In general, unless the separating staff member has had a history of poor health, exercising the conversion privilege will be more costly than acquiring new insurance coverage. **In addition, the conversion privilege does not mean that the same insurance premium rates or schedule of benefits in effect for the United Nations group policy will be offered in respect of individual insurance contracts.** It should be noted, moreover, that the conversion privilege may be exercised only for separating staff who continue to reside in the United States, as the insurers cannot write individual policies for persons residing abroad. In all cases, the conversion privilege must be exercised **within 31 days of the date of separation**. Details concerning conversion to individual policies under Aetna and Empire Blue Cross may be obtained from the

Insurance Service, room S-2765. Details concerning conversion to individual policies under the HIP Health Plan of New York should be obtained from HIP directly. **The CIGNA dental plan does not have a conversion option.**

Claims and benefit inquiries and disputes

23. Although the staff of the Insurance Service is available to assist staff members in administrative matters concerning participation in the various Headquarters insurance plans and problematic claims issues, claims questions should always be taken up in the first instance directly with the insurance company concerned. The addresses and relevant telephone numbers of the insurance companies are listed in annex VIII to the present circular.

24. Staff members are reminded that the plan descriptions set out in annexes I to IV constitute summaries of the benefits available under the respective plans. Every care has been taken to ensure that the plan summaries are as comprehensive as possible. A more detailed description of the benefits of each plan, including certain exclusions and limitations, is set out in a Summary Plan Description (SPD) booklet. Updated SPDs are in preparation for each carrier and will be distributed when available. In the event of a claim dispute with any of the insurance carriers or plan administrators concerned, the resolution of such dispute will be guided by the terms and conditions of the policy contract in question and the final decision will rest with the insurance carrier or plan administrator and not with the United Nations.

Headquarters health insurance plans: outlines and summaries of benefits

How plans are costed

25. The United Nations policies with Aetna, Empire Blue Cross and CIGNA are “experience-rated”. This means that the premium cost each year of the Aetna, Empire Blue Cross and CIGNA dental plans is based on the level of claims incurred in the prior year and expected rates of utilization and medical cost inflation for the renewal period. In effect, the costs of these plans (claims incurred plus administrative expenses) are borne collectively by the participants in these schemes and the Organization. In a year following a period of heavy utilization, premium increases are likely to be relatively high. Conversely, if utilization in the prior year has been moderate, the premium increase in the subsequent year will be correspondingly moderate. The HIP plan is “community-rated”. This means the premium scale is based on the combined experience of all employers participating in the plan and not just the United Nations, and is approved by the relevant state insurance authorities. It should be emphasized, particularly with respect to the three experience-rated plans, that prudent utilization by all participants concerned will have the effect of moderating premium costs for the benefit of all.

Plan outlines and benefit summaries

26. Outlines of the health insurance plans offered as well as summaries of benefits of each plan are set out in the following annexes:

Page

I. Empire Blue Cross PPO 11

II. Aetna "Open Choice" Plan 22

III. HIP Health Plan of New York (HIP) 34

IV. CIGNA Dental PPO Plan 37

27. In addition, information regarding the World Access emergency facility for Aetna and Empire Blue Cross subscribers, participating Aetna and Empire Blue Cross pharmacies as well as insurance carrier addresses and telephone numbers are set out in the following annexes:

V. World Access 42

VI. Aetna and Empire Blue Cross Plans: participating pharmacies 43

VII. Eligibility and enrolment rules and procedures 44

VIII. Insurance carrier addresses and telephone numbers for claims and benefit inquiries 48

Finding providers through the Internet

28. As printed provider directories rapidly become outdated, and as there is limited space to store them, online provider directories should be used to search for health-care providers, physicians, participating hospitals, pharmacies, medical equipment suppliers and dentists. Please refer to the chart on page 10, which provides the Internet address for each carrier as well as related instructions. Subscribers may search by location and/or by name.

Finding PPO providers through the UN Intranet "Insurance" web site

29. As an alternative to searching for providers directly on the Internet, participants may also initiate a search from the United Nations Intranet web site of the Insurance Service. On the United Nations Intranet home page, click on "Insurance" under the "Quicklinks" drop-down menu and then click on the insurance company desired from the Insurance Service home page. Then follow the instructions set out on page 10 of the present circular.

Claim forms

30. Arrangements have been made with Empire Blue Cross, Aetna and CIGNA to provide claim forms online through the United Nations Intranet (claim forms cannot be accessed through the Internet). Claim forms for these three companies will be found through the Insurance Service home page.

Provider Internet web sites

Online provider directories	Instructions
AETNA www.aetna.com/docfind/index.html	1. Select a search category, such as “Physicians and Other Health Care Professionals” or “Vision One Providers”. 2. Select “OpenChoice PPO” from the Health Plan menu. 3. Enter the “Geographical Information” and “Search Criteria” to be used. 4. Click on the “Continue” button to see the list of providers. If there are matches for the criteria you selected, you will be presented with a summary list of results.
EMPIRE BLUE CROSS www.empireblue.com	1. Click on “Find a Doctor or Specialist” at the top of the menu in the upper right hand corner of the home page. 2. The screen displayed allows you to select the following options: “New York Provider Search”, “Nationwide Provider Search” and “Find A Laboratory”. 3. Follow the prompts depending on your selection.
CIGNA www.cigna.com/providerdirectory	1. Select “Dentist” on the “Select the type of provider” search. 2. Select “Search by name”, and “Enter zip code OR city and state” if you already know the name of the dentist. 3. If you are searching for the name of a new dentist, select “Enter zip code OR city and state” and select the distance you are willing to travel. 4. Click on “Continue” button. 5. Select “Managed care plan with open access to dentists CIGNA Dental PPO”. 6. Select “Specialty” on drop-down menu (i.e., Endodontics, General Dentistry, etc.). 7. Select “Language spoken” preference. 8. Click on “Continue” button to view search results.

Annex I

Empire Blue Cross PPO

Plan outline

The Empire Blue Cross PPO plan provides in-network benefits, including an extensive network of participating providers covering most medical specialties, as well as out-of-network (non-network) benefits. A network of physicians covering New York City, the New York metropolitan area and nationally, participate in the Empire Blue Cross PPO plan and accept as payment a fee schedule arranged with Empire Blue Cross. When treatment is rendered by an in-network provider, the only charge to the participant is a small co-payment, mostly $10 (for certain services co-payments vary between $0 and $35). On the other hand, the participant may also be treated by a physician who is not a participating practitioner in the plan. **Medical services rendered by non-participating (out-of-network) providers, when covered, will be reimbursed at 80 per cent, subject to the deductible and 20 per cent co-insurance and subject to the providers' fees falling within reasonable and customary norms**. If a participating physician refers a patient to another provider who is non-participating, the deductible and 20 per cent co-insurance will apply in connection with reimbursement of the cost of the services rendered by the non-participating provider, including mental health providers. A number of diagnostic laboratories are participating providers under the Empire Blue Cross PPO plan. When laboratory tests are required, it is important that the physician be told to send the tests to a participating laboratory, if possible. If this is done, the cost of the test will be paid in full and will not be subject to the normal deductible and co-insurance.

Premiums

Effective 1 July 2002, premiums for the BlueCross plan will increase by 11.5 per cent. The premiums and related percentages of salary contribution are shown on page 2 of the present circular.

Benefits

The package of benefits under the Empire Blue Cross PPO plan is itemized in the plan summary (p. 14). Effective 1 July 2002, the following benefit changes will come into effect:

Deductible. The annual deductible is $150 per individual and $450 per family.

Lifetime maximum. There is no lifetime maximum with respect to network-incurred expenses. With effect from 1 July 2002, the $1,000,000 lifetime maximum with respect to non-network reimbursements will be eliminated. Therefore, no lifetime maximum reimbursement ceiling will apply to the BlueCross plan.

Chiropractic care. Effective 1 July 2002, an annual $1,000 benefit limit will apply to treatment rendered by chiropractors.

Smoking cessation. Though not a new benefit, participants should be aware that the BlueCross prescription drug plan covers smoking-cessation products that require a prescription, for up to three 30-day supplies in a lifetime.

Services for which pre-certification is required

Pre-certification of hospital and other institutional services with the Medical Management Program (telephone: 1 (800) 982-8089) is required. The reason for this is constructive, as pre-certification ensures that (a) all expenses related to the hospitalization or treatment will be covered and (b) that a hospitalization case is medically monitored from the first day of admission so that if complications should arise, or if after-hospital care should be required, the case may be managed promptly and effectively.

When to call the Medical Management Program

– At least two weeks prior to any planned surgery or hospital admission. This applies to ambulatory surgery as well as in-patient surgery;

– Within 24 hours of an emergency hospital admission;

– Within the first three months of pregnancy and no more than one business day after the actual delivery;

– Prior to receiving home health care or home infusion therapy services (the network vendor must call medical management to pre-certify benefits);

– Prior to admission to a skilled nursing facility;

– Prior to receiving hospice care;

– Prior to receiving physical, occupational, speech or vision therapy;

– Prior to cardiac rehabilitation;

– Prior to renting or purchasing durable medical equipment, prosthetics or orthotics (the network vendor must call medical management to pre-certify);

– Prior to undergoing magnetic resonance imaging scans (MRIs).

With respect to mental health care and alcohol and substance abuse treatments, pre-approval must be sought from Magellan Behavioral Health (telephone: 1 (800) 626-3643).

Medical Management penalties

If you do not comply with the Medical Management requirement, your hospital/facility benefits may be reduced as follows (does not apply for providers outside the United States):

– In-patient hospital admissions, ambulatory surgery, cardiac rehabilitation and home health care, hospice care, occupational speech and vision therapy, physical therapy, MRIs, and skilled nursing facilities — 50 per cent up to $2,500 maximum per admission;

– Home infusion therapy and prosthetics, orthotics and durable medical equipment (vendor is penalized, member is held harmless).

Home health care

Home health care is covered at 100 per cent and is limited annually to 200 visits of up to 4 hours per visit. To be eligible for reimbursement, home health care must be prescribed by a physician and determined to be medically necessary. A

written prescription or home health care treatment plan is required as well as any supporting documentation from the physician to facilitate Empire Blue Cross' review of a claim for the payment of benefits. It is also a requirement (subject to a monetary penalty) that proposed home health care services be submitted to the Blue Cross Medical Management Program for a predetermination of benefits payable prior to contracting with a nursing or home health care agency. Services provided at home need not follow a hospital confinement.

It is important to note that covered home health care services **exclude** all types of custodial care services. Custodial care services are categorized as personal care and comprise services designed to help a person perform activities of daily living, which include assistance with bathing, eating, dressing, toileting, continence and transferring. Such services are performed at home or in other facilities such as nursing homes, adult day care centres and assisted living facilities. Custodial care services may be of a short-term nature or provided on a long-term basis. Health insurance plans, including the Empire Blue Cross PPO plan, provide no coverage for custodial care.

Worldwide participating Blue Cross hospitals

Subscribers to Empire Blue Cross health insurance plans have the benefit of a network of hospitals in more than 40 countries worldwide which accept the Empire Blue Cross ID card and which bill Empire Blue Cross directly for any medical services rendered. A list of these hospitals may be obtained from the **Insurance "Quicklink" on the UN Intranet web site** (click on "Empire Blue Cross PPO", go to "Online Provider Directory" and then click on "Empire Blue Cross Worldwide Hospitals"). Alternatively, the same listing can be obtained from the **Internet web site** www.bluecares.com/healthtravel/worldwide.html.

EMPIRE BLUE CROSS PPO BENEFITS SUMMARY

BENEFITS	IN-NETWORK[a]	OUT-OF-NETWORK
ANNUAL DEDUCTIBLE	$0	$150 Individual $450 Maximum for a Family
CO-INSURANCE	$0	20%
ANNUAL OUT-OF-POCKET MAXIMUM	$0	$1,000 Individual $2,500 Family in addition to annual deductible
LIFETIME MAXIMUM	Unlimited benefits	
DEPENDENT CHILDREN	Covered to end of calendar year in which child reaches age 25	
HOSPITAL BENEFITS		
Inpatient[b] (except behavioural health) - Unlimited days – semiprivate room & board - Hospital-provided services - Routine nursery care	$0	Deductible and 20% co-insurance
Outpatient - Surgery and ambulatory surgery[b] - Pre-surgical testing (performed within 7 days of scheduled surgery) - Blood - Chemotherapy and radiation therapy - Mammography screening and cervical cancer screening	$0	Deductible and 20% co-insurance
Emergency Room/Facility[c] (initial visit) - Accidental injury - Sudden and serious medical condition	$35 co-payment (waived if admitted within 24 hours)	$35 co-payment (waived if admitted within 24 hours)
OTHER FACILITY BENEFITS		
Home Health Care[b,d] - Up to 200 visits per calendar year - Home Infusion Therapy	 $0 $0	- 20% co-insurance only (deductible does not apply) - Covered in-network only
Outpatient Kidney Dialysis Home, hospital based or free-standing facility treatment	$0	Deductible and 20% co-insurance
Skilled Nursing Facility[b] Up to 120 days per calendar year	$0	In-network only

BENEFITS	IN-NETWORK	OUT-OF-NETWORK
Hospice[b] Up to 210 days per lifetime	$0	In-network only
Physical Therapy[b] Up to 60 inpatient days per calendar year	$0	Deductible and 20% co-insurance
PREVENTIVE CARE BENEFITS		
Annual Physical Exam	$10 co-payment	In-network only
Diagnostic Screening Tests	$0	Deductible and 20% co-insurance
Prostate Specific Antigen (PSA) Test	$0	Deductible and 20% co-insurance
Well Woman Care	$10 co-payment	Deductible and 20% co-insurance
Mammography Screening	$0	Deductible and 20% co-insurance
Well Child Care **(including recommended immunizations)**[d] - Newborn Baby 1 in-hospital exam at birth - Birth to 1 year of age 6 visits - 1 through 2 years of age 3 visits - 3 through 6 years of age 4 visits - 7 up to 19th birthday 6 visits	$0	Deductible and 20% co-insurance
MEDICAL BENEFITS		
Office/Home Visits/Office Consultations	$10 co-payment	Deductible and 20% co-insurance
Surgery	$0	Deductible and 20% co-insurance
Surgical Assistant[e]	$0	Deductible and 20% co-insurance
Anaesthesia[f]	$0	Deductible and 20% co-insurance
Inpatient Visits/Consultations	$0	Deductible and 20% co-insurance
Maternity Care	$0	Deductible and 20% co-insurance
Diagnostic X-Rays	$0	Deductible and 20% co-insurance
Lab Tests	$0	Deductible and 20% co-insurance
Chemotherapy & Radiation Therapy Hospital outpatient or physician's office	$0	Deductible and 20% co-insurance
MRIs[b]	$0	Deductible and 20% co-insurance
Cardiac Rehabilitation[b]	$10 co-payment	Deductible and 20% co-insurance

BENEFITS	IN-NETWORK	OUT-OF-NETWORK
Second Surgical Opinion[g]	$10 co-payment	Deductible and 20% co-insurance
Second Medical Opinion for Cancer Diagnosis	$10 co-payment	Deductible and 20% co-insurance[h]
Allergy Testing and Allergy Treatment	$10 co-payment per office visit for testing $0 for testing fees and treatment visits	Deductible and 20% co-insurance
Prosthetic, Orthotics and Durable Medical Equipment[i]	$0	In-network only
Medical Supplies	$0	$0
PHYSICAL THERAPY and OTHER SKILLED THERAPIES		
Physical Therapy[b] - 60 inpatient visits, and - 60 visits combined in home, office or outpatient facility	$0 $10 co-payment	Deductible and 20% co-insurance In-network only
Occupational, Speech, Vision[b] 30 visits combined in home, office or outpatient facility	$10 co-payment	In-network only
BEHAVIORAL HEALTH CARE BENEFITS		
Mental Health Care[d,j] - Up to 90 inpatient days per calendar year - Up to 60 outpatient visits in office or facility - Up to 90 professional visits per calendar year while in an inpatient facility	$0 $25 co-payment per visit $0	Deductible and 20% co-insurance
Outpatient Alcohol and Substance Abuse[d,j] Up to 60 outpatient visits which include 20 family counselling visits per calendar year	$0	Deductible and 20% co-insurance
Inpatient Alcohol and Substance Abuse[d,j] Up to 7 days detoxification and 30 days rehabilitation per calendar year	$0	Deductible and 20% co-insurance
OTHER BENEFITS		
Acupuncture	$10 co-payment	Deductible and 20% co-insurance
Chiropractic Care	$10 co-payment $1,000 annual limit	Deductible and 20% co-insurance $1,000 annual limit
Hearing Exam (every 3 years) **Hearing Appliance**	$10 co-payment Not covered	Deductible and 20% co-insurance Not covered
Ambulance[k]	$0 up to the allowed amount	

BENEFITS	IN-NETWORK	OUT-OF-NETWORK
Prescription Drugs (Card and Mail Order Programme)	- 15% co-payment up to a maximum of $15 per prescription - $10 co-payment for mail order	*Within US:* 40% co-insurance after deductible *Outside US:* 20% co-insurance after deductible (claim form must be filed for reimbursement)
Vision Care Programme (in-network only through a designated group of providers)	- $5 co-payment for 1 exam every 24 months - $10 co-payment for basic frames - $35 co-payment for non-plan eyewear allowance	In-network only

[a] In-network services (except Mental Health or Alcohol/Substance Abuse) are those from a provider that participates with Empire or another BlueCross BlueShield Plan through the BlueCard Program, or a participating provider with another BlueCross BlueShield Plan that does not have a PPO network and does accept a negotiated rate arrangement as payment-in-full.

[b] Medical Management Programme must pre-approve or benefits will be reduced 50% up to $2,500.

[c] If admitted, Medical Management must be called within 24 hours or as soon as reasonably possible.

[d] Combined maximum visits for in-network and out-of-network services.

[e] If the surgical assistant is an out-of-network provider and is assisting a participating surgeon, payment will be made in full.

[f] If the anaesthesiologist is an out-of-network provider but is affiliated with a participating hospital, payment will be made in full.

[g] Charges to member do not apply if the second surgical opinion is arranged through the Medical Management Programme.

[h] If arranged through the Medical Management Programme, services provided by an out-of-network specialist will be covered as if the services had been in-network (i.e., subject to the in-network co-payment).

[i] In-network vendor must call Medical Management to pre-certify.

[j] Magellan Behavioral Health must pre-approve or benefits will be reduced 50% up to $2,500. Out-of-network mental health care does not require pre-certification; however, out-patient alcohol and substance abuse visits must be pre-certified. In-network mental health services are those from providers that participate with Magellan Behavioral Health.

[k] Air Ambulance and Ambulette services are not covered.

Discount prescription drug programme (Empire Pharmacy Management)

The Blue Cross Empire Pharmacy Management (EPM) discount prescription drug programme is administered by AdvanceRX. The Empire Pharmacy Management (EPM) programme reimburses at significant savings prescription drugs obtained from participating pharmacies. Under this programme, a retail pharmacy network as well as a mail order facility are provided by Empire Pharmacy Management through AdvanceRX.

Significant cost savings are being passed on to participants by utilizing either a participating pharmacy or the mail order facility. In respect of drugs obtained at participating pharmacies, the discount will be at least 15 per cent off the average wholesale price (AWP) of the drug. If the physician does not request on the written prescription that a brand-name drug be dispensed by indicating "Dispense as written" or "DAW", a generic equivalent drug will be provided by the pharmacist, and the discount off the AWP will average 43 per cent depending on the generic equivalent supplied. The discount for maintenance drugs obtained through AdvanceRX will range from 18 per cent to as high as 50 per cent off AWP, depending on whether or not a generic equivalent to the brand-name drug is provided. (Maintenance drugs are drugs used on a continual basis for the treatment of chronic health conditions.) Whenever a prescription carries the words "Dispense as written" or "DAW", the pharmacist or mail order firm will fill the prescription accordingly and no substitution will be made.

The procedure under which prescription drugs are reimbursed through the Empire Pharmacy Management programme is as follows. Written prescriptions for drugs are presented at a participating pharmacy of one's choice **along with the Empire Blue Cross PPO card** (please refer to annex VI). The pharmacist will fill the prescription for up to a 34-day supply and charge a co-insurance of 15 per cent (rather than the normal 20 per cent co-insurance) on the discounted price of the drug, but never more than $15 per prescription. No claim form is required for prescriptions filled at participating pharmacies.

Prescriptions for maintenance drugs may provide for up to a 90-day supply and are most economically filled through the AdvanceRX mail order facility, which will charge a fixed $10 co-payment per prescription. The AdvanceRX claim form supplied with the Empire Blue Cross PPO card should be utilized for ordering maintenance drugs by mail. A new order form will be sent along with the filled prescription. The address and telephone number of the mail order prescription drug facility is as follows:

AdvanceRX
P.O. Box 660783
Dallas, TX 75266-0783

Tel. No. (888) 266-5691

It should be noted that if a generic equivalent is available and a participant receives a brand-name drug at his or her request, even though the physician has not specified a brand name by indicating "Dispense as written" (DAW) on the prescription, the participating pharmacy and/or the AdvanceRX mail order facility will charge the participant the normal co-payment ($10) in addition to the difference between the cost of the brand-name drug and the allowance for the generic equivalent.

As the prescription drug programme is administered separately by Empire Pharmacy Management, the annual deductible under the Empire Blue Cross PPO plan will **not** be applied to prescription drugs. At the same time, the prescription drug co-payment will also **not** count towards meeting the annual co-insurance limit of $1,000. Prescription drugs obtained outside the United States or within the United States but not through the Empire Pharmacy Management AdvanceRX participating network will be reimbursed through the submission of a claim form to the claims office at the following address:

Empire BCBS (EPM)
Pharmacy Unit
P.O. Box 5099
Middletown, NY 10940-9099

Tel. No. (800) 839-8442

The special claim form to be utilized for this purpose is available in the offices of the Insurance Service, room S-2765. **Claims submitted to the prescription drug claims office will be subject to the annual deductible.** Claims for prescription drugs dispensed outside the United States will be reimbursed at 80 per cent after deductible, while claims for prescription drugs dispensed within the United States but **not** through the Empire Pharmacy Management programme will be reimbursed at the rate of 60 per cent. In addition, the 20 or 40 per cent co-insurance will **not** count towards meeting the annual co-insurance limit of $1,000.

Behavioural health and substance abuse benefits

In-patient care for both the treatment of mental and nervous conditions and substance abuse as well as in-network out-patient treatment by a psychiatrist, clinical psychologist or psychiatric social worker requires prior approval by Behavioral Health Care Management (1-800-626-3643).

Vision care

To qualify for vision care benefits, you must receive care from a provider participating in the Empire Blue Cross PPO Davis Vision Network. There are no out-of-network benefits for vision care. To find a participating Davis Vision Network provider in your area, simply call 1-888-EYEBLUE (1-888-393-2583) between 9 a.m. and 5 p.m. weekdays, **or visit their web site at www.davisvision.com**.

The vision care benefits include an eye exam and eyewear, consisting of a select group of frames, and soft contact lenses once every 24 months. During this benefit period, you are **not** required to purchase the eyewear at the time of the examination, nor are you required to purchase the covered eyewear from the same provider who rendered the eye examination.

Service	*Amount you pay*
Eye exam	$5.00
Frames (limited selection)	$10.00
Premier frames	$40.00
Soft contact lenses — per pair (standard daily wear)	$25.00
Single vision lenses	0
Bifocal lenses	0
Trifocal lenses	0
Progressive addition lenses	$80.00
Blended segment lenses	$20.00
Photochromic single vision lenses	$15.00
Photochromic multifocal vision lenses	$25.00
Supershield single vision lenses	$15.00
Supershield multifocal lenses	$25.00
Ultraviolet coating	$10.00
Reflection-free coating	$33.00
Polaroid lenses	$60.00
Polycarbonate lenses	$30.00
High index lenses	$55.00
Transition lenses	$70.00

In addition, vision care benefits include a $35.00 allowance for non-plan frames.

Laser vision correction: Though not a new benefit, participants should be aware that discounts are now available for laser vision correction from Davis Vision. To receive information regarding the laser vision correction savings, go to www.davisvision.com on the Internet and click on “laser vision correction” and proceed to “laser vision correction programme”, which will require your BlueCross member ID number (the number on your BlueCross card) or login name and password. If you have not yet established a login name and password, go to www.empireblue.com and register by entering “member” in the “I am a:” drop-down menu and clicking on the “register” button (see also paragraph on Empire’s Internet site as set out below). For more information on the laser vision correction programme, contact a Davis Vision at 1-(877)-92DAVIS.

Exclusions and other provisions

Certain expenses are not covered under the Empire Blue Cross PPO plan. These comprise expenses for services or supplies not deemed by Empire Blue Cross as being necessary, reasonable and customary or not recommended by the attending physician. There are also certain exclusions and limitations under the plan. For example, cosmetic surgery and certain experimental or investigational procedures are not covered. In addition, inoculations for travel purposes are not covered. If a participant has any question as to whether a medical procedure or service will be recognized by Empire Blue Cross as reimbursable under the plan, Empire Blue Cross should be contacted at (800) 342-9816 prior to commencement of treatment. In addition, the Empire Blue Cross policy contract document is on file in the offices

of the Insurance Service and may be consulted and photocopied, as necessary. An appointment should be made for this purpose.

Recourse if a claim is denied

If Empire Blue Cross denies a claim in whole or in part, the subscriber has the right to appeal the decision. Empire Blue Cross will send written notice of the reason for the denial. The subscriber then has 60 days to submit a written request for review. Empire Blue Cross will send a written decision with an explanation within 60 days of receiving the appeal. If special circumstances require more time, Empire Blue Cross can extend the review period up to 120 days from the date the appeal was received. For a review of a hospital or medical claim, write to:

Empire Blue Cross Blue Shield
PPO Member Services
P.O. Box 1407
Church Street Station
New York, NY 10008-1407

Time limit for filing a claim

Subscribers should note that claims for reimbursement must be submitted to Empire Blue Cross no later than two years from the date on which the medical expense was incurred. **Claims received by Empire Blue Cross later than two years after the date on which the expense was incurred will not be eligible for reimbursement.**

Empire's Internet site

Subscribers in the Empire Blue Cross PPO plan are encouraged to activate an account on Empire Blue Cross's web site which permits participants to more effectively manage their coverage. The site is called **Empireblue.com** and can be accessed directly at www.empireblue.com.

Empireblue.com allows you to access the following services 24 hours a day, 7 days a week:

- Check and resolve claims
- Change your phone number
- Request ID cards
- Research and choose doctors
- Print an explanation of benefits
- Update your address*

* If you update your address on the Empire Blue Cross site, please also update your address change on the United Nations Intranet site so that the change becomes permanent in both systems.

To register on the Empire Blue Cross site:

- Click on "Register" in the Member Services window
- Enter your name, member ID number and date of birth
- Create your own personal password and login ID
- Request, and then enter your personal activation key

If you have any problems registering, please call Empire Blue Cross at 1-877-603-0923. Each member of your household over the age of 18 must register separately, and members under 18 can access their information through their parents' or guardians' personal home page.

Annex II

Aetna "Open Choice" Plan

Plan outline

The Aetna "Open Choice" health benefits plan (Aetna) offers worldwide coverage for hospitalization and surgical, medical and prescription drug expenses. Under this plan, medically necessary treatment for a covered illness or injury may be obtained at a hospital or from a physician of one's own choosing, whether an in-network or non-network provider.

Aetna "Open Choice" is a dual-track plan that offers all the benefits of the traditional Aetna indemnity plan, plus the option of a preferred provider organization (PPO) network of physicians and other medical providers nationwide. This means that participants can choose, if they wish, to go to a doctor who is in-network and pay only $10 per visit or treatment without any further need to file a claim with Aetna. Alternatively, **participants may opt to receive treatment from any physician not in the network and be reimbursed by Aetna in the usual way, subject to the annual deductible and the normal co-insurance and subject to the providers' fees falling within reasonable and customary norms**. A summary of the plan, both the in-network and the non-network (traditional indemnity) benefits, is set out in outline form commencing on page 24.

Under the non-network (traditional) track of the Aetna plan, when a participant has met the annual deductible of $125 per individual and $375 per family and a further $1,000 per covered individual in co-insurance (20 per cent of $5,000 of recognized expenses), Aetna will reimburse all further claims incurred in the year, subject to the provision that they be "reasonable and customary", at 100 per cent. The deductible and co-insurance requirement must be met each calendar year. There is no lifetime reimbursement limit under the Aetna plan. When a participant is treated by a network physician, paying the fixed $10 co-payment for each visit, it is important to note that those $10 amounts do not count towards meeting the $1,000 out-of-pocket expense limit referred to above. This is so because, under the in-network track of the plan, medical expenses are already considered to have been paid at 100 per cent to the network provider after the participant has met the fixed $10 co-pay.

Premium

Effective 1 July 2002, premiums for the Aetna plan will increase by 19.5 per cent. The premiums and related percentages of salary contribution are shown on page 2 of the present circular.

Benefits

The package of benefits under the Aetna "Open Choice" plan is itemized in the plan summary (pp. 24-33). Effective 1 July 2002, the following benefit changes will come into effect:

In-patient alcohol/substance abuse treatment. Heretofore, a limitation of two confinements in a lifetime was in place in respect of in-patient alcohol/substance abuse treatment. With effect from 1 July 2002, this limitation is eliminated and is

replaced by an annual 60-day per calendar year maximum benefit, with no lifetime limitation.

Smoking cessation. A new benefit has been added to the Aetna prescription drug programme, namely, coverage of prescription smoking-cessation aids for two 60-day periods per calendar year.

Participants are reminded of the following particular provisions in the plan:

Private duty nursing and home health care. Private duty nursing is covered on an in-home basis only (no in-hospital benefit). In addition, the benefit is limited to $5,000 per year, with a $10,000 lifetime maximum. Home health care is covered at 100 per cent and is limited annually to 200 visits of up to 4 hours per visit. To be eligible for reimbursement, both private duty nursing and home health care services must be prescribed by a physician and determined to be medically necessary. A written prescription or home health care treatment plan is required as well as any supporting documentation from the physician to facilitate Aetna's review of a claim for the payment of benefits. It is strongly recommended that both in-home private duty nursing and home health care requirements be submitted to Aetna for a predetermination of benefits payable prior to contracting with a nursing or home health care agency. Services provided at home need not follow a hospital confinement.

It is important to note that covered home health care services exclude all types of custodial care services. Custodial care services are categorized as personal care and comprise services designed to help a person perform activities of daily living, which include assistance with bathing, eating, dressing, toileting, continence and transferring. Such services are performed at home or in other facilities such as nursing homes, adult day-care centres and assisted living facilities. Custodial care services may be of a short-term nature or provided on a long-term basis. Health insurance plans, including the Aetna plan, provide no coverage for custodial care.

Pre-registration of hospital and other institutional services. Mandatory pre-registration applies to in-hospital admissions, skilled nursing facility admissions, home health care, private duty nursing and hospice care. The reason for such pre-registration (to which no financial penalty attaches) is a constructive one, namely that pre-registration assures the patient (a) that all related hospital expenses will be covered under the plan, and most importantly that (b) a hospitalization case is medically monitored from the first day of admission, so that if complications should arise, or if after-hospital care should be required, the case may be managed promptly and effectively. The telephone number to call for pre-registration of hospital admissions and the other services is: 1-800-333-4432. For an emergency admission, call within 48 hours, or the next business day if admitted on a weekend.

Artificial insemination. This benefit is subject to a maximum of six courses of treatment in a covered person's lifetime.

Non-network prescription drug reimbursement. Participants are reminded that non-network prescription drugs will be reimbursed at the rate of 60 per cent (40 per cent co-insurance), after deductible. In addition, the 40 per cent co-insurance which is the responsibility of the participant will **not** count towards meeting the annual out-of-pocket limit of $1,000. All prescriptions filled at pharmacies outside the United States will be reimbursed at 80 per cent after deductible. However, the co-insurance will not count towards fulfilment of the annual $1,000 out-of-pocket limit.

AETNA OPEN CHOICE SUMMARY OF BENEFITS		
BENEFITS	**IN-NETWORK**	**OUT-OF-NETWORK**
ANNUAL DEDUCTIBLE Individual Family	 $0 $0	 $125 $375
CO-INSURANCE (% at which the plan pays benefits)	100% except where noted	100% Hospital; 80% all other, except where noted
OUT-OF-POCKET LIMIT Individual Family	N/A	 $1,000 $3,000 (network and prescription drug co-pays do not count towards the out-of-pocket limit)
LIFETIME MAXIMUM	Unlimited	Unlimited
CLAIM SUBMISSION	**PROVIDER** files claims	**YOU** file claims
HOSPITAL SERVICES AND RELATED CARE		
COVERAGE In-patient coverage Out-patient coverage	 100% 100%	
MANDATORY PRE-REGISTRATION (1-800-333-4432) Applies to in-patient hospital, skilled nursing facility, home health care, hospice care, and private duty nursing care	**Provider responsible**	**Subscriber or provider responsible**
(For emergency admission, call within 48 hours or next business day if admitted on weekend)		
Hospital Emergency Room Based on symptoms, i.e. constituting a perceived life threatening situation	100% including physician's charges after $35 co-pay (waived if admitted within 24 hours)	100% including physician's charges after $35 co-pay (waived if admitted within 24 hours)
Hospital Emergency Room For non-emergency care (examples of conditions: skin rash, ear ache, bronchitis, etc.)	80%	80% after deductible
Ambulance ***[There are no network providers for these services at the present time.]***	100%	
Skilled Nursing Facility	100% Up to 365 days per year as determined by medical necessity.	
Private Duty Nursing (in-home only)	100% subject to a $5,000 maximum per year and $10,000 lifetime Must be determined to be medically necessary and supported by a doctor's prescription/medical report. Pre-certification is strongly recommended.	
Home Health Care Up to 200 visits per year	100% Must be determined to be medically necessary and supported by a doctor's prescription/medical report. Pre-certification is strongly recommended.	

BENEFITS	IN-NETWORK	OUT-OF-NETWORK
Hospice (210 days) Plus 5 days bereavement counselling	100%	
PHYSICIAN SERVICES **(excluding mental health and substance abuse treatment)**		
Office Visits For treatment of illness or injury (non-surgical)	100% after $10 co-pay	80% after deductible
Maternity (includes voluntary sterilization and voluntary abortion, see Family Planning)	100% after $10 co-pay	80% after deductible
Physician In-Hospital Services	100%	80% after deductible
Other In-Hospital Physician Services (e.g. attending/independent physician who does not bill through hospital)	100%	80% after deductible
Surgery (in hospital or office)	100%	80% after deductible
Second Surgical Opinion	100% after $10 co-pay	100% after deductible
Anaesthesia	100% (if participating hospital)	80% after deductible
Allergy Testing and Treatment (given by a physician)	100% after $10 co-pay	80% after deductible
Allergy Injections (not given by a physician)	100%	80% after deductible
PREVENTIVE CARE		
Routine Physicals and Immunizations - Children age 19+ and adults: one routine exam every 24 months - Age 65+: one routine exam every 12 months	100% after $10 co-pay	80% after deductible
Well-child Care and Immunizations Well-child care to age 7: - 6 visits per year age 0 to 1 year - 2 visits per year age 1 to 2 years - 1 visit per year age 2 to 7 years One visit every 24 months from age 7 to 19	100%	
Routine Ob/Gyn Exam One routine exam per calendar year including one Pap smear	100% after $10 co-pay	80% after deductible
Family Planning - Office visits including tests and counselling - Surgical sterilization procedures for vasectomy/tubal ligation (excludes reversals)	100% after $10 co-pay 100%	80% after deductible 80% (deductible waived)

BENEFITS	IN-NETWORK	OUT-OF-NETWORK
Infertility Treatment - Office visits including testing and counselling - Limited to procedures for correction of infertility including artificial insemination (but excluding in-vitro fertilization, G.I.F.T., Z.I.F.T., etc.)	100% after $10 co-pay 100%	80% after deductible 80% after deductible
Routine Mammogram (no age limit)	100%	80% after deductible 100% if performed on an in-patient basis or in the out-patient department of a hospital
Annual Urological exam by Urologist	100%	80% after deductible
MENTAL HEALTH AND ALCOHOL/DRUG ABUSE SERVICES		
MENTAL HEALTH IN-PATIENT SERVICES (1-800-424-1601) **In-patient Coverage** *[The benefit maximum is for network and non-network services combined.]*	100% Maximum benefit of 90 days per calendar year	100% after deductible Maximum benefit of 90 days per calendar year
These services are provided under the Focused Psychiatric Review (FPR) programme. Pre-registration of in-patient confinements is required. For in-network services, the network provider is responsible for pre-registration. For non-network in-patient services, either the physician or the participant must pre-register the confinement.		
Out-patient Coverage *[The benefit maximum is for network and non-network services combined.]*	100% Up to 50 visits per calendar year	80% after deductible Up to 50 visits per calendar year
Crisis Intervention	100% Up to 3 visits per calendar year	80% after deductible Up to 3 visits per calendar year
ALCOHOL/DRUG ABUSE **In-patient Coverage** *[The benefit maximum is for network and non-network services combined.]*	100% Up to 60 days per calendar year	100% after deductible Up to 60 days per calendar year
Out-patient Coverage *[The benefit maximum is for network and non-network services combined.]*	100% Up to 60 visits per calendar year	80% after deductible Up to 60 visits per calendar year
PRESCRIPTION DRUG BENEFITS		
Retail Programme (1-888-792-8742) **(30-day supply)**	15% co-pay up to a maximum of $15 per prescription	*Within US:* 60% after deductible *Outside US:* 80% after deductible The co-payment will not count towards $1,000/$3,000 out-of-pocket limit
Mail Order Programme (1-877-849-5521) **(90-day supply)**	100% after $10 co-pay for up to a 90-day supply from participating mail order vendor	
Prescriptions for both Retail Programme and Mail Order Programme — when brand name is requested, you pay the co-pay plus the difference between the brand and generic price, unless the physician specifically prescribes the brand-name drug.		

BENEFITS	IN-NETWORK	OUT-OF-NETWORK
VISION AND HEARING CARE		
Eye Exam (once every 12 months)	100% after $10 co-pay	80% after deductible
Optical Lenses (including contact lenses once every 12 months)	80%, deductible does not apply; $100 maximum for any two lenses and frames purchased in a 12-month period	
Vision One Programme **(1-800-793-8616)** **Discount information for laser surgery** **(1-800-422-6600)**	Save up to 65% on frames, up to 50% on lenses, and about 20% on contact lenses at participating Cole Vision Centers. Discounts available for laser surgery.	
Hearing Exam Evaluation and Audiometric exam	100% after $10 co-pay (one exam every three years; exam must be performed by otolaryngologist or state certified audiologist)	80% after deductible (one exam every three years; exam must be performed by otolaryngologist or state certified audiologist)
Hearing Device ***[There are no network providers for these services at the present time.]***	80%, deductible does not apply; $750 maximum benefit, one hearing aid per ear every three years	
OTHER HEALTH CARE		
Short-term Rehabilitation **Physical and Occupational Therapy**	100%	80% after deductible
Laboratory Tests, Diagnostic X-Rays	100%	80% after deductible
Speech Therapy	80%, deductible does not apply (where services are rendered by a participating provider, 100% reimbursement applies after $10 co-pay)	
Out-patient Diabetic Self-Management Education Programme	80%, deductible does not apply *[If services are rendered in a hospital, 100% reimbursement applies with no co-pay. If rendered in a network doctor's office, 100% reimbursement with $10 co-pay applies]*	
Durable Medical Equipment	80%, deductible does not apply *[If services are rendered by a network provider or within a hospital setting, 100% reimbursement applies with no co-pay]*	
Acupuncture (for chronic pain treatment only; services must be rendered by a medical doctor or licensed acupuncturist)	100% after $10 co-pay up to a maximum benefit of $1,000/year	80% after deductible up to a maximum benefit of $1,000/year
	[Network and non-network benefits are combined for a maximum of $1,000 per calendar year]	
Chiropractic Care	100% after $10 co-pay up to a maximum benefit of $1,000/year	80% after deductible up to a maximum benefit of $1,000/year
	[Network and non-network benefits are combined for a maximum of $1,000 per calendar year]	

Eye examination

An eye examination once every 12 months is covered at 100 per cent after a $10 co-payment if carried out by a network provider, and at 80 per cent after deductible if carried out by an out-of-network provider.

“Vision One” eyecare discount programme

The Vision One programme offers subscribers and covered family members immediate discounts on eyecare needs, including frames, lenses and contact lenses. This programme is an addition to, not a substitute for, the existing optical lens benefit which will be continued as before. The programme is available at over 2,500 locations nationwide, including the optical centres in national retail outlets, such as Sears, JC Penney and Montgomery Ward and many of the Pearle Vision Centers, as well as selected independent providers/offices. To obtain the discounts available under this programme, it is only necessary to show the provider the Aetna identification card at the time of the visit. The provider will apply the discounts to any purchases made and will accept valid prescriptions from any licensed optometrist or ophthalmologist. The Vision One programme may be used as often as desired. As it is simply a discount programme, claim forms are not required. For more details and outlet locations, call Vision One at (800) 793-8616, weekdays from 9 a.m. to 9 p.m. and Saturdays from 9 a.m. to 5 p.m. Vision One providers can also be found on the Internet at www.aetna.com/docfind/index.html and click on “Vision One Providers”. A schedule of costs and typical savings is set out below.

Benefits	*Vision One cost*
Frames	
Priced up to $60.00 retail	$16.00
Priced from $61.00 to $80.00 retail	$26.00
Priced from $81.00 to $100.00 retail	$36.00
Priced from $101.00 to $200.00 retail	50 per cent
Lenses — per pair (uncoated plastic)	
Single vision	$28.00
Bifocal	$48.00
Trifocal	$58.00
Lenticular	$98.00
Lens options — per pair (add to lens prices above)	
Standard-Progressive (no-line bifocals)	$50.00
Polycarbonate	$30.00
Scratch-resistant coating	$12.00
Ultraviolet coating	$12.00
Solid or gradient tint	$8.00
Glass	$18.00
Photochromic	$34.00
Anti-reflective coating	$35.00

Eye examinations (by licensed independent doctors of optometry)

Eyeglasses — $34.00

Contact lenses — $10.00 off normal fee

Contact lenses (two ways to save on contact lenses)

1. Visit the more than 2,500 locations nationwide and save 20 per cent discount from regular retail prices.
2. Use the Vision One Contact Lens Replacement Program for additional savings and convenience.

   Call (800) 391-5367 for this service.

Dispensing fee

The fee for fitting and dispensing (including unlimited eyeglass adjustments) is only $10.00.

Vision One Lasik (laser vision corrective procedure discount programme)

1. A 15 per cent discount off the vision provider's usual retail charge for Lasik surgery is offered by Cole/LCA — Vision LLC through the national Lasik network of LCA Vision. Included in the discounted services are patient education, an initial screening, the Lasik procedure and follow-up care. Members not found to be suitable candidates for this procedure will not be charged for the initial consultation.
2. There are currently 100 providers in 59 designated market areas in 32 states. To find the closest surgeon, participants may call 1-(800)-422-6600 to speak with a customer service representative. Contact is made with a provider for an initial screening, at which time, the participant presents the Aetna ID card. If Lasik surgery is scheduled, the Lasik Customer Service office needs to be called (at the above number) with the date of the surgery in order to arrange to pay a deposit. An authorization number is provided by Lasik Customer Service in order to receive the discount. The surgeon will also receive written confirmation verifying the discount and the amount of deposit. At the time of treatment, the discount and deposit will be deducted from the surgeon's fee.

Acupuncture benefits

The Aetna "Open Choice" plan provides benefits for acupuncture treatment rendered by a medical doctor or licensed acupuncturist, up to a maximum benefit of $1,000 per calendar year. The scope of the benefit may be summarized as follows:

Covered diagnoses for treatment by acupuncture include the following types of chronic pain syndrome:

- Tension headache
- Migraine headache
- Psychalgia
- Neuralgia
- Backache
- Lumbago
- Muscle spasm
- Bursitis

Acupuncture treatment in lieu of anaesthesia has been recognized as a reimbursable procedure by Aetna under the traditional plan. This benefit, as well as all other benefits under the traditional plan, will be maintained under Aetna "Open Choice".

Mental and nervous and substance abuse benefits

A. In-patient benefits

All hospitalization for mental and nervous and substance abuse conditions is subject to the Focused Psychiatric Review (FPR) procedure. **Staff members are assured that the FPR programme is conducted in the strictest confidence.** The procedure is as follows:

Prior to a non-emergency hospital admission, Aetna must be informed of the intended admission. This is accomplished by placing a telephone call to a toll-free Aetna number (800-424-1601). The call will be taken by an employee of the Aetna FPR team. The telephone call may be placed by the subscriber, the attending physician, a family member, or any other person acting for the patient to be hospitalized.

The initial information required by Aetna in order to pre-certify the admission includes the subscriber's identification number (payroll index number), the reason for the admission, the physician's name, address and telephone number, the hospital name, address and telephone number, and the scheduled admission date.

The FPR specialist then contacts the attending physician to review the information prior to certification of the admission. If the attending physician makes the original call to the 800 number, this step will be accomplished at that time. The FPR specialist certifies a certain number of in-patient days, if appropriate, and develops a plan of regular follow-up visits with the attending physician.

An emergency admission, which cannot be pre-certified before the confinement begins, must be called in to the Aetna FPR number within 48 hours of the emergency admission.

B. In-patient mental and nervous and substance abuse care

The full cost (semi-private accommodation) of 30 days of hospitalization for the treatment of mental and nervous disorders. Hospital confinements beyond 30 days are reimbursed subject to the normal deductible and co-insurance provisions.

The full cost (semi-private accommodation) of 30 days of hospitalization for substance (alcohol and/or drug) abuse detoxification and rehabilitation, limited to two 30-day benefit periods in a lifetime. Continuous confinement of up to 30 days beyond this 30-day limit is subject to the provision under the paragraph below.

Coverage for up to 30 days of hospitalization for substance abuse (alcohol and/or drug) rehabilitation after the 30-day hospitalization benefit described in the paragraph above has been exhausted. This benefit is available twice in a lifetime and is applicable only as a continuation of each of the two 30-day hospitalization periods provided under the preceding paragraph.

C. Out-patient mental and nervous and substance abuse care

A maximum of 50 out-patient visits per year to a medical doctor engaged in the practice of psychiatry (and, depending on the state in which the provider is licensed, for the services of a psychologist and psychiatric social worker). If treatment is obtained from a network provider, the plan pays 100 per cent of the cost. If the provider does not participate in the PPO network, reimbursement will be at 80 per cent of the reasonable and customary fee level for the area in which the services are rendered, and will be subject to the annual deductible. The 50-visit annual maximum is for network and non-network treatment combined. Co-insurance payments made in respect of out-of-network treatment will not be applied to the $1,000 annual co-insurance maximum.

Sixty out-patient visits per calendar year for the treatment of alcoholism or drug abuse diagnosed by a physician. Of these 60 annual visits, 20 may be utilized for the counselling of the patient's family if directly related to the patient's alcoholism or drug abuse.

Discount prescription drug programme (Aetna Pharmacy Management)

As announced in ST/IC/2000/38, with effect from 1 July 2000, Express Scripts Inc. (ESI) mail service programme replaced Walgreens Healthcare Plus as Aetna's contracted mail order pharmacy administrator. Prescriptions for maintenance drugs may provide for up to a 90-day supply and are most economically filled through ESI which will charge a fixed $10 co-payment. ESI order forms are available at the Insurance Service office, room S-2765.

The Aetna Pharmacy Management (APM) prescription drug programme, along with its mail order affiliate, Express Scripts Inc. (ESI), reimburses, at significant savings, the cost of prescription drugs obtained from participating pharmacies and from the Express Scripts Inc. (ESI) mail order facility.

In respect of drugs obtained at participating pharmacies, the discount will be at least 15 per cent off the average wholesale price (AWP) of the drug. If the physician does not request on the written prescription that a specific brand be dispensed by indicating "Dispense as written" or "DAW", the generic equivalent drug will be provided by the pharmacist, and the discount off the AWP can be as high as 50 per cent, depending on the generic equivalent supplied. The discount for maintenance drugs obtained by mail through the Express Scripts Inc. (ESI) mail order facility will range from 18 per cent to as high as 50 per cent off AWP depending on whether or not a generic equivalent to the brand-name drug is provided. (Maintenance drugs are drugs used on a continual basis for the treatment of chronic health conditions.) Whenever a prescription carries the words "Dispense as written" or "DAW", the pharmacist or mail order firm will fill the prescription accordingly and no substitution will be made.

The procedure under which prescription drugs are reimbursed through the Aetna Pharmacy Management Programme is as follows. Written prescriptions for drugs are presented at a participating pharmacy of one's choice **along with the Aetna card** (please refer to annex VI). The pharmacist will fill the prescription for up to a 30-day supply and charge a co-insurance of 15 per cent (rather than the normal 20 per cent co-insurance) based upon the discounted price of the drug, but never more than $15 per prescription. No claim form is required for prescriptions filled at participating pharmacies.

It should be noted that if a participant wishes to receive the brand-name drug even though the physician has not specifically prescribed the brand name, the participating pharmacy will charge a participant 15 per cent of the cost of the brand-name drug, but not more than $15 per prescription. In cases in which a brand-name maintenance drug is ordered through the ESI mail order facility even though it has not been specifically prescribed, ESI will charge the participant the normal co-payment ($10) in addition to the difference between the cost of the brand-name drug and the allowance for the generic equivalent.

As the Aetna prescription drug programme benefit is administered separately by Aetna Pharmacy Management, the annual deductible under the Aetna plan will **not** be applied to prescription drugs obtained at network pharmacies. At the same time, however, prescription drug co-payment expenses will **not** count towards meeting the annual co-insurance limit of $1,000. **Prescription drugs obtained at pharmacies in the United States, but not through network pharmacies, will be reimbursed at 60 per cent and be subject to deductible. In addition, the 40 per cent co-insurance amount will not count towards the annual $1,000 out-of-pocket limit.** Prescription drugs obtained outside the United States will be reimbursed through submission of the standard claim form to the Aetna claims office in Allentown, Pennsylvania. In such cases, the annual deductible will have to be met before reimbursement is made, as well as the 20 per cent co-insurance, which will **not** count towards meeting the annual limit of $1,000.

Exclusions and other provisions

Special conditions apply to certain medical procedures for injury-related dental and cosmetic injury, for convalescent facility expenses and for treatment of temporo-mandibular joint syndrome (TMJ). Participants are advised to consult the Aetna claims office in advance of commencing treatment for these conditions.

Certain expenses are not covered under the Aetna plan. These comprise expenses for services or supplies not deemed by Aetna as being necessary, reasonable and customary or not recommended by the attending physician. There are also certain exclusions and limitations under the plan. For example, cosmetic surgery and certain experimental or investigational procedures are not covered. In addition, inoculations for travel purposes are not covered. If a participant has any question as to whether a medical procedure or service will be recognized by Aetna as reimbursable under the plan, Aetna Member Services should be contacted at (800) 784-3991 prior to commencement of treatment. In addition, the Aetna policy contract document is on file in the offices of the Insurance Service and may be consulted and photocopied, as necessary. An appointment should be made for this purpose.

Aetna claims

The address to which Aetna claim forms should be sent is as follows:

Aetna U.S. Healthcare
Unit 73
3541 Winchester Road
Allentown, PA 18195-0513

Recourse if a claim is denied

If Aetna denies a claim in whole or in part, the subscriber will receive a written notice from Aetna. This notice will explain the reason for the denial and the appeal procedure. The request for review must be submitted in writing within 60 days of receipt of the notice. The subscriber should include the reasons for requesting the review and submit the request to the Aetna Allentown Claim Office. Aetna will review the claim and ordinarily notify the subscriber of its final decision within 60 days of receipt of the request. If special circumstances require an extension of time, notification will be given to that effect.

Time limit for filing claims

Subscribers should note that claims for reimbursement must be submitted to Aetna no later than two years from the date on which the medical expense was incurred. **Claims received by Aetna later than two years after the date on which the expense was incurred will not be eligible for reimbursement.**

Annex III

HIP Health Plan of New York (HIP)

Plan outline

The HIP plan follows the concept of total prepaid group practice hospital and medical care, that is, there is no out-of-pocket cost to the staff member for covered services at numerous participating medical groups in the Greater New York area. The costs of necessary emergency treatment obtained outside the covered area are included in the plan coverage. Additionally, prescription drugs (a $5 co-payment applies) and medical appliances (in full) are covered when obtained through HIP participating pharmacies and are prescribed by HIP physicians or any physician in a covered emergency. HIP participants may select a physician at a HIP medical centre or from a listing of 16,000 affiliated physicians for primary care services. The affiliated physician is visited in his or her private office. If you require specialty care, your primary care physician will refer you to a HIP specialist with a referral form. To select an affiliated physician, the HIP participant should call HIP at (800) HIP-TALK, go to the web site at www.HIPUSA.com or call the physician you wish to visit. Additional information regarding HIP providers will be provided to participants during the annual enrolment campaign and also mailed by HIP to all participants upon request.

Premium

The premiums and related percentages of salary contribution are shown on page 2 of the present circular.

Benefits

Benefits under the HIP plan will remain unchanged in the renewal period.

HIP benefits summary

Type of benefit	HIP coverage
Hospital services	Covered in full when authorized by a HIP- affiliated physician.
In-hospital physician's services	Covered in full when rendered by a HIP-affiliated physician.
Private duty nursing	Covered in full when authorized by a HIP-affiliated physician.
Skilled nursing facility	Covered in full when authorized by a HIP-affiliated physician.
Visits to physician's office/health centre	Covered in full at any HIP medical centre or if care is rendered by a HIP-affiliated physician.
House calls	Covered in full when authorized by a HIP-affiliated physician.
Maternity care	No waiting periods. Covered in full when care is rendered by a HIP-affiliated physician. Prenatal, post-natal and well-baby check-ups are covered in full up to age 19.
Preventive care:	
Annual physicals, well-baby care, eye examinations, hearing tests, diagnostic X-rays, laboratory tests, immunizations and allergens	Covered in full when care is rendered by a HIP-affiliated physician. Eye examinations are covered in full when rendered by a HIP-affiliated provider (a $45 allowance is provided for eyeglasses every 2 years at HIP-affiliated providers. Hearing aids are excluded).
Mental health services: Call 888-447-2526 for a provider referral.	
In-patient	Covered in full for 30 days per calendar year for mental or nervous disorders.
Out-patient	Covered in full for 60 visits per year with HIP-affiliated providers.
	Individual, family or group therapy sessions are provided as long as treatment is effective. Intensive psychotherapy is excluded.
Alcoholism and substance abuse:	
In-patient	Covered in full for up to 30 days per year for rehabilitation. Detoxification is covered in full for 7 days per year.
Out-patient	Rehabilitation treatment covered in full up to 60 visits per year.

Type of benefit	HIP coverage
Emergency services:	
In-area/Out-of-area	Emergency care covered in full worldwide including ambulance. Call within 48 hours after care commences, either the HIP primary care physician, or directly to HIP at 888-447-2884.
	For an emergency physician referral in the U.S. only, call HIP at 800-223-0654.
Prescription drugs and medical appliances	Covered in full. $5 co-payment for prescription drugs when obtained at HIP participating pharmacies. The drugs and appliances must be prescribed by HIP-affiliated physicians or any physician in a covered emergency.
Preventive dental care	$10 co-payment for a semi-annual cleaning. $5 co-payment for a semi-annual oral examination. $5 co-payment for a semi-annual fluoride treatment for children to age 16. Members must use HIP-participating dentists for all care. Other dental procedures are discounted (see fees in the HIP dental handbook obtained from HIP).
Grievance procedure	Refer to member handbook sent to subscribers.

Annex IV

CIGNA Dental PPO Plan

Plan outline

The design of the CIGNA Dental PPO plan offers staff not only a large network of participating providers in the Greater New York metropolitan area and nationally, but also two distinct plan options, Option A and Option B, while retaining a single premium structure. The dual option structure is designed to ensure (a) that staff members have the dental treatment for themselves and their family members provided by a PPO network of dentists, and (b) that those staff members whose dental treatment is not rendered by network (or participating) dentists, will have the option of selecting a track which reimburses on the basis of a percentage of "reasonable and customary" dental fees, in much the same way as do the Aetna and Blue Cross PPO health plans. Please note that the CIGNA ID card does not indicate the option selected. The selection of either Option A or Option B is recorded in CIGNA's database and will be known to a provider at the time that coverage eligibility is checked by the provider's office.

Premium

Effective 1 July 2002, premiums for the Cigna plan will decrease by 6.42 per cent. The premiums and related percentages of salary contribution for the CIGNA plan are shown on page 2 of the present circular.

Benefits
Option A

Option A provides for 100 per cent coverage for most dental procedures without any deductible if the dental treatment is rendered by a dentist participating in the CIGNA provider network (a few dental procedures involving costly materials may require additional payment to the dentist by the participant). The CIGNA participating provider network is nationwide, and includes a total of over 53,000 dentists, with approximately 18,000 in New York State (9,000 in New York City), 9,000 in New Jersey and 3,500 in Connecticut.

Participants who choose Option A may also visit non-participating (or out-of-network) dentists and will be reimbursed the CIGNA in-network fee contracted with participating dentists who practice in the same area as the non-participating dentists. If the out-of-network dentist's fee is higher than the contracted in-network fee, the difference will be payable by the participant. It is important to note that, under the CIGNA plan, there is no single PPO contracted fee schedule. The contracted fee levels vary in accordance with prevailing costs in the different areas in which the dental practices are located. A chart summarizing the Option A benefits and reimbursement levels is set out on page 40.

Option B

The key feature of Option B is the reimbursement allowance formula for participants who wish to utilize out-of-network dentists. Under this option, out-of-network dental treatment will be reimbursed at certain percentage levels after an annual deductible of $50 per person or $150 per family has been met. The percentage reimbursement levels apply to the "reasonable and customary" dental fee

levels prevailing in the dentist's zip-code area. Reasonable and customary fee levels are determined by reference to a national database maintained by the Health Insurance Association of America (HIAA). The percentage reimbursement rate depends on the level of dental treatment as follows: 90 per cent for preventive/diagnostic treatment; 80 per cent for major and minor restorative treatment; 70 per cent for orthodontics.

Under Option B, participants may also be treated by in-network dentists. In this case there is no deductible. The reimbursement percentages for preventive/diagnostic care, major and minor restorative treatment and orthodontics are 100 per cent, 90 per cent and 80 per cent, respectively, based on the network provider's contracted fee level with CIGNA. Thus the amount payable by the participant will be the difference between the 90 or 80 per cent reimbursement and the CIGNA contracted PPO fee for the service provided. A chart summarizing the Option B benefits and reimbursement levels is set out on page 41.

Pre-treatment review (pre-determination of benefits)

If a course of treatment can reasonably be expected to involve covered dental expenses of $300 or more, a description of the procedures to be performed and an estimate of the dentist's charges should be filed with CIGNA before the course of treatment begins. The dentist should be sure to include the American Dental Association (ADA) procedure code for each procedure claimed. This process will inform the participant as to whether the proposed dental fee is within reasonable and customary norms (the Insurance Service has no information in this regard) and exactly how much will be reimbursed.

Dental treatment outside the United States

Participants who obtain dental treatment outside the United States may file their claims with CIGNA and are eligible for reimbursement on the same basis as a participant who visits a non-participating dentist in New York.

Maximum annual benefits

The annual benefit ceiling is $2,000 per covered person, and is the same for Option A and Option B. There is an additional lifetime allowance of $2,000 for orthodontic treatment, limited to dependent children up to 19 years of age.

CIGNA web site

Access to CIGNA's nationwide network of participating dentists is also available through the Insurance home page of the Insurance Service on the United Nations Intranet. In addition, the CIGNA dental provider directory can be accessed directly from the CIGNA Internet web site at: www.cigna.com/providerdirectory.

Benefit summaries

The benefit summaries on pages 40 and 41 highlight the many benefits which are available under the CIGNA Dental PPO plan.

How to appeal a claim

If you do not agree with the reason given for denial of your claim in whole or in part, you should write within 60 days to the CIGNA claims office. Be sure you state why you believe the claim should not have been denied and submit any data, questions or comments you think are appropriate. Your appeal will be reviewed by the office that processed your claim. Any appeal that cannot be resolved by that office will be forwarded to the company's Home Office for review and final decision. You will be notified of the final decision within 60 days of the date your appeal is received, unless there are special circumstances, in which case you will be notified within 120 days. If you are not satisfied with the final decision, and you wish to review the documents pertinent to any appealed claim, you should write to the office that processed your claim.

Benefit exclusions

The following list, while not necessarily complete, gives examples of benefit exclusions:

– Services performed solely for cosmetic reasons
– Replacement of a lost or stolen appliance
– Replacement of a bridge or denture within five years following the date of its original installation
– Replacement of a bridge or denture which can be made usable according to dental standards
– Procedures, appliances or restorations, other than full dentures, whose main purpose is to change vertical dimension, diagnose or treat conditions of TMJ, stabilize periodontally involved teeth, or restore occlusion
– Veneers of porcelain or acrylic materials on crowns or pontics on or replacing the upper and lower first, second and third molars
– Bite registrations; precision or semi-precision attachments; splinting
– Surgical implant of any type, including any prosthetic device attached to it
– Instruction for plaque control, oral hygiene and diet
– Dental services that do not meet common dental standards
– Services that are deemed to be medical services
– Services and supplies received from a hospital
– Charges which the person is not legally required to pay
– Experimental or investigational procedures and treatments
– Any injury resulting from, or in the course of, any employment for wage or profit
– Any sickness covered under any workers' compensation or similar law
– Charges in excess of the reasonable and customary allowances

OPTION A
CIGNA DENTAL PPO SUMMARY OF BENEFITS

BENEFITS[a]	IN-NETWORK[b]		OUT-OF-NETWORK[b]	
Plan Year Maximum – 1 July 2002-30 June 2003 (Class I, II and III expenses)	$2,000		$2,000	
Plan Year Deductible – 1 July 2002-30 June 2003	None		None	
Reimbursement Levels	Based on reduced contracted fees		Based on in-network reduced contracted fees	
	Plan Pays	***You Pay***	***Plan Pays***	***You Pay***
Class I – Preventive & Diagnostic Care Oral Exams (two per year) Cleanings (two per year) Full Mouth X-Rays (one complete set every three years) Bitewing X-Rays (two per year) Panoramic X-Ray (one every three years) Fluoride Application (one per year for persons under 19) Scalants (Limited to posterior tooth for a person less than 14. One treatment per tooth every three years) Space Maintainers (Limited to non-orthodontic treatment) Emergency Care to relieve pain	100%	No Charge	100% of in-network contracted fee	Remainder of dentist's fee
Class II – Basic Restorative Care[c] Fillings Root Canal therapy Osseous Surgery Periodontal Scaling and Root Planing Denture Adjustments and Repairs Extractions Oral Surgery	100%	No Charge	100% of in-network contracted fee	Remainder of dentist's fee
Class III – Major Restorative Care[c] Crowns Dentures Bridges	100%	No Charge	100% of in-network contracted fee	Remainder of dentist's fee
Class IV – Orthodontia	100%	No Charge	100% of in-network contracted fee	Remainder of dentist's fee
Lifetime Maximum (in addition to the Class I, II and III maximum)	$2,000 Dependent children up to age 19[d]		$2,000 Dependent children up to age 19[d]	

[a] Pre-treatment review (pre-determination of benefits) is strongly recommended when dental work in excess of $300 is proposed. The dentist deals directly with CIGNA in this regard.
[b] The $2,000 maximum is for the plan year, whether the provider is in-network or out-of-network, or a combination of the two.
[c] Some dental procedures involving costly materials may require additional payment by the participant to the provider.
[d] The orthodontia benefit ends on the dependent child's 19th birthday.

OPTION B
CIGNA DENTAL PPO SUMMARY OF BENEFITS

BENEFITS[a]	IN-NETWORK[b]		OUT-OF-NETWORK[b]	
Plan Year Maximum – 1 July 2002-30 June 2003 (Class I, II and III expenses)	$2,000		$2,000	
Plan Year Deductible – 1 July 2002-30 June 2003 Individual Family	None None		$50 per person $150 per family	
Reimbursement Levels	Based on reduced contracted fees		Based on Reasonable and Customary Allowances	
	Plan Pays	***You Pay***	***Plan Pays***	***You Pay***
Class I – Preventive & Diagnostic Care Oral Exams (two per year) Cleanings (two per year) Full Mouth X-Rays (one complete set every three years) Bitewing X-Rays (two per year) Panoramic X-Ray (one every three years) Fluoride Application (one per year for persons under 19) Scalants (Limited to posterior tooth for a person less than 14. One treatment per tooth every three years) Space Maintainers (Limited to non-orthodontic treatment) Emergency Care to relieve pain	100%	No Charge	90%	10%
Class II – Basic Restorative Care[c] Fillings Root Canal therapy Osseous Surgery Periodontal Scaling and Root Planing Denture Adjustments and Repairs Extractions Oral Surgery	90%	10%	80%[d]	20%[d]
Class III – Major Restorative Care[c] Crowns Dentures Bridges	90%	10%	80%[d]	20%[d]
Class IV – Orthodontia Lifetime Maximum (in addition to the Class I, II and III maximum)	80% $2,000 Dependent children up to age 19[e]	20%	70%[d] $2,000 Dependent children up to age 19[e]	30%[d]

[a] Pre-treatment review (pre-determination of benefits) is strongly recommended when dental work in excess of $300 is proposed. The dentist deals directly with CIGNA in this regard.
[b] The $2,000 maximum is for the plan year, whether the provider is in-network or out-of-network, or a combination of the two.
[c] Some dental procedures involving costly materials may require additional payment by the participant to the provider.
[d] Subject to plan year deductible.
[e] The orthodontia benefit ends on the dependent child's 19th birthday.

Annex V

World Access

World Access (formerly known as Access America) is a facility available to Aetna and Empire Blue Cross subscribers. The $0.25 per month per subscriber cost of the World Access facility is built into the premium schedule for Aetna and Empire Blue Cross set out on page 2 of the present circular.

World Access provides an international travellers' 24-hour hotline assistance programme for obtaining medical care abroad, or within the United States, when at least 100 miles from one's normal place of residence. Participants who call the hotline numbers below will, where possible, be provided with referrals from a worldwide network of physicians, dentists, hospitals, pharmacies and other medical facilities. In addition, in most cases, World Access will settle the costs of emergency foreign hospital admission and treatment. If the emergency hospitalization occurs in the United States and the hospital does not accept the Aetna or the Empire Blue Cross PPO identification cards, World Access will also settle the related costs directly with the hospital and then claim reimbursement directly from Aetna or Empire Blue Cross as the case may be. In the case of hospitalization, World Access medical staff will contact the insured patient's local physician in order to monitor the case and services being received. In the event of an emergency hospitalization in the circumstances described above, it is important that World Access be contacted upon admission to the hospital or, at the latest, before discharge. It should also be emphasized that any hospital bill paid by the participant must be sent to Aetna or Empire Blue Cross for reimbursement, as World Access does not reimburse participants directly.

The hotline numbers are:

(800) 654-1901 (in the United States, Canada, Puerto Rico and the Virgin Islands)

(804) 673-1159 — collect (from Alaska, Washington, D.C. and all other locations), or

Fax No. (804) 673-1179 or (519) 742-8553

When contacting World Access, be sure to identify yourself as a United Nations participant. Please state the World Access identification number for the United Nations, which is 2065 (for a Blue Cross enrollee) and 9211 (for an Aetna enrollee), in addition to your United Nations index number.

Annex VI

Aetna and Empire Blue Cross Plans: participating pharmacies

Aetna

The most up-to-date information regarding participating Aetna pharmacies is obtained through the Internet. Set out below is Aetna's Internet web site. In addition, if a participating pharmacy is needed while travelling, referral information is available from Aetna by calling 888-792-8742 toll-free.

www.aetna.com/docfind/index.html

Empire Blue Cross

Empire's partnership with AdvanceRX includes more than 57,000 participating pharmacies nationwide. Listed below are just some of the major participating chain pharmacies. For additional information about participating pharmacies in your area, please call 800-839-8442.

A & P	Acme Pharmacy	Arbor
Bartell Drug	Bi-Lo	Bi-Mart
Big B	Biggs Pharmacy	Bolger Pharmacy
Brooks	Brookshire's	Costco
Cub Pharmacy	CVS	Dillons
Duane Reade	Eckerd	Epic Pharmacies
Finast	Genovese	Giant
Grand Union Pharmacy	Harvest Foods	K-Mart
Kash N Karry	Keystone/Medicine Chest	Kinney Drugs
Kroger	Mays	Medicap Pharmacy
Medisave	Pathmark	Rite Aid Pharmacy
Safeway	Sav-On Pharmacy	Shopko Stores
Shoprite	Snyder Drug Stores	Stop & Shop
Target	Thrift	Tops
Twin Valu Pharmacy	United Managed Care Pharmacies	United Supermarkets
Wal-Mart	Walgreens	

Annex VII

Eligibility and enrolment rules and procedures

1. All staff members holding appointments of three months or longer (or six months or longer for dental coverage) under the 100 series of the Staff Rules whose duty station is New York and who are not enrolled in a Headquarters medical/dental insurance plan may enrol during this annual campaign. Medical insurance provisions pertaining to technical assistance project personnel are set out under staff rule 206.4. Staff members holding appointments of limited duration under the 300 series of the Staff Rules, except those who receive a fixed monthly cash amount towards the cost of health insurance, are also eligible to enrol in line with the relevant provisions of administrative instruction ST/AI/2001/2, dated 15 March 2001. Currently enrolled staff members may take the opportunity of the annual enrolment campaign to review their coverage and change from one plan to another, or change their coverage in respect of members of their family. The medical scheme applicable to staff holding appointments of less than three months under the 100 series of the Staff Rules or who hold short-term appointments under the 300 series of the Staff Rules is administered by J. Van Breda & Co. International; information regarding this insurance programme can be obtained from the Insurance Service, room S-2765.

2. For enrolment purposes, applicants will be required to present proof of eligibility from their respective personnel or administrative officers attesting to their current contractual status. Eligible family members may also be enrolled at this time, provided that evidence of the status (Personnel Action form) of such family members is presented to the Insurance Service. Interested staff members should carefully review the current status of their family's enrolment, both as to the continued eligibility of their children and/or inclusion of those newly eligible or not covered at present.

3. "Eligible family members" refers to a spouse and one or more eligible children. A spouse is always eligible. A child is eligible to be covered under this scheme until the end of the calendar year in which he or she attains the age of 25, provided that he or she is not married and not engaged in full-time employment; disabled children may be eligible for continued coverage after the age of 25.

4. Staff members, particularly those who have no coverage under a United Nations plan or through another family member, are strongly urged to obtain medical insurance coverage for themselves and their eligible family members, especially since the high cost of medical care could result in financial hardship for individuals who fall ill and/or are injured and have no such coverage.

5. **In the case of a staff member married to another staff member, the insurance coverage, whether at the two-person or family level, must be carried by the higher-salaried staff member.** It should also be noted that if one spouse retires from service with the Organization before the other spouse, the spouse who remains in active service must become the subscriber even if the retired spouse had been the subscriber up to the date of retirement and is eligible for after-service health insurance benefits following separation from service.

Enrolment between annual campaigns

6. Between annual campaigns, staff members and their family members may be allowed to enrol in the Headquarters medical and dental insurance plans only if at least one of the following events occurs and application for enrolment is made within 31 days thereafter:

(a) In respect of medical insurance coverage, upon receipt of an initial appointment of at least three months' duration at Headquarters under the 100 or 300 series of the Staff Rules or upon appointment under the 200 series of the Staff Rules;

(b) In respect of dental insurance coverage, upon receipt of an initial appointment of at least six months' duration at Headquarters under the 100 or 200 series of the Staff Rules;

(c) Upon transfer to Headquarters from another duty station;

(d) Upon return from special leave without pay, but only under the health scheme in which insured prior to taking leave (see para. 9 below);

(e) Upon assignment to a mission, under certain conditions (see para. 10 below); and/or

(f) Upon marriage, birth or legal adoption of a child for coverage of the related family member;

(g) Upon the provision of evidence that the staff member was on mission or annual or sick leave for the entire duration of the annual campaign, staff members may enrol within 31 days of their return to Headquarters.

7. In all the cases cited in paragraph 6 above, the completed application for enrolment or re-enrolment must be certified by the appropriate personnel or administrative officer and received by the Insurance Service within 31 days of the occurrence of the event giving rise to entitlement to enrol. Applications and inquiries with regard to changes relating to such events occurring between campaigns should be directed to the Insurance Service as follows:

Insurance Service
Office of Programme Planning, Budget and Accounts
Room S-2765
United Nations Headquarters
New York, NY 10017

8. **Applications between enrolment campaigns based on any other circumstances or not received within 31 days of the event giving rise to eligibility will not be receivable by the Insurance Service and will be returned.** In this regard, it should be noted that termination of health insurance coverage under a scheme not offered by the United Nations will in no case give rise to any right on the part of a staff member or family member to immediate enrolment in a United Nations plan. If such termination occurs between annual enrolment campaigns, the staff member must wait until the next campaign to enrol in a United Nations plan. Staff members who for any reason may be uncertain about the continuity of their outside coverage are urged to consider enrolling in a United Nations scheme during the present campaign.

Staff on special leave without pay

9. Staff members who are granted special leave without pay are reminded that they may retain coverage for medical and dental insurance during such periods or may elect to discontinue such coverage for the period of the special leave:

(a) *Insurance coverage maintained during special leave without pay*. If the staff member decides to retain coverage during the period of special leave without pay, the Insurance Service must be informed directly by the staff member of his or her intention at least one month in advance of the commencement of the special leave, in person if at Headquarters, or in writing if stationed away from Headquarters. At that time, the Insurance Service will require evidence of the approval of the special leave, together with payment covering the full amount of the cost of the coverage(s) retained (both the staff member's contribution as well as the Organization's share, since no subsidy is payable during such leave);

(b) *Insurance dropped while on special leave without pay*. Should a staff member decide not to retain insurance coverage(s) while on special leave without pay, no action is required upon commencement of the special leave;

(c) *Re-enrolment upon return to duty following special leave without pay*. Regardless of whether a staff member has decided to retain or drop insurance coverage(s) during a period of special leave without pay, it is essential that he or she re-enrol in the plan(s) with the Insurance Service upon return to duty, in person if at Headquarters, or in writing if away from Headquarters. This must be done **within 31 days of return to duty**. Failure to do so will mean that the staff member will be unable to resume participation in the insurance plan(s) until the next annual enrolment campaign in the month of June.

Staff members assigned on mission

10. In view of the large number of staff members who go on mission assignment, a special medical/dental plan enrolment opportunity is extended to such staff members. The provisions in this respect, which will apply to all staff members going on mission for six months or more, are as follows:

(a) Staff members who at present are not enrolled in any United Nations health insurance plan will be allowed to enrol themselves and eligible family members. The insurance will become effective on the first day of the month in which the mission assignment commences. Enrolment in a health insurance plan in these circumstances must be completed prior to the departure of the staff member on mission assignment;

(b) Staff members assigned to a mission who are enrolled in HIP, a plan which does not offer full services at locations away from Headquarters, may switch to either Aetna or Empire Blue Cross. These two plans provide benefits on a worldwide basis. Enrolment in the Aetna or Empire Blue Cross plans under this provision must be completed prior to the departure of the staff member on mission assignment;

(c) Staff members who, at the time of commencement of the mission assignment, do not have dental coverage but who are already enrolled, together with eligible family members, in Aetna or Empire Blue Cross, may enrol themselves and

family members covered under their medical insurance plan in the dental plan. Such enrolment must be completed prior to the departure of the staff member on mission assignment;

(d) Staff members who elect to enrol in a health insurance plan in the circumstances provided under subparagraphs (a) to (c) above forgo the right to make any further change during the annual enrolment campaign taking place in the same calendar year as the commencement of the mission assignment. The next opportunity for these staff members to make any change in their insurance coverage will be at the time of the annual enrolment campaign of the following year;

(e) Staff members who are already enrolled in Aetna or Empire Blue Cross at the time of the mission assignment must retain their existing coverage until the next annual enrolment campaign;

(f) Staff members who will be on mission assignment for six months or more **and who will not have eligible covered family members residing in the United States** for the duration of the mission assignment may opt for coverage under the Van Breda Medical, Hospital and Dental Insurance plan for staff overseas. Details of this plan are available in the offices of the Insurance Service, room S-2765;

(g) Staff members returning to Headquarters from mission assignment, other than those who qualified and opted for the Van Breda plan, may not change their insurance coverage until the next annual enrolment campaign. **Staff members who switched to the Van Breda plan, as provided under subparagraph (f) above, must revert, upon return to Headquarters, to the insurance plan that they had prior to the mission assignment, at least until the next annual enrolment campaign.** It is essential that such staff members advise the Insurance Service within 31 days of their return to Headquarters. **Failure to re-enrol in the prior Headquarters plan within 31 days of return to duty from mission assignment will result in suspension of health insurance coverage.**

11. **In all cases, staff members going on mission assignment who wish to enrol in a health insurance plan or change their present coverage, as provided above, must present evidence to the Insurance Service of the mission assignment and its duration.**

Annex VIII

Insurance carrier addresses and telephone numbers for claims and benefit inquiries

I. Aetna "Open Choice" Plan (medical and out-of-network pharmacy claims)

Aetna U.S. Healthcare
Unit 73
3541 Winchester Road
Allentown, PA 18195-0513

Tel.:	(800) 784-3991	Member Services (benefit/claim questions)
Tel.:	(800) 333-4432	Pre-registration of hospital/institutional services
Tel.:	(888) 792-8742	Participating pharmacy referral
Tel.:	(877) 849-5521	Express Scripts (ESI) (mail order drugs)
Tel.:	(888) 792-8742	Maintenance drug automated refills (credit card)
Tel.:	(800) 424-1601	Focused Psychiatric Review (FPR)
Tel.:	(800) 793-8616	Vision One
Tel.:	(800) 422-6600	Discount Information on Lasik Surgery

II. Empire Blue Cross PPO Plan

Empire Blue Cross Blue Shield
PPO Member Services
P.O. Box 1407
Church Street Station
New York, NY 10008-1407

Tel.:	(800) 342-9816	Member Services (benefit/claim questions)
Tel.:	(800) 982-8089	Medical Management Program (pre-certification for hospital admissions, elective surgery, home care, skilled nursing facilities, second opinion referrals)
Tel.:	(800) 626-3643	Behavioral Health Care Management Program (prior approval of mental health/substance abuse care)
Tel.:	(888) 266-5691	AdvanceRX (maintenance drug mail order)
Tel.:	(800) 839-8442	Empire Pharmacy Management Program/AdvanceRX (prescription card programme and pharmacy network information)
Tel.:	(888) 393-2583 (877) 92DAVIS	Davis Vision (vision care programme)

III. HIP

HIP Member Services Department
7 West 34th Street
New York, NY 10001

Tel.: (800) HIP-TALK
{(800) 447-8255}

IV. CIGNA Dental PPO Plan

CIGNA Healthcare Service Center
P.O. Box 188003
Chattanooga, TN 37422-8003

Tel.: (800) 355-5965 claim submission, ID card requests and customer service

Tel.: (888) DENTAL8 for participating provider referrals

V. World Access

Tel.: (800) 654-1901 (in the United States, Canada, Puerto Rico and the Virgin Islands)

Tel.: (804) 673-1159 (collect from Alaska, Washington, D.C. and all other locations)

Fax: (804) 673-1179 or (519) 742-8553