United Nations ST/IC/2012/16

Secretariat

9 July 2012

Information circular*

To: Staff members whose benefits are administered by United Nations Headquarters

From: The Controller

Subject: **Renewal of the United Nations Headquarters-administered health insurance programme, effective 1 July 2012****

Contents

	Page
General	3
Costing of United Nations insurance programmes	3
Annual campaign	4
Fraud and abuse	5
Eligibility and enrolment rules and procedures	5
Enrolment between annual campaigns	7
Staff on special leave without pay	8
Staff members assigned on mission	8
Elections for discontinuation of dental coverage	9
Address for Insurance Purposes	10
Effective commencement and termination date for health insurance coverage	10
Movement between organizations at Headquarters, breaks in appointment and movement between payrolling offices	10
Cessation of coverage of staff member and/or family members	11
Insurance enrolment resulting from loss of employment of spouse	11
After-service health insurance (ASHI)	11

* Expiration date of the present information circular: 30 June 2013.

** The present circular is being issued without formal editing.

12-41270 (E) 130712

Conversion privilege 12

Claim filing time limits 12

Claims and benefit enquiries and disputes 12

Other information 13

Accessing the websites of the Health and Life Insurance Section and of the insurance providers 13

Headquarters medical and dental insurance schedule of monthly premiums[a] and contribution rates[b] 18

Vanbreda health insurance schedule of monthly premiumsa and contribution rates[b] 19

Annexes

I. Empire Blue Cross PPO 23

II. Aetna Open Choice PPO/POS II 37

III. HIP Health Plan of New York 50

IV. CIGNA dental PPO 56

V. FrontierMEDEX Assistance Corporation 62

VI. ActiveHealth Wellness Programme 68

VII. Vanbreda Insurance Benefits Summary 72

VIII. Insurance carrier addresses and telephone numbers for claims and benefit enquiries 104

General

1. The purpose of the present circular is to provide information regarding health insurance plans administrated by UNHQ and to announce the 2012 administrative and plan changes, including premium and contribution rates changes.

2. Changes in the premium and contribution rates are effective 1 July 2012 for the health insurance programmes offered at Headquarters as follows:

a. Aetna PPO/POS II: increase of 4.89%;

b. Empire Blue Cross PPO: increase of 8.25%;

c. HIP Health Plan of New York: increase of 8.45%;

d. CIGNA Dental PPO: increase of 7.35%.

Please refer to the table on page 18 entitled "Headquarters medical and dental insurance schedule of monthly premiums and contribution rates" for more details.

3. The Health and Life Insurance Committee (HLIC) has approved a one-month premium holiday for participants of the Aetna PPO/POS II for the plan year effective 1 July 2012.

4. Effective 1 July 2011, coverage can be terminated only during the Annual Campaign except for specific qualifying events such as marriage, divorce, death, transfers, or birth/adoption of a child.

Costing of United Nations insurance programmes

5. All plans administered by United Nations Headquarters other than HIP are self-funded health benefit plans; they are not insured programmes. The cost of the programme is entirely based on the medical services provided to plan participants and directly reflects the level of utilization of the plan by its participants. The yearly contributions paid by the participants and the portion of the premium paid by participating United Nations entities are used to cover claim costs plus a fixed administrative fee per contract which represents less than 5 per cent of the total programme cost.

a. All costs of the United Nations Headquarters plans are borne by the United Nations and by plan participants through a "two-thirds to one-third" cost-sharing arrangement approved by the General Assembly.

b. All costs of the Vanbreda plan are borne by the United Nations and by plan participants through a 50:50 cost-sharing arrangement approved by the General Assembly.

6. Aetna, Empire Blue Cross, CIGNA and Vanbreda provide administrative services to the United Nations based on "administrative services only" contracts entered into by the United Nations with these carriers. These arrangements make it possible for the United Nations to use the carrier's eligibility and claim processing expertise, and benefit from discounted services that the carriers have negotiated with medical providers in their networks.

Annual campaign

7. The annual campaign is held during the month of June of each year. The staff of the Health and Life Insurance Section of the Insurance and Disbursement Service is available to provide information and answer specific questions regarding the health plans being offered to staff. Staff may send their questions or completed forms to the e-mail address or fax number indicated below. In addition, the Insurance and Disbursement Service also offers in-person client services at the location and hours indicated below.

Health and Life Insurance In-Person Client Service

Room FF-300, 304 East 45th Street, New York, New York 10017

Client service hours:	1 p.m.-4 p.m.	M, T, Th, F
	9.30 a.m.-4 p.m.	Wed

E-mail: insurance-unhq@un.org
Website: www.un.org/insurance

Tel: (212) 963 5804 — for general inquiries
Fax: (212) 963 4222

8. As was the case in prior years, representatives from the insurance carriers will be available at the above location to provide information about the various insurance plans offered. The UN Health and Life Insurance Section website (www.un.org/insurance) will provide the details regarding the representatives' schedules.

9. Staff members are reminded that the Annual Campaign is the only opportunity until June 2013 to enrol in the United Nations Headquarters insurance programmes, to change to a different plan, and/or to add eligible dependants, aside from the specific "qualifying" circumstances, such as marriage, divorce, death, transfer or birth or adoption of a child, regarding which special provisions for enrolment between campaigns are established.

10. 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 2012.

11. Staff members who switch coverage between the Aetna and Blue Cross plans and who have met the annual deductible or any portion thereof under either of these plans during the first six months of the year may be credited with such deductible payment(s) under the new plan for the second six months of the year, 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 dependant.

The deductible credit application form is available by e-mailing insurance-unhq@un.org and must be submitted to the Health and Life Insurance Section (**not to Aetna or Blue Cross**) together with the relevant EOB statements **no later than 15 December 2012** in order to receive such deductible credit.

Coordination of Benefits

12. The UN insurance programme does not reimburse the cost of services that have been, or are expected to be reimbursed under another insurance, social security or similar arrangement. For those members covered by two or more plans, the United Nations insurance programme coordinates benefits to ensure that the member receives as much coverage as possible but not in excess of expenses incurred. Members covered under the UN insurance programme are expected to advise the insurance carriers, or "Third Party Administrators" (TPA), when a claim can also be made against another insurer.

a. Aetna and Empire Blue Cross conduct coordination of benefits (COB) exercises as part of the administrative services they provide to the United Nations.

b. Empire Blue Cross conducts their own exercises by mailing out annual questionnaires to members and Aetna uses the services of The Rawlings Company to conduct its COB exercises.

c. Plan participants are required to complete and return all questionnaires sent to them by insurance carriers.

Fraud and abuse

13. Fraud or abuse of the plan by any member (i.e., active staff member or retiree and their covered family members) will result in immediate recovery of monies, and disciplinary measures in accordance with the UN Staff Regulations and Rules and other administrative directives. Such measures may include the forfeiture or suspension of participation in any health insurance plan of the Organization.

14. Fraud or abuse of the plan by any provider will be handled according to the applicable procedures of the insurance carrier and may be referred to the local authorities.

Eligibility and enrolment rules and procedures

15. All staff members holding appointments of three months or more may enrol themselves and eligible family members in the UN insurance programme. Additionally, staff members holding temporary contracts with one or more extensions which, when taken cumulatively will amount to three months or more of continuous service, can enrol themselves and eligible family members from the beginning of the contract that will meet the three-month minimum threshold.

16. Staff members holding temporary appointments of less than three months are eligible to enrol in the Vanbreda short-term medical insurance plan on an individual basis. Information regarding the insurance programme for temporary appointments of less than three months can be obtained from the Health and Life Insurance Section, Room FF-300.

17. Staff members enrolled in a plan may take the opportunity provided during the annual campaign to review their coverage and make changes from one plan to another, or change their coverage in respect of members of their family.

18. Post-retirement appointees who are covered under the UN plans in accordance with After Service Health Insurance provisions may continue such coverage until their service period requires re-entry into the United Nations Joint Staff Pension Fund as a contributing participant. The post-retirement appointee who returns to service on a temporary appointment must discontinue After Service Health Insurance coverage and enrol in the health plan as an active staff member once he or she re-enters the Pension Fund as a contributing participant. At that time the staff member may retain his level of coverage or change the level of coverage if he or she desires. After-service health insurance coverage will resume upon separation from service and reapplication within 31 days of such separation, but at the level of coverage that existed on the initial ASHI application. Failure to reapply for after-service health insurance within 31 days of separation will cause the post-retirement appointee to lose his or her eligibility for ASHI.

19. 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 (approved Personnel Action) of such family members is presented to the Health and Life Insurance Section. 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 presently covered.

20. "Eligible family members" referenced in this annex do not include family members of temporary staff with appointments of less than three months, or family members of occasional workers. "Eligible family members" refers to a recognized spouse and one or more dependent children. A spouse is always eligible. A dependent child must be the natural-born or legally adopted child of the staff member, or a stepchild reflected as a household member in the Integrated Management Information System (IMIS) of the UN, the Atlas system of UNDP, or the SAP system of UNICEF in order to be eligible. A child is eligible to be covered under this programme until the end of the calendar year in which he or she attains the age of 25 years, provided that he or she is not married and not employed full-time. Disabled children may be eligible for continued coverage after the age of 25.

21. 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.

22. 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. In the case where staff

members who are married to each other would like to maintain their own individual insurance coverage, this is permitted at the "individual only" coverage level.

Enrolment between annual campaigns

23. Between annual campaigns, staff members and their eligible 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 fixed-term or temporary appointment of at least three months' duration at Headquarters; and for temporary appointees, upon having achieved a threshold duration of continuous active employment at a minimum of half-time for at least three months;

b. In respect of dental insurance coverage, upon receipt of an initial fixed-term or temporary appointment of at least three months' duration at Headquarters;

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;

e. Upon assignment to a mission, under certain conditions;

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.

24. In all the cases cited in paragraph 23 above, the completed application for enrolment or re-enrolment must be certified by the appropriate personnel or administrative officer and received by the Insurance and Disbursement Service within 31 days of the occurrence of the event giving rise to entitlement to enrol. Applications and enquiries with regard to changes relating to such events occurring between campaigns should be directed to the Health and Life Insurance Section as follows:

Health and Life Insurance Section
Office of Programme Planning, Budget and Accounts
United Nations
E-mail: insurance-unhq@un.org

Room FF-300
304 East 45th Street
New York, NY 10017

25. 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 Health and Life Insurance Section and will be returned. Staff members who, for any reason, may be uncertain about the continuity of any outside coverage are urged to consider enrolling in a United Nations scheme during the present campaign.

Staff on special leave without pay

26. Staff members 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 Health and Life Insurance Section 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 Health and Life Insurance Section 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 (i.e., 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 Health and Life Insurance Section 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 enrolment campaign in the month of June.

Staff members assigned on mission

27. 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, Empire Blue Cross or HIP, 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 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 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 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 Vanbreda International Medical, Hospital and Dental Insurance plan for staff overseas. Details of this plan are available in annex VII of this information circular;

g. Staff members returning to Headquarters from mission assignment, other than those who qualified and opted for the Vanbreda International plan, may not change their insurance coverage until the next annual campaign. **However, staff members who switched to the Vanbreda International 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 campaign.** It is essential that such staff members advise the Health and Life Insurance Section 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.**

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

Elections for discontinuation of coverage

29. In the case where a staff member switches coverage to the Vanbreda International plan in accordance with paragraph 27 (f) above, elections to discontinue coverage will be accepted. For all other situations, the following applies:

a. A staff member with CIGNA dental coverage must continue such coverage for the entire plan year. The annual campaign is the only time that elections for discontinuation will be accepted.

b. Vanbreda, Aetna, Empire, and HIP insurance coverage can only be discontinued outside of the annual campaign by providing proof of medical insurance coverage from outside sources.

Participant's address for insurance purposes

30. It is the responsibility of each staff member of the UN, UNICEF and UNDP to ensure that his or her correct, up-to-date mailing address is stored in the IMIS, SAP, and ATLAS systems, respectively. As addresses are a part of a staff member's personnel profile, staff members should contact their personnel or executive offices in order to provide or update their address. Please be aware that the insurance carriers only recognize addresses that are electronically transmitted to them by the United Nations from the above systems. It is also essential that the address bear the United States postal abbreviation for states (e.g. New York and New Jersey must be designated as NY and NJ, respectively). Zip codes must also be part of the address. Incomplete address information will result in the insurance carriers rejecting the data transmission, as well as in misdirected mail and failure to receive important correspondence, ID cards or even benefit cheques.

Effective commencement and termination date for health insurance coverage

31. Provided that application is made within the prescribed 31-day time frame, new coverage for a staff member's enrolment in a health insurance plan commences on the first day of a qualifying contract or the first of the following month. When a contract terminates before the last day of a month, coverage will remain in place until the last day of that month.

32. Any expenditure, including those related to ongoing treatment, incurred after the expiry of coverage will not be covered by the health insurance programme.

Movement between organizations at Headquarters, breaks in appointment and movement between payrolling offices

33. It is important to note that coverage is **terminated automatically but not restored automatically** for staff members:

a. Whose contracts expire or who are separated from service; or

b. Who transfer between organizations, e.g., United Nations, UNDP, UNICEF; or

c. Who are reappointed following any or no break in employment, or following a change in employment contract/appointment; or

d. Who transfer to a different payrolling office.

34. Most individuals whose contracts end do in fact leave the United Nations common system. However, many insured staff members are reappointed or transferred, for example, between the UN, UNDP or UNICEF or between different United Nations payrolling offices. These staff members must reapply for health insurance coverage as soon as a personnel action has been generated by their employing organization. Such reapplication for health insurance coverage must be made within 31 days of the effective date of the reappointment or transfer. Strict attention to this requirement is necessary to ensure continuity of health insurance coverage because, as noted, separation from an organization and transfers between payrolling offices 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 database so that coverage can be reinstated under the receiving organization.

Cessation of coverage of staff member and/or family members

35. Staff members are required to immediately notify the Health and Life Insurance Section 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. Other than with respect to children reaching age 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 wishing to discontinue their coverage, or that of an eligible family member, must communicate the instruction to the Health and Life Insurance Section in writing. It is in the interest of staff members to notify the Health and Life Insurance Section promptly whenever changes in coverage occur, in order to benefit from any reduction in premium contribution which may result. Changes will be implemented on the first of the month following receipt of an approved written notification. **No retroactive refund of contribution can be made as a result of the staff member's failure to provide timely notification of any change to the Health and Life Insurance Section.**

Insurance enrolment resulting from loss of employment of spouse

36. Loss of coverage under a spouse's health insurance plan owing to the spouse's loss of employment beyond his or her control is considered a qualifying event for the purpose of enrolment in a United Nations Headquarters programme, provided that the staff member is otherwise eligible to participate in the programme. Application for enrolment in a United Nations plan under these circumstances must be made within 31 days of the qualifying event and must be accompanied by an official letter from the spouse's employer, certifying the termination of employment and its effective date and end date of insurance coverage and its type.

After-service health insurance (ASHI)

37. 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. Enrolment in the after-service health insurance programme is **not** automatic. Application for enrolment must be made within 31 days prior to, or immediately 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/2007/3 of 1 July 2007.

38. Beginning 1 July 2011, the United Nations Headquarters required all former staff members and dependents (including surviving spouses and eligible dependent children) who are enrolled as participants in the after-service health insurance and who qualify for participation in Medicare B to enrol in the United States Medicare B programme. Those retirees who are eligible to enrol in Medicare B but choose not to enrol will have their claims adjudicated as if they were enrolled. Full details on the requirements of the Medicare B Programme are set out in the information circular ST/IC/2011/3.

Conversion privilege

39. A “conversion” privilege is part of the United Nations group insurance programme. This privilege allows staff members (subscribers) who cease employment with the United Nations and do not qualify for after-service health insurance benefits to arrange for medical coverage under an individual contract by contacting the insurance companies directly to purchase private insurance. This provision applies to the Aetna, Empire Blue Cross Blue Shield, HIP, and Vanbreda medical plans. The CIGNA dental plan does not have a conversion option.

40. The conversion privilege means that the insurer cannot refuse to insure an applicant and that no certification of medical eligibility is required. **However, 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. The plans offered by the insurance carriers are not UN group plans; benefits and premiums will therefore be different. Please also note that the UN Health and Life Insurance Section does not handle or administer any of the insurance carriers’ private plans.** Moreover, the conversion privilege for participants enrolled in a US-based insurance plan 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.

41. Staff members may apply for a policy of individual coverage under the conversion privilege for themselves only or for themselves and their covered eligible dependants. Moreover, eligible dependants who are members of the UN insurance programme may also apply on their own for a policy under the conversion privilege. **The conversion privilege must be exercised within 31 days of the date of separation or end of coverage.**

42. Details on purchasing individual policies under Aetna, Empire Blue Cross, HIP, and Vanbreda should be obtained from the companies directly.

Claim filing time limits

43. Subscribers should note that claims for reimbursement for out-of-network utilization must be received by the plans’ administrators no later than two years from the date on which the health expense was incurred. **Claims received by Empire Blue Cross, Aetna, CIGNA, or Vanbreda, later than two years after the date on which the expense was incurred will not be eligible for reimbursement.**

Claims and benefit enquiries and disputes

44. Claims questions must be addressed directly with the insurance company concerned. In the case of disputed claims, the staff member must exhaust the appeal process with the insurance company before requesting assistance from the Health and Life Insurance Section. Addresses and relevant telephone numbers of the insurance companies are listed in annex VIII. The staff of the Health and Life Insurance Section is available to advise staff members on problematic claims issues and administrative matters concerning participation in the Headquarters insurance plans once the staff members have exhausted their various options with the insurance carriers.

45. Staff members are reminded that the plan outlines in the annexes to the present document constitute summaries of the benefits. For more detailed descriptions of the benefits in the Aetna, Blue Cross, HIP and CIGNA programmes, including most

exclusions and limitations, staff members should contact the insurance carriers. **In the event of a claim dispute, resolution of such dispute will be guided by the terms and conditions of the policy or contract in question. The final decision rests with the insurance company (in the case of HIP) or the plan administrator (in the case of Aetna, Blue Cross, CIGNA, and Vanbreda), and not with the United Nations.**

Other information

46. Except for HIP, the United Nations medical insurance and dental insurance programmes are “experience-rated”. This means the premiums each year are based on the cost of medical or dental treatment received by United Nations participants in the prior year, plus the expected effect of higher utilization and medical inflation, plus the appropriate allowance for administrative expenses. The underlying elements in the cost of health insurance for participants are therefore:

a. continuing growth in utilization of services and medications;

b. continuing increases in prices for services and medications; and

c. expenses that are incurred in high-cost health-care markets.

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 likely be moderate. The yearly premiums are calculated to meet medical expense and administration costs in the forthcoming 12-month contract period. The underlying cost of medical expenses is normally about 95 per cent of the premium, and administrative expenses make up the remaining 5 per cent. Each year the expected overall costs of the programme are first expressed as premiums and then borne collectively by the participants and by the Organization in accordance with the cost-sharing ratios set by the General Assembly.

47. The HIP plan is “community-rated”. This means HIP premiums are based on the average medical cost of all employers who purchase the same kind of coverage from HIP, and not just that of United Nations participants. The New York State Insurance Department regulates the premium rates for community-rated programmes such as HIP.

Accessing the websites of the Health and Life Insurance Section and of the insurance providers

48. The Health and Life Insurance Section Internet website can be accessed at **http://www.un.org/insurance**. Within the website, you will find information about the United Nations programmes, relevant forms and, through computer links, lists of health-care service providers that participate in the various programmes. Detailed descriptions of the Aetna, Blue Cross, CIGNA, and ActiveHealth programmes are also posted on the website. The site is intuitive and therefore easy to navigate.

49. Online resources of the insurance providers are available to search for items such as:

a. health-care providers;

b. physicians;

c. participating hospitals;

d. pharmacies;

e. prosthetics, orthotics, durable medical equipment and medical supplies vendors;

f. dentists;

g. health education;

h. covered services; and

i. replacement insurance cards.

Please refer to annex VIII, which provides the Internet address for each carrier, as well as related instructions.

Benefit Changes to US-based plan provisions between 1 July 2009 and 1 July 2012

50. The United Nations health insurance programmes are reviewed annually to ensure that benefit provisions continue to be competitive and are in line with benefits offered by other large organizations and government entities both in terms of the health insurance protection provided and in deductible and co-payment levels. After the normal consultative process within the Health and Life Insurance Committee[1] and the Joint Negotiation Committee[2] the following changes were made to the medical and dental insurance plans between 1 July 2009 and 1 July 2011:

a. Benefit Changes that went into effect 1 July 2009:

i. Office visit co-payments for in-network specialist services are increased from $15.00 to $20.00 per office visit but remain at $15.00 for in-network primary care physicians (PCP) such as family and general practitioners, pediatricians, obstetricians-gynecologists (ob-gyn), and internists;

ii. Emergency room co-payments are increased from $35.00 to $50.00;

iii. Out-of-network deductibles are increased by $50 per person and $150 per family in both Aetna and Empire Blue Cross plans;

iv. Prescription oral contraceptive and birth control devices are covered under the Empire Blue Cross plan;

v. The Aetna Open Choice PPO benefit plan was put on an Aetna Choice POS II Platform beginning 1 November 2009. This change in platform will be transparent to participants and all benefits will continue as currently offered under the PPO plan. The change in platform will enable the UN to benefit from the deepest discounts Aetna has negotiated with providers who participate in more than one of Aetna networks;

vi. Disease management and wellness initiatives were incorporated in the Aetna and Empire plans in December 2008.

---

[1] The Health and Life Insurance Committee was established in accordance with ST/SGB/275, and consists of a Chairperson and six members — three representing the staff and three representing the administration.

[2] The Joint Negotiation Committee was established in accordance with ST/SGB/2007/9, and consists of eight members — four representing the staff and four representing the administration.

b. Benefit Changes that went into effect 1 July 2010:

i. Limits were removed on outpatient visits and inpatient hospital days for mental health and substance abuse services in all medical plans;

ii. Birth control devices are covered under the Aetna plan;

iii. Dental implants are reimbursed under the CIGNA plan;

iv. Empire Blue Cross vision services are administered by Blue View Vision (Eye Med).

c. Changes effective 1 July 2011:

i. Coverage can be terminated only during Annual Campaign except for specific qualifying events such as divorce, death or transfers.

d. Changes effective 1 July 2012:

i. Reimbursements of annual routine physical exams are covered under the Aetna plan;

ii. Introduction of a progressive/regressive enhancement to the Cigna dental plan that involves an increase to the annual maximum reimbursement rate by $100 per year (up to a maximum of $300 from the current maximum amount) provided that at least one preventive care procedure (e.g., exam, prophylaxis or cleaning) is received by the plan participant. Following an increase, failure to continue receiving such preventive care in the following year will result in the reduction of the annual maximum reimbursement rate by $100. The annual maximum amount will not be reduced below the current annual maximum amount of $2,250 per participant.

51. The Health and Life Insurance Section will continue its education campaign geared towards providing information to all plan participants, to help participants make informed decisions to contain health costs while continuing to have access to high quality care. Plan participants are likewise encouraged to be knowledgeable consumers and selecting care providers from the vast number of doctors in the Aetna, CIGNA and Empire Blue Cross networks.

52. Cost containment is also available through wellness initiatives. Health improvements and cost reductions have started to become apparent as staff and retirees are using the disease management and wellness features available to Aetna and Empire Blue Cross participants through the ActiveHealth programme implemented in December 2008. Plan participants are encouraged to make full use of the ActiveHealth programme so as to obtain maximum benefits from both a health/wellness perspective and plan cost perspective. Aetna and Empire Blue Cross participants are strongly encouraged to access the ActiveHealth website and make full use of the program.

Benefit changes to the Vanbreda plan provisions

53. Vanbreda plan changes

a. Programme changes beginning 1 January 2012:

i. Increase daily room and board ceiling from $400 to $450 for admissions in countries belonging to Rate Group 2 (Chile and Mexico);

ii. Increase daily room and board ceiling from $750 to $900 for admissions in countries belonging to Rate Group 3 (Countries in Western Europe);

iii. Introduce a $200/$600 individual/family annual deductible for basic medical and major medical services received in the United States and introduce an additional $1,000/$3,000 individual/family out-of-pocket (OOP) maximum for major medical services received in the United States;

iv. Reimbursement in other currencies if the expenses were incurred in that specific currency and the currency is specifically requested on the claim form. In addition to US dollar and euro, the extended list of currencies now include Australian dollar, Canadian dollar, Swiss franc, Danish krone, Egyptian pound, Pound sterling, Hong Kong dollar, Indonesian rupiah, Jordanian dinar, Moroccan dirham, New Zealand dollar, Philippine peso, Swedish krona, Singapore dollar, Thai baht, Tunisian dinar and West African franc;

v. Note that reimbursement in a non-USD currency will be made by bank transfer only.

b. Programme changes beginning 1 January 2011:

i. Reimburse orthodontic treatments/surgeries after accidents as any other surgery under the major medical benefit plan;

ii. Increase reimbursement for hearing aid to $750 per apparatus every 36 months;

iii. Reimburse all birth control devices that require a prescription;

iv. Reimburse frames for eye glasses and increase the maximum benefit for optical care to $250 per 24 months;

v. Allow a one-year carry-over of unspent annual balance under the dental benefits of the Vanbreda plan, i.e., unspent balance for dental care on 31/12/2011 can be carried over and used in 2012;

vi. Remove reimbursement limits on specific mental health and substance abuse illnesses that are medically necessary and preauthorized by Vanbreda based on a detailed medical prescription;

vii. Reimburse immunizations for Hepatitis A, Hepatitis B, Hepatitis A+B, Yellow Fever, Tetanus (diphtheria), and Pneumococcal.

c. Programme changes beginning 1 January 2010:

i. Annual routine physical exams will be reimbursed at the rate of 100 per cent and the ceiling will be raised to $750;

ii. Education programmes that create awareness of, and lead to better management of chronic illnesses will be provided to members covered under the Vanbreda plan and reimbursed at the rate of 80 per cent;

iii. HIV/AIDS tests will be reimbursed at the rate of 100 per cent with no limit on the number of tests allowed in a plan year;

iv. The ceiling on optical coverage will be raised to $150 per plan year and lenses will be replaced when there is a change in dioptre;

v. Traditional Chinese medicine (TCM) or alternative medicine will be reimbursed under the following conditions: (a) if there is a medical condition that requires the treatment; (b) if the treatment is provided by a licensed medical doctor in the country where treatment is rendered; and (c) if the treatment is recognized as a valid treatment modality by the competent health authorities in the country of treatment;

vi. There will be no ceiling on home health care (hospitalization) services.

Headquarters medical and dental insurance schedule of monthly premiums[a] and contribution rates[b] (Effective 1 July 2012)

(Prices in United States dollars)

	Aetna Open Choice PPO/ POS II		*Empire Blue Cross PPO*		*HIP*		*CIGNA Dental PPO with Aetna, Blue Cross or HIP*		*CIGNA Dental PPO alone*
Type of coverage	*2011 rates*	*2012 rates*	*2011 rates*	*2012 rates*	*2011 rates*	*2012 rates*	*2011 rates*	*2012 rates*	*2012 rates*
Staff member only									
Premium rate (price)	872.81	915.51	563.34	609.81	669.45	726.03	57.59	61.82	61.82
Contribution rate (percentage)	4.83	4.96	3.24	3.39	4.24	4.42	0.32	0.32	0.45
Staff member and one child									
Premium rate (price)	1 741.86	1 827.09	1 123.92	1 216.66	1 222.32	1 325.71	115.19	123.65	123.65
Contribution rate (percentage)	8.43	8.66	5.74	6.00	6.48	6.76	0.56	0.56	0.79
Staff member and spouse									
Premium rate (price)	1 741.86	1 827.09	1 123.92	1 216.66	1 222.32	1 325.71	115.19	123.65	123.65
Contribution rate (percentage)	8.43	8.66	5.74	6.00	6.48	6.76	0.56	0.56	0.79
Staff member and two or more eligible family members									
Premium rate (price)	2 179.73	2 286.39	1 631.79	1 766.44	1 946.06	2 110.56	185.99	199.65	199.65
Contribution rate (percentage)	9.42	9.67	7.32	7.65	9.08	9.478	0.86	0.86	1.35

[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 (percentage) 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.

Vanbreda health insurance schedule of monthly premiums[a] and contribution rates[b]
(Effective 1 January 2012)

(Prices in United States dollars)

The schedule of premiums that became effective on 1 January 2012, as well as the related staff contribution rates, is set out in the table below.

	Monthly premium (United States dollars)		*Percentage of medical net salary*	
	Effective 1 January 2012		*Effective 1 January 2012*	
Type of coverage	*2011*	*2012*	*2011*	*2012*
Rate group 1[a]				
Staff member only	133	134	1.51	1.51
Staff member and one family member	283	286	2.33	2.33
Staff member and two or more eligible family members	467	472	3.67	3.67
Rate group 2[b]				
Staff member only	228	230	2.31	2.31
Staff member and one family member	480	485	3.73	3.73
Staff member and two or more eligible family members	793	801	5.86	5.86
Rate group 3[c]				
Staff member only	219	221	2.41	2.41
Staff member and one family member	461	466	3.88	3.88
Staff member and two or more eligible family members	760	768	6.11	6.11

[a] **Rate group 1 includes**: all locations outside of the United States of America other than those listed under rate groups 2 and 3.

[b] **Rate group 2 includes**: Chile and Mexico.

[c] **Rate group 3 includes**: Andorra, Austria, Belgium, Crete, Cyprus, Denmark, Finland, France, Germany, Greece, Iceland, Ireland, Italy, Luxembourg, Malta, the Netherlands, Norway, Portugal, Spain, Sweden, Switzerland, Turkey (European portion) and the United Kingdom of Great Britain and Northern Ireland.

Headquarters medical benefits — plan comparison chart

(A more detailed summary of benefits for each plan is contained in annexes I-III)

	In-Network			Out-of-Network	
Benefits	**HIP Health Plan of New York (In-Network Only)**	**AETNA**	**BLUE CROSS**	**AETNA**	**BLUE CROSS**
Annual Deductible	$0.00	$0.00	$0.00	Individual: $175 Family: $525	Individual: $200 Family: $600
Insurance Coverage	100%	100%	100%	80% after deductible	80% after deductible
Annual Out-of-Pocket Maximum	N/A	N/A	N/A	Individual: $1,175 Family: $3,525 (w/deductible)	Individual: $1,200 Family: $3,100 (w/deductible)
Lifetime Maximum	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited
Claim Submission	Provider files	Provider files	Provider files	You file	You file
			HOSPITAL BENEFITS		
Inpatient Pre-registration required	100%	100%	100%	100%	US: 80% after deductible Int'l: 100%
Outpatient	100%	100%	100%	100%	US: 80% after deductible Int'l: 100%
Emergency Room (initial visit)	100% Accidental injury; Sudden and serious medical condition	100% after $50 co-pay (waived if admitted within 24 hours)	100% after $50 co-pay (waived if admitted within 24 hours)	100% after $50 co-pay (waived if admitted within 24 hours)	100% after $50 co-pay (waived if admitted within 24 hours)
Emergency Room visit (for non-emergency care)	100% Urgent care covered in the United States	80%	Not covered	80% after deductible	Not covered

12-41270

MEDICAL BENEFITS					
Office/Home visits	100%	100% after $15/$20 PCP/ Specialist co-pay	100% after $15/$20 PCP/ Specialist co-pay	80% after deductible	80% after deductible
Routine Physical	100% once every 12 months	100% after $15 co-pay once every 12 months	100% after $15 co-pay once every 12 months	80% after deductible once every 12 months	80% after deductible once every 12 months
Surgery	100%	100%	100%	80% after deductible	80% after deductible
PRESCRIPTION DRUGS					
Pharmacy	$5.00 for generic/ brand per 30-day supply	20% co-pay up to $20 per 30-day supply	20% co-pay up to $20 per 30-day supply	US: 60% after deductible Int’l: 80% after deductible	US: 60% after deductible Int’l: 80% after deductible
Mail Order	$2.50 for generic/ brand per 30-day supply	100% after $15 co-pay per 90-day supply	100% after $15 co-pay per 90-day supply	N/A	N/A
BEHAVIOURAL HEALTH CARE BENEFITS (must be pre-certified; benefit maximum for in-network and out-of-network combined)					
Inpatient Mental Health Care	100%	100%	100%	100% after	80% after deductible
Outpatient Mental Health Care	100%	100%	100%	80% after deductible	80% after deductible
Inpatient Alcohol and Substance Abuse Care	100%	100%	100%	100% after	80% after deductible
Outpatient Alcohol and Substance Abuse Care	100%	100%	100%	80% after deductible	80% after deductible

VISION CARE					
Eye Exam	100% 1 exam every 12 months	100% after $20 co-pay 1 exam every 12 months	100% after $15 co-pay 1 exam every 12 months	80% 1 exam every 12 months	$40 allowance 1 exam every 12 months
Frames and Optical Lenses	$45 every 24 months for frames and lenses from select group	Save up to 65% at participating centres	$130 allowance then 20% discount on remaining balance for frames, $10 co-pay for lenses	80% up to $100 per year	$45 for frames $25/pair single vision $40/pair Bifocal lenses $55/pair Trifocal lenses (amounts listed are allowances provided by insurance)
OTHER BENEFITS					
Physical and other Inpatient Therapy	100% 90 visits	100%	100% 60 visits	80%	80% after deductible 60 visits
Physical and other Outpatient Therapy	100% 90 visits	100%	100% after $20 co-pay 60 visits	80% after deductible	80% after deductible 60 visits
Durable Medical Equipment	100%	100%	100%	80%	Not covered

Annex I: Empire Blue Cross PPO

Plan outline

The Empire Blue Cross PPO plan provides 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 out-of-network provider.

Participants can choose if they wish to go to a doctor who is in-network and pay only $15 per visit to a PCP or $20 per visit to a specialist without any further need to file a claim with Empire. Alternatively, participants may elect to receive treatment from any physician not in the network and obtain reimbursement by filing a claim with Empire, subject to the annual deductible, the normal co-insurance and subject to the providers' fees falling within the Medicare Allowable Amount (MAA).

For out-of-network services, when a participant has met the annual deductible of $200 per individual ($600 per family) and a further $1,000 in co-insurance per covered individual (limited to $2,500 per family), Empire will reimburse at 100 per cent all further covered expenses incurred in the year, subject to the requirement that they be medically necessary and the fee falls within the MAA as determined by Empire. The deductible and co-insurance requirement must be met each calendar year. There is no lifetime reimbursement limit under the Empire plan. When a participant is treated by a network physician, the $15/$20 co-payment for each PCP/Specialist visit do not count towards meeting the deductible or the out-of-pocket expense limit referred to above for out-of-network medical costs.

If a participating physician refers a patient to another provider who is non-participating, the deductible and 20 per cent co-insurance will apply to 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 advised 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 2012, overall premiums for the Blue Cross plan increased by 8.25%. The new premium rates and related percentages of salary contribution are shown in the table entitled "Headquarters medical and dental insurance schedule of monthly premiums and contribution rates".

Benefits

The benefits under the Empire Blue Cross PPO plan are summarized in this annex; please review this information carefully. It should be noted that there were no change to benefits under the Empire plan effective 1 July 2012.

Services for which precertification is required

Pre-certification of hospital and other institutional services with the Medical Management Program (telephone: **1-800-982-8089**) is required. The United Nations **staff member is responsible for calling** this number to obtain the required precertification. 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.

The Blue Cross programme imposes a benefit penalty for failure to pre-certify a service when required. Therefore it is important that you take note of the circumstances when pre-certification is required.

When to call the Medical Management Programme

c. At least two weeks prior to any planned surgery or hospital admission. This applies to ambulatory surgery as well as inpatient surgery;

d. Within 48 hours of an emergency hospital admission;

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

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

g. Prior to admission to a skilled nursing facility;

h. Prior to receiving hospice care;

i. Prior to receiving physical, occupational, speech or vision therapy;

j. Prior to receiving air ambulance service;

k. Prior to cardiac rehabilitation;

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

m. Prior to receiving magnetic resonance imaging scans, magnetic resonance angiography scans (MRI or MRA), PET/CAT scans, or nuclear cardiology scans.

With respect to mental health care and alcohol and substance abuse treatments, pre-approval must be sought directly from Empire Behavioural Health Services (**1-800-342-9816**).

Medical management penalties

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

- Inpatient 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, among other activities, assistance with bathing, eating, dressing, toileting, continence and transferring. Custodial services can be performed at home or in 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, do not provide coverage for custodial care.

Worldwide participating Blue Cross hospitals and providers

Subscribers to Empire Blue Cross health insurance plans have the benefit of a network of hospitals 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 and providers may be obtained by selecting BlueCard Worldwide from the following Internet site:

http://provider.bcbs.com

Upon accessing Blue Cross worldwide hospitals, you will obtain instructions regarding how to proceed when you need health care outside of the United States, in addition to being able to view a list of Blue Cross worldwide hospitals.

Health care outside the United States & BlueCard Worldwide Service

If you need emergency medical care, go to the nearest hospital. Call the BlueCard Worldwide Service Center at 1.800.810.BLUE (2583) or call collect at 1.804.673.1177 if you are admitted.

If you need non-emergency inpatient medical care, you must call the BlueCard Worldwide Service Center. The Service Center will facilitate hospitalization at a BlueCard Worldwide hospital or make an appointment with a doctor. It is important that you call the BlueCard Worldwide Service Center in order to obtain access for

inpatient care without pre-payment. The Service Center is staffed with multilingual representatives and is available 24 hours a day, 7 days a week.

Claims filing and payment information for health care outside the United States

In the case of inpatient care at a BlueCard Worldwide® hospital that was arranged through the BlueCard Worldwide Service Center, 1.800.810.BLUE (2583), the provider files the claim for you.

For all outpatient and professional medical care, you pay the provider and submit a claim. You may also have to pay the hospital (and submit a claim) for inpatient care obtained from a non-BlueCard Worldwide® hospital or when inpatient care was not arranged through the BlueCard Worldwide Service Center.

To submit a claim, complete an International Claim Form and send it along with itemized bills and proof of payment to the BlueCard Worldwide Service Center. The claim form must be completed fully otherwise it will be returned to you and payment will be delayed. Foreign claims should be mailed to:

BlueCard Worldwide Service Center
P.O. Box 72017
Richmond, VA 23255-2017

Claims can also be e-mailed to ihc@mondialusa.com.

EMPIRE BLUE CROSS PPO SUMMARY OF BENEFITS

BENEFITS	IN-NETWORK[a]	OUT-OF-NETWORK
ANNUAL DEDUCTIBLE Individual Family	 $0 $0	 $200 $600
INSURANCE COVERAGE **(% at which the plan pays benefits)**	100%	80%
ANNUAL OUT-OF-POCKET MAXIMUM Individual Family	$0 $0	$1,200 $3,100 (includes annual deductible; network and prescription drug co-pays do not count towards the out-of-pocket limit)
LIFETIME MAXIMUM	Unlimited	
DEPENDENT CHILDREN	Covered to end of calendar year in which child reaches age 25	
CLAIM SUBMISSION	**PROVIDER** files claims	**YOU** file claims
HOSPITAL SERVICES AND RELATED CARE COVERAGE		
Inpatient[b] - Unlimited days — semi-private room and board - Hospital-provided services - Routine nursery care	100%	80% after deductible within the United States 100% outside the United States
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	100%	80% after deductible within the United States 100% outside the United States
MANDATORY PRE-REGISTRATION[b] **(1-800-982-8089)** Refer to *"When to call the Medical Management Program"* above	**Pre-registrations are your responsibility**	**Pre-registrations are your responsibility**
(For emergency admission, call within 48 hours or next business day if admitted on weekend)		
Hospital Emergency Room[c] **(initial visit)** - Accidental injury - Sudden and serious medical condition	100% including physician's charges after $50 co-pay (waived if admitted within 24 hours)	100% including physician's charges after $50 co-pay (waived if admitted within 24 hours)
Emergency Room visit for non-emergency care is not covered		
Ambulance **Air Ambulance (transportation to nearest acute care hospital for emergency inpatient admissions)**	100% up to the allowed amount 100%	

BENEFITS	IN-NETWORK	OUT-OF-NETWORK
Home Health Care[b,d] - Up to 200 visits per calendar year - Home Infusion Therapy	 100% 100%	- 80% within the United States (deductible does not apply) - 100% outside the United States - Covered in-network only
Outpatient Kidney Dialysis Home, hospital based or free-standing facility treatment	100%	80% after deductible
Skilled Nursing Facility[b] Up to 120 days per calendar year	100%	In-network only within the United States 80% after deductible outside the United States
Hospice[b] Up to 210 days per lifetime	100%	In-network only
PHYSICIAN SERVICES AND OTHER MEDICAL BENEFITS (excluding behavioural health and substance abuse care)		
Office/Home Visits/Office Consultations	100% after $15/$20 PCP/Specialist co-pay	80% after deductible
Surgery	100%	80% after deductible
Surgical Assistant[e]	100%	80% after deductible
Anaesthesia[f]	100%	80% after deductible
Inpatient Visits/Consultations	100%	80% after deductible
Maternity Care	100% after initial visit	80% after deductible
Diagnostic X-rays	100%	80% after deductible
Lab Tests	100%	80% after deductible
Chemotherapy and Radiation Therapy Hospital outpatient or physician's office	100%	80% after deductible
MRIs/MRAs, PET/CAT scans and nuclear cardiology scans[b]	100%	80% after deductible
Cardiac Rehabilitation[b]	100% after $20 Specialist co-pay	80% after deductible
Second Surgical Opinion[g]	100% after $20 Specialist co-pay	80% after deductible
Second Medical Opinion for Cancer Diagnosis	100% after $20 Specialist co-pay	80% after deductible[h]

BENEFITS	IN-NETWORK	OUT-OF-NETWORK
Allergy Testing and Allergy Treatment	100% after $20 Specialist co-pay per office visit for testing 100% for treatment visits	80% after deductible
Prosthetic, Orthotics, Durable Medical Equipment[i]	100%	In-network only
Medical Supplies	100%	100% up to the allowed amount
PREVENTIVE CARE		
Annual Physical Exam	100% after $15 co-pay	80% after deductible
Diagnostic Screening Tests	100%	80% after deductible
Prostate Specific Antigen (PSA) Test	100%	80% after deductible
Well-woman Care	100% after $15 co-pay	80% after deductible
Mammography Screening	100%	80% after deductible
Well-child Care (including recommended immunizations)[d] - Under one year of age: 7 visits - 1-4 years old: 7 visits - 5-11 years old: 7 visits - 12-17 years old: 6 visits - 18 years-19th birthday: 2 visits	100%	100%
PHYSICAL THERAPY AND OTHER SKILLED THERAPIES		
Physical Therapy[b] - 60 inpatient visits, and - 60 visits combined in home, office or outpatient facility	 100% 100% after $20 Specialist co-pay	 80% after deductible 80% after deductible
Occupational, Speech, Vision[b] 30 visits combined in home, office or outpatient facility	100% after $20 Specialist co-pay	80% after deductible
BEHAVIOURAL HEALTH AND SUBSTANCE ABUSE SERVICES		
Inpatient Mental Health Care[j] **Outpatient Mental Health Care**[j]	100% 100%	80% after deductible 80% after deductible

BENEFITS	IN-NETWORK	OUT-OF-NETWORK
Inpatient Alcohol and Substance Abuse[j]	100%	80% after deductible
Outpatient Alcohol and Substance Abuse[j]	100%	80% after deductible
PRESCRIPTION DRUG BENEFITS		
Card Program 30-day supply (800) 373-6770	20% co-pay with $5 minimum and up to a maximum of $20 per prescription	***Within US***: 60% after deductible ***Outside US***: 80% after deductible (claim form must be filed for reimbursement) The co-insurance will not count towards $1,000/$3,000 out-of-pocket limit
Mail Order (Express Scripts) – **Facsimile: (877) 426-1097**	100% after $15 co-pay for up to a 90-day supply from participating mail order vendor	
Prescriptions for Mail Order Program — when a brand-name drug is dispensed and an equivalent generic is available, the member will pay the $15 co-pay PLUS the difference in cost between the generic and the brand-name drug UNLESS the doctor specifies the brand-name drug by writing "DAW" or "Dispense as Written" on the prescription. In that event, you pay the normal $15 co-pay only.		
VISION CARE PROGRAM		
Blue View Vision (866) 723-0515		*Out-of-network allowances*
(Eye Med in New Jersey)		
Exams (one every 12 months)	$15 co-pay per exam	$40
Frames	$130 allowance then 20% off balance	$45
Eyeglass Lenses		
Single	$10 co-pay	$25
Bifocal	$10 co-pay	$40
Trifocal	$10 co-pay	$55
Contact Lenses		
Elective Conventional	$130 allowance then 20% off balance	$105
Elective Disposable	$130 allowance then 20% off balance	$105
Non-Elective Disposal	Covered in full	$210

BENEFITS	IN-NETWORK	OUT-OF-NETWORK
OTHER HEALTH CARE		
Acupuncture	100% after $20 co-pay	80% after deductible
Chiropractic Care *$1,000 annual limit on combined in and out-of-network benefits*	100% after $20 co-pay	80% after deductible
Hearing Exam (every 3 years) **Hearing Appliance**	100% after $20 Specialist co-pay Not covered	80% after deductible Not covered

[a] In-network services (except Mental Health or Alcohol/Substance Abuse) are those from a provider that participates with Empire or another Blue Cross Blue Shield Plan through the BlueCard Program, or a participating provider with another Blue Cross Blue Shield Plan that does not have a PPO network and does accept a negotiated rate arrangement as payment-in-full.
[b] Medical Management Program must pre-approve or benefits will be reduced 50 per cent 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 members do not apply if the second surgical opinion is arranged through the Medical Management Program.
[h] If arranged through the Medical Management Program, 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 precertify.
[j] Empire Behavioural Health Services must pre-approve or benefits will be reduced 50 per cent up to $2,500. Out-of-network mental health care does not require precertification; however, outpatient alcohol and substance abuse visits must be precertified. In-network mental health services are those from providers that participate with Empire Behavioural Health Services.

Discount prescription drug programme (Empire Pharmacy Management)

The Blue Cross Empire Pharmacy Management (EPM) discount prescription drug programme is administered by Express Scripts. EPM delivers significant savings both to programme participants and to the Organization because of significant price discounts obtained from participating pharmacies. EPM provides a retail pharmacy network as well as a mail order pharmacy through Express Scripts.

Significant cost savings are passed on to participants in either a participating retail pharmacy or the mail order pharmacy. In respect of drugs obtained at participating retail pharmacies, the discounts are at least 15 per cent off the average wholesale price (AWP) of the drug.

If the physician does not write “Dispense as Written” or “DAW” on the prescription, the pharmacist will fill the prescription with a therapeutically equivalent generic drug if one is available. Discounts for generic drugs are typically higher than for brands, and the discount off the AWP may average 40 per cent or more, depending on the particular generic drug dispensed. The discount for maintenance drugs obtained through Express Scripts will range from 18 per cent to as high as 50 per cent off AWP, again depending on whether a generic equivalent to the brand-name drug is dispensed. (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 pharmacy will fill the prescription accordingly and no substitution will be made.

The procedure under which prescription drugs are reimbursed through the Express Scripts 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 VII). The pharmacist will fill the prescription for up to a 30-day supply and charge a co-insurance of 20 per cent on the discounted price of the drug. The minimum co-insurance will be the lesser of the cost of the prescription or $5 and the maximum co-insurance amount will be $20 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 filled through the Express Scripts mail order facility, which will charge a fixed $15 co-payment per 90-day prescription. The Express Scripts 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 back to you with each filled prescription. The address and telephone number of the mail order prescription drug facility is as follows:

Express Home Delivery Service
P.O. Box 66558
St. Louis, MO 63166-6558
Fax No. (866) 272-8856

It should be noted that New York State law requires pharmacists to dispense an approved generic equivalent drug instead of the brand-name drug, when the doctor does not indicate “Dispense as Written” or “DAW” on the prescription. If your doctor does not specify “DAW” when a generic drug is available, and **you request** a brand-name drug, you must pay your normal co-pay PLUS the difference between the generic drug’s allowed amount and the price of the brand-name drug.

As the prescription drug programme is administered separately by Express Scripts, 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.

Empire's partnership with Express Scripts includes more than 57,000 participating pharmacies nationwide. For additional information about participating pharmacies in your area, please call 1-800-839-8442 or visit their website www.empireblue.com.

Prescription drugs obtained outside the United States or within the United States but not through the Express Scripts will be reimbursed but you must submit a claim form to the Blue Cross claims office at the following address in order to obtain reimbursement:

ESI
Attn: STD — ACCTS
P.O. Box 66583
Saint Louis, MO 63166-6583

There is a special claim form for this purpose that you can obtain online at the insurance website or directly from Empire Blue Cross. **Claims that you submit to the Empire Pharmacy unit will be subject to the annual deductible for the medical programme, and to co-insurance.** Claims for prescription drugs dispensed outside the United States will be reimbursed at 80 per cent after the deductible is met, 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 after the deductible. In addition, the 20 or 40 per cent co-insurance that you pay for such drugs will not count towards meeting the annual co-insurance limit of $1,000.

Behavioural health and substance abuse benefits

Inpatient care for the treatment of mental and nervous conditions and substance abuse as well as in-network, outpatient treatment by a psychiatrist, clinical psychologist or psychiatric social worker requires prior approval by Empire Behavioural Health Services (1-800-342-9816).

Vision Care

A full schedule of Vision Care benefits is provided at the end of this section. Vision care benefits are provided to UN programme participants by Blue View Vision (Eye Med) under contract to Empire Blue Cross.

To find a participating Blue View Vision (Eye Med) Network provider in your area, call 866-723-0515 between 9 a.m. and 5 p.m. weekdays. When you receive eye care or eyewear from a non-participating provider, you will pay in full at the time of service then file a claim for reimbursement to:

Blue View Vision
Attn.: OON Claims
P.O. Box 8504
Mason, OH 45040-7111

The vision care benefits include an eye exam and eyewear, consisting of frames, or contact lenses once every 12 months.

Eligibility

In order to establish eligibility when you visit an Empire Blue View Vision provider, present your Empire ID card to Provider, tell provider you are a member of “Empire Blue View” and/or “EyeMed Select Network” and the provider should be able to pull up your record.

If you are using the automated programme, call customer service at (866) 723-0515, give your full medical id number, and add “00” at the end. This is the only way the automated program will recognize you. For example, if your Empire medical ID number is “123456700”, you should respond by saying or keying in “12345670000” when prompted to provide your ID number. Please note that this is not the case at the provider location, it is an issue solely with the automated customer service system which is programmed to accept 11-digit ID numbers only.

If you prefer to speak directly to a representative when you call customer service, do not make any selection when prompted and the call will automatically be transferred to a live person. There is no prompt to speak directly to a representative. The only way to reach a representative is by waiting at which time you will be transferred to a representative.

Service	*In-network*	*Out of network*
Routine eye exam (once every 12 months)	$15 co-pay	$40 allowance
Eyeglass frames (once every 12 months)	$130 allowance, then 20% off balance	$45 allowance
Standard plastic single vision lenses	$10 co-pay, then covered in full	$25 allowance
Standard plastic bifocal lenses	$10 co-pay, then covered in full	$40 allowance
Standard plastic trifocal lenses	$10 co-pay, then covered in full	$55 allowance
Eyeglass lens upgrades		
UV Coating	$15 member cost	$0
Tint (Solid and Gradient)	$15 member cost	$0
Standard Scratch-Resistance	$15 member cost	$0
Standard Polycarbonate	$40 member cost	$0
Standard Progressive	$65 member cost	$0
Standard Anti-Reflective Coating	$45 member cost	$0
Other Add-ons and Services	20% off retail price	$0
Elective conventional contact lenses	$130 allowance, then 15% off balance	$105 allowance
Elective disposable contact lenses	$130 allowance	$105 allowance
Non-Elective contact lenses	Covered in full	$210 allowance
Standard contact lens fitting	Up to $55	$0
Premium contact lens fitting	10% off retail price	$0

In addition, Blue View Vision gives members 40% off an additional pair of complete eyeglasses, 15% of the retail price of conventional contact lenses, and 20% off the retail price of eyewear accessories (some non-prescription sunglasses, lens cleaning supplies, contact lens solutions, and eyeglass cases).

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, long-term care, 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 1-800-342-9816 prior to commencement of treatment.

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 received by 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' website which permits participants to more effectively manage their coverage. The site 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
- Get personalized health information
- Request ID cards
- Research and choose doctors
- Print an explanation of benefits
- Update your address[a]

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.

[a] *Important*: If you update your address on the Empire Blue Cross site, please also request your Executive Office to update your mailing address in IMIS; otherwise, the IMIS address that the United Nations has on file will supersede your Blue Cross update in the following month.

Annex II: Aetna Open Choice PPO/POS II

Plan outline

The Aetna Open Choice PPO/Aetna Choice POS II 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 out-of-network provider.

Participants can choose if they wish to go to a doctor who is in-network and pay only $15 per visit to a PCP or $20 per visit to a specialist without any further need to file a claim with Aetna. Alternatively, participants may elect to receive treatment from any physician not in the network and obtain reimbursement by filing a claim with Aetna, subject to the annual deductible, the normal co-insurance and subject to the providers' fees falling within reasonable and customary norms.

For out-of-network services, when a participant has met the annual deductible of $175 per individual ($525 per family) and a further $1,000 in co-insurance per covered individual (limited to $3,000 per family), Aetna will reimburse at 100 per cent all further covered expenses incurred in the year, subject to the requirement that they be medically necessary and "reasonable and customary" as determined by Aetna. 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, the $15/$20 co-payment for each PCP/Specialist visit do not count towards meeting the deductible or the out-of-pocket expense limit referred to above for out-of-network medical costs.

Premiums

Effective 1 July 2012, overall premiums for the Aetna plan has increased by 4.89 per cent. The premium rates and related percentages of salary contribution are shown in the table entitled "Headquarters medical and dental insurance schedule of monthly premiums and contribution rates".

Benefits

The benefits under the Aetna Open Choice PPO/POS II plan are summarized in this annex; please review this information carefully. It should be noted that effective 1 July 2012, routine physical examinations will now be covered once every 12 months at 100 per cent after the $15 co-pay for members over the age of 19 if provided within network, and at 80 per cent after meeting the annual deductible if provided out of network.

Participants are reminded of the following 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, among others, assistance with bathing, eating, dressing, toileting, continence and transferring. Such services can be performed at home or in 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 programmes, including the Aetna Open Choice PPO/POS II, provide no coverage for custodial care.

Pre-registration of hospital and other institutional services. Members are requested to advise Aetna of any inpatient 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 is attached) is a constructive one, namely that pre-registration assures the patient that (a) all related hospital expenses will be covered under the plan, and most importantly, that (b) the confinement 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 Aetna for pre-registration of hospital admissions and the other services is: 1-800-333-4432. The corresponding number for Aetna International is 1-800-231-7729 or 1-813-775-0190 (call collect from outside USA). For an emergency admission, you are requested to 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.

Out-of-network prescription drug reimbursement. Participants are reminded that out-of-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. In this case also, the co-insurance will not count towards fulfilment of the annual $1,000 out-of-pocket limit.

Network of pharmacies. Aetna’s overall network consists of more than 52,000 neighbourhood pharmacies, including but not limited to all national pharmacy chains, and most regional pharmacy chains. The most up-to-date information regarding participating Aetna pharmacies is obtained through the Internet. Set out below is Aetna’s Internet website. In addition, if a participating pharmacy is needed while travelling, referral information is available from Aetna by calling 1-800-784-3991 toll-free or http://www.aetna.com/docfind/index.html.

Aetna International

Aetna International provides claim services for active and retired staff who meet the following eligibility requirements:

a. Participate in the Aetna Medical programme, and

b. Have an established principal residence outside the United States or

c. Are on mission assignment of six months or more outside the United States.

The Aetna International services are fully described in ST/IC/2005/55. Instructions for filing claims and obtaining reimbursement for covered expenses are also included in that information circular. Claim forms can be obtained in English, Arabic, Portuguese, Spanish, Chinese, Japanese, French, German and Italian.

Aetna members who are eligible for Aetna International services are automatically issued the Aetna International ID card and have toll-free access to Aetna's Tampa, Florida service center 24 hours a day, 7 days a week, 365 days a year. The Tampa service center is solely dedicated to serving programme participants who reside outside of the United States. It is staffed by Aetna personnel who are knowledgeable of international health care, including multiple language capability on-site.

The Aetna International ID cards contain a logo identifying the holder of the card to hospitals outside the U.S. with which Aetna has negotiated direct-payment arrangements and, in many cases, discounted prices. There are presently more than 700 such hospitals and the contracted hospitals in each country and city can be found at the Aetna International website (www.aetnainternational.com).

Aetna International is an Aetna subsidiary. The services provided by Aetna International are administrative only. There is no effect on your, or your family's, benefits or contributions as participants in the Aetna programme, or on "in-network" (from a provider on Aetna's list) or "out-of-network" (from a provider not on Aetna's list) reimbursements.

AETNA OPEN CHOICE PPO/POS II SUMMARY OF BENEFITS

BENEFITS	IN-NETWORK	OUT-OF-NETWORK
ANNUAL DEDUCTIBLE		
Individual	$0	$175
Family	$0	$525
INSURANCE COVERAGE (% at which the plan pays benefits)	100% except where noted	100% Hospital; 80% all other, except where noted
ANNUAL OUT-OF-POCKET MAXIMUM		
Individual	$0	$1,175
Family	$0	$3,525 (includes annual deductible; network and prescription drug co-pays do not count towards the out-of-pocket limit)
LIFETIME MAXIMUM	Unlimited	Unlimited
DEPENDENT CHILDREN	Covered to end of calendar year in which child reaches age 25	
CLAIM SUBMISSION	**PROVIDER** files claims	**YOU** file claims
HOSPITAL SERVICES AND RELATED CARE COVERAGE		
Inpatient coverage	100%	
Outpatient coverage	100%	
MANDATORY PRE-REGISTRATION (1-800-333-4432) Applies to inpatient hospital, skilled nursing facility, home health care, hospice care and private duty nursing care	**Provider is responsible**	**You or provider are 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 $50 co-pay (waived if admitted within 24 hours)	100% including physician's charges after $50 co-pay (waived if admitted within 24 hours)
Hospital Emergency Room For non-emergency care (examples of conditions: skin rash, earache, 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 for restorative care as determined by medical necessity.	
Private Duty Nursing (in-home only)	100% subject to yearly limits of $5,000 and 70 "shifts" as well as $10,000 lifetime. Must be determined to be medically necessary and supported by a doctor's prescription/medical report. Precertification 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. Precertification is strongly recommended.	

BENEFITS	IN-NETWORK	OUT-OF-NETWORK
Hospice (210 days) Plus 5 days bereavement counselling	100%, deductible does not apply.	
PHYSICIAN SERVICES		
Office Visits For treatment of illness or injury (non-surgical)	100% after $15/$20 PCP/Specialist co-pay	80% after deductible
Maternity (includes voluntary sterilization and voluntary abortion, see Family Planning)	100% after $15 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%	100% after deductible
Anaesthesia	100% (if participating hospital)	80% after deductible
Allergy Testing and Treatment (given by a physician)	100% after $20 Specialist 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 12 months - Age 65+: one routine exam every 12 months	100% after $15 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 $15 co-pay	80% after deductible
Family Planning - Office visits including tests and counselling - Surgical sterilization procedures for vasectomy/tubal ligation (excludes reversals)	100% after $20 Specialist 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.) Limited to 6 treatments per lifetime.	100% after $20 Specialist co-pay 100%	80% after deductible 80% after deductible
Routine Mammogram (no age limit)	100%	80% after deductible 100% if performed on an inpatient basis or in the outpatient department of a hospital
Annual Urological exam by Urologist	100%	80% after deductible
BEHAVIOURAL HEALTH AND SUBSTANCE ABUSE SERVICES		
MENTAL HEALTH INPATIENT SERVICES (1-800-424-1601) **Inpatient Coverage**	100%	100% after deductible
These services are provided by Aetna Behavioural Health. Pre-registration of inpatient confinements is required. For in-network services, the network provider is responsible for pre-registration. For non-network inpatient services, either the physician or the participant must pre-register the confinement.		
Outpatient Coverage	100%	80% after deductible
For Out of Network Outpatient Behavioural Health and Substance Abuse Benefits the patient coinsurance does not count towards meeting the annual out of pocket limits.		
Crisis Intervention	100%	80% after deductible
ALCOHOL/DRUG ABUSE **Inpatient Coverage**	100%	100% after deductible
Outpatient Coverage	100%	80% after deductible
PRESCRIPTION DRUG BENEFITS		
Aetna Retail Rx (1-800-784-3991) **Aetna International Retail Rx (1-800-231-7729)** **Retail means regular 30-day supplies**	20% co-pay with minimum of $5 and up to a maximum of $20 per prescription	*Within US*: 60% after deductible *Outside US*: 80% after deductible The co-insurance will not count towards $1,000/$3,000 out-of-pocket limit
Aetna Mail Order Rx (1-866-612-3862) **Aetna International Mail Order Rx (1-800-231-7729)** **Mail Order means 90-day supply**	100% after $15 co-pay for up to a 90-day supply from participating mail order vendor	
Prescriptions for Mail Order Program — when a brand-name drug is dispensed and an equivalent generic is available, the member will pay the $15 co-pay PLUS the difference in cost between the generic and the brand-name drug UNLESS the doctor specifies the brand-name drug by writing "DAW" or "Dispense as Written" on the prescription. In that event, you pay the normal $15 co-pay only.		

BENEFITS	IN-NETWORK	OUT-OF-NETWORK
VISION AND HEARING CARE		
Eye Exam (once every 12 months)	100%	80%, deductible does not apply
Optical Lenses (including contact lenses once every 12 months)	$100 maximum for any two lenses and frames purchased in a 12-month period.	
Aetna Vision Discount Program (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 EyeMed Centers. Discounts available for laser surgery.	
Hearing Exam Evaluation and Audiometric exam	100% after $20 co-pay (one exam every three years; exam must be performed by otolaryngologist or state certified audiologist)	80% after deductible (one exam, limited to $100 reimbursement 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		
Physical and Occupational Therapy	100%	80% after deductible
Laboratory Tests, Diagnostic X-rays	100%	80% after deductible
Speech Therapy	80% after deductible for out-of-network services (where services are rendered by a participating provider, 100% reimbursement applies after $20 co-pay)	
Outpatient Diabetic Self-Management Education Program	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 $20 specialist 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	100% after $20 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 $20 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 is covered once every 12 months at 100 per cent, if carried out by a network provider, and at 80 per cent without a deductible if carried out by an out-of-network provider.

Aetna Vision Discount eye care discount programme

The Aetna Vision Discount Programme offers subscribers and covered family members immediate discounts on eye care needs, including frames, lenses and contact lenses. The Aetna Vision Discount Programme is available at over 13,000 locations nationwide, and includes Lenscrafters, Target Optical, and most of the Sears and Pearle Vision Centers, as well as selected independent providers/offices. JCPenney and Montgomery Ward no longer participate in the Aetna Vision Discount Programme.

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 Aetna Vision Discount at (800) 793-8616, weekdays from 9 a.m. to 9 p.m. and Saturdays from 9 a.m. to 5 p.m. Aetna Vision Discount providers can also be found on the Internet at www.aetna.com/docfind/index.html and click on "Aetna Vision Discount Providers". A schedule of costs and typical savings is set out below.

Benefits	*Aetna Vision Discount Discounted Fee*
Frames	
Priced up to $60.99 retail	40 per cent off retail
Priced from $61.00 to $80.99 retail	40 per cent off retail
Priced from $81.00 to $100.99 retail	40 per cent off retail
Priced from $101.00 and up	40 per cent off retail
Lenses — per pair (uncoated plastic)	
Single vision	$40.00
Bifocal	$60.00
Trifocal	$80.00
Standard progressive (no-line bifocal)	$120.00
Lens options — per pair (add to lens prices above)	
Polycarbonate	$40.00
Scratch-resistant coating	$15.00

12-41270

Benefits	*Aetna Vision Discount Discounted Fee*
Ultraviolet coating	$15.00
Solid or gradient tint	$15.00
Glass	20 per cent off retail
Photochromic	20 per cent off retail
Anti-reflective coating	$45.00

Eye examinations (by licensed independent doctors of optometry)

Eyeglasses — $42.00

Standard contact lenses — $40 (plus a $42.00 exam fee)

Specialty contact lenses — $10 off normal fee (plus $42 exam fee)

Contact lenses (two ways to save on contact lenses)

1. Visit the more than 2,500 locations nationwide and save 15 per cent discount from regular retail prices.

2. Use the Aetna Vision Discount Contact Lens Replacement Program for additional savings and convenience.

   Call (800) 391-5367 for this service.

Aetna Vision Discount 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 through the US Laser Network. The US Laser Network offers 470 locations nationwide compared with less than 300 through the prior service vendor. 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. You must contact the US Laser Network first, before contacting a provider to receive the discounted fee.

2. To find the closest surgeon, participants may call 1-800-793-8616 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 same number given above, 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.

Behavioural health and substance abuse benefits

A. Inpatient focused psychiatric review

All hospitalizations for behavioural health and substance abuse conditions are subject to review by Aetna Behavioural Health. **Staff members are assured that the Aetna Behavioural Health programme is conducted in the strictest confidence.** The procedure is as follows:

Prior to a non-emergency hospital admission, Aetna should be informed of the intended admission. This is accomplished by placing a telephone call to a special toll-free Aetna number (800-424-1601) that connects directly to Aetna Behavioural Health. 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 precertify 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 Aetna Behavioural Health 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 Aetna Behavioural Health specialist certifies a certain number of inpatient days, if appropriate, and develops a plan of regular follow-up visits with the attending physician.

An emergency admission, which cannot be precertified before the confinement begins, must be called in to the Aetna Behavioural Health number within 48 hours of the emergency admission.

Aetna Pharmacy Management — discount prescription drug programme

The Aetna Pharmacy Management prescription drug programme (APM) is administered by Aetna. APM delivers significant savings both to programme participants and to the Organization because of significant price discounts obtained from participating pharmacies. APM provides the retail pharmacy network as well as Aetna's proprietary mail order pharmacy, Aetna Rx Home Delivery.

Cost savings are passed on to participants in either a participating retail pharmacy or the mail order pharmacy. In respect of drugs obtained at participating retail pharmacies, the discounts are at least 15 per cent off the average wholesale price (AWP) of the drug.

If the physician does not write "Dispense as Written" or "DAW" on the prescription, the pharmacist will fill the prescription with a therapeutically equivalent generic drug if one is available. Discounts for generic drugs are typically higher than for brands, and the discount off the AWP may average 40 per cent or more, depending on the particular generic drug dispensed.

The discount for maintenance drugs obtained by mail through Aetna Rx Home Delivery ranges from 18 per cent to as high as 50 per cent off AWP, depending on whether a generic equivalent to the brand-name drug is dispensed. (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 pharmacy 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 20 per cent based upon the discounted price of the drug. The minimum co-insurance will be the lesser of the cost of the prescription or $5 and the maximum co-insurance amount will never be more than $20 per prescription. No claim form is required for prescriptions filled at participating pharmacies.

Aetna Rx Home Delivery — Aetna's mail order service

To obtain prescription drugs through Aetna Rx Home Delivery, first ask your physician for a 90-day prescription with up to three refills for each of the medications that you take regularly. Then, complete and mail the Aetna Rx Home Delivery order form together with your original prescription and $15 co-pay, to the address on the order form (do NOT send cash). The order form is submitted with your **first prescription only**. Order forms can be obtained from the Health and Life Insurance Section website at www.un.org/insurance or http://intranet/Insurance under "Forms and Circulars", or from the Aetna website at http://www.aetnarxhomedelivery.com. Aetna Member Service will also mail or fax you a form if you do not have Internet access.

Your prescriptions will be filled and mailed in a secure package to the address you supply on the order form, within 7 to 10 days after the order is received by Aetna.

Obtaining refills is also easy. Each time you receive medications by mail, you will receive a receipt that indicates when you can request a refill. You can request the next refill by phone (1-866-612-3862) or by using the Internet, at www.aetnarxhomedelivery.com/ or, if you prefer, you may use the reorder form that Aetna also encloses in the package with each filled prescription. If you wish to use the Internet, you first need to register on the Aetna Rx Home Delivery Internet site. Registration must be done only once. Please take note that most prescriptions, including refills, expire in one year and sometimes sooner. After the expiration date, you must obtain a new prescription from your doctor and send it to Aetna Rx Home Delivery, even if the old prescription still shows refills remaining.

The cost to you for using Aetna Rx Home Delivery is only $15 per 90-day prescription, as opposed to a possible $60 if filled at a retail pharmacy (based on retail co-pay of $20 per 30-day prescription).

Please also note that Aetna Rx Home Delivery will fill the prescription with a United States-approved generic equivalent, unless the physician has written "Dispense as Written" or "DAW" on the prescription. If the prescription includes this notation from the physician, the prescription will be filled accordingly and you will be charged only the $15 co-pay. If the prescription does not include this notation from the physician, and **you request** a brand-name drug, then you will be

charged the $15 co-pay PLUS the difference in price between the brand-name drug and the generic drug.

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, prescription drug co-payment expenses will **not** count towards meeting the annual co-insurance limit of $1,000 per individual. **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 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 address. 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. When you are submitting pharmacy bills yourself for reimbursement, it will help speed processing if you include a copy of the pharmacy receipts whenever possible.

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 temporomandibular joint syndrome (TMJ). Participants are advised to consult the Aetna Member Service in advance of commencing treatment for these conditions.

Certain expenses are not covered under the Aetna plan. These are expenses for services or supplies not deemed by Aetna's physician staff as being necessary, reasonable and customary or not recommended by your attending physician. There are also certain exclusions and limitations under the plan. For example, long-term care, 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 1-800-784-3991 prior to commencement of treatment. In addition, you may consult the detailed plan description that is posted to the Insurance website.

Where to submit claims

The addresses to which claim forms should be sent are as follows:

Aetna PPO/POS II

Aetna Inc.
P.O. Box 981106
El Paso, TX 79998-1106

Aetna International PPO

Aetna International®
P.O. Box 981543
El Paso, TX 79998-1543 USA

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 to Aetna within 180 days of

receipt of the notice. The subscriber should include the reasons for requesting the review. The addresses for submitting appeals are:

Aetna PPO/POS II

National Accounts Member Appeals-CRT
Aetna, Inc.
P.O. Box 14463
Lexington, KY 40512

Aetna International PPO

Aetna International
P.O. Box 981543
El Paso, TX 79998-1543

Aetna or Aetna International as the case may be will review the claim and will normally notify the subscriber of its decision within 30 days of receipt of the request. If special circumstances require more time, notice will be given to that effect.

Time limit for filing claims

Subscribers should note that claims for reimbursement must be received by 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.**

Aetna's Navigator™ Internet site

Subscribers in the Aetna plan are encouraged to activate an account on Aetna's Navigator™ website which permits participants to more effectively manage their coverage. The site can be accessed through a link at Aetna's website at www.aetna.com, or directly at http://www.aetnanavigator.com/.

Aetna's Navigator™ is a self-service website packed with valuable health and benefits information. Subscribers can:

- Review who is covered under their plan
- Check claim status and review Explanation of Benefits (EOB) statements
- Locate doctors and hospitals using Aetna Docfind
- Look up the estimated cost of common medical (and dental) procedures in the area where you live, before the service is performed
- Research the price of a drug and learn if there are less-costly alternatives
- Request ID cards
- Contact Aetna Member Services

To register, go to www.aetna.com and click on Aetna Navigator™ in the "Quick Tools" drop-down box, or access Aetna Navigator™ directly at http://www.aetnanavigator.com/. Members can follow easy instructions for registering to use personal tools. Members and non-members can "point and click" on Docfind to search for doctors and other health-care providers. Important note: Aetna Navigator registration IDs require a United States Social Security format which is xxx-xx-xxxx (3 digits, then 2 digits, then 4 digits). When entering your United Nations index number, be sure to "prefill" your index number with zeroes in order to satisfy this format.

Annex III: HIP Health Plan of New York

Plan outline

The HIP plan is an HMO, and 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 worldwide emergency treatment obtained outside the covered area are included in the plan coverage. In addition, 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 31,000 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 except no referral form is needed for OB/GYN appointments and in certain other instances. (See plan summary.) To select an affiliated physician, the HIP participant should call HIP at (800) HIP-TALK, go to the website at www.HIPUSA.com or call the physician you wish to visit. The website is available in Spanish, Chinese and Korean. Any language may also be accessed through 1-800-HIP-TALK. Additional information regarding HIP providers will be provided to participants during the annual campaign and also mailed by HIP to all participants upon request.

Premium

Effective 1 July 2011, premiums for the HIP plan will increase by 8.45 per cent. The new premium rates and related percentages of salary contribution are shown in the table entitled “Headquarters medical and dental insurance schedule of monthly premiums and contribution rates”. More information is provided in paragraph 30.

Benefits

Effective 1 July 2011, there will be no limits on outpatient visits and inpatient hospital days for mental health and substance abuse services under the HIP plan. The benefits under the HIP plan are itemized in this annex; please review this information carefully.

Worldwide emergency care

Participants are covered 100 per cent for emergency treatment anywhere in the world. The member needs to call his primary care physician. In some cases air transport would also be covered to return to New York.

HIP participating pharmacies

Many national chains participate with HIP as well as many smaller pharmacies. These include: A&P; Acme Pharmacy; Brooks; CVS; Eckerd; Duane Reade; Genovese; Kmart; King Kullen; Pathmark; Revco; Rite Aid; Sav-On Pharmacy; Stop & Shop; Walgreens; Waldbaum’s. More information can be found through http://www.HIPUSA.com or through 1-800-HIP-TALK.

Discount prescription drug programme

Prescriptions for maintenance drugs are $2.50 per month through Medco Health Solutions Mail Order Service (www.medco.com). Up to a 90-day supply can be requested. Once you have an account at Medco Health Solutions, your physician may call to reorder or place another maintenance prescription order. The address and telephone number are:

Medco Health Solutions
P.O. Box 30496
Tampa, FL 33630-3496

Telephone: 1-800-473-3455 (Press 0 to speak with a representative)

Vision care

Participants are covered 100 per cent for a routine annual eye examination at affiliated optometrists. Prescription lenses and frames from a select group cost $45 and are available every 24 months. Participants are not required to purchase the eyewear from the same provider rendering the eye examination. Lasik surgery discounts are available through Davis Vision.

Dental

Participants are able to have cleanings every six months for a $10 co-payment. Children 16 and under additionally may receive fluoride treatment for a $5 co-payment. All other services are covered based on a discounted fee schedule. The fee schedule is available with member information or by consulting the HIPUSA.com website.

Additional services, including but not limited to x-rays, fillings, crowns or dentures, will be provided at a discounted rate subject to a fee schedule which may change from time to time. There are several schedules of services based on the geographic location of the provider's office. Therefore, members will pay different fees based on the location of the dentist's office. Specialist dental services, such as endodontic, oral and maxillofacial surgery, orthodontic, paediatrics, periodontic, and prosthodontic procedures are also available from participating dentists. Charges for specialist services are discounted by 20 per cent off the dentist's usual and customary rates. No schedule of services applies to specialist dental services. Both general and specialist dental services may be self-referred or referred by a participating dentist.

HIP Internet site

Subscribers in the HIP plan are encouraged to activate an account on the HIP website which permits participants to more effectively manage their coverage. The site is: www.HIPUSA.com. Participants can access their benefits and perform the following tasks:

- Request an ID card
- Change primary care physician
- Change phone number and address
- Research physicians/hospitals

- View alternative medicine providers (chiropractors, acupuncturists, etc.)
- View and print drug formulary
- Sign up as a member and view benefits and claims online
- Review procedure to receive prescription, if not on the formulary
- See Fitness Center locations and discounts
- Website available in: Spanish, Chinese and Korean

HIP HEALTH PLAN OF NEW YORK SUMMARY OF BENEFITS	
BENEFITS	**COVERAGE**
HOSPITAL SERVICES AND RELATED CARE	
Inpatient - Unlimited days — semi-private room & board - Hospital-provided services - Routine nursing care	100%
Outpatient - Surgery and ambulatory surgery - Pre-surgical testing (performed within 7 days of scheduled surgery) - Chemotherapy & radiation therapy - Mammography screening and cervical cancer screening	100%
Emergency Room/Facility (initial visit) - Accidental injury - Sudden and serious medical condition	100%
Ambulance	100%
Home Health Care - Up to 200 visits per calendar year - Home Infusion Therapy	100% 100%
Outpatient Kidney Dialysis Home, hospital-based or free-standing facility treatment	100% after $10 co-pay
Skilled Nursing Facility Unlimited days per calendar year	100%
Hospice Up to 210 days per lifetime	100%

BENEFITS	COVERAGE
PHYSICIAN SERVICES	
Office or Home Visits/Office Consultations	100%
Surgery	100%
Surgical Assistant	100%
Anaesthesia	100%
Inpatient Visits/Consultations	100%
Maternity Care	100%
Artificial Insemination/Unlimited Procedures based on NY State Mandate.	100%
Diagnostic X-Rays, MRI, CAT scans	100%
Lab Tests	100%
Inpatient Hospital Private Duty Nursing	100%
Cardiac Rehabilitation	100%
Second Surgical Opinion	100%
Second Medical Opinion for Cancer Diagnosis	100%
Allergy Testing and Allergy Treatment	100%
Prosthetic, Orthotic and Durable Medical Equipment	100%
Medical Supplies	100%
PREVENTIVE CARE	
Annual Physical Exam	100%
Diagnostic Screening Test	100%
Prostate Specific Antigen (PSA) Test	100%
Well-woman Care (no referral needed)	100%
Mammography Screening/Pap Smears	100%
Well-child Care (including recommended immunizations) - 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	100%

BENEFITS	COVERAGE
PHYSICAL THERAPY AND OTHER SKILLED THERAPIES	
Physical Therapy Up to 90 inpatient days per calendar year **Physical Therapy (Benefit combined with occupational, respiratory and speech)** - 90 inpatient visits - 90 outpatient visits	 100% 100% 100%
Occupational, Respiratory, Speech (Benefit combined with physical therapy) - 90 inpatient visits - 90 outpatient visits	 100% 100%
BEHAVIOURAL HEALTH AND SUBSTANCE ABUSE SERVICES	
Mental Health Care	100%
Outpatient Alcohol and Substance Abuse	100%
Inpatient Alcohol and Substance Abuse/Rehab	100%
PRESCRIPTION DRUG BENEFITS	
Pharmacy	100% after $5 co-pay for generic/brand, 30-day supply
Mail Order Program	100% after $2.50 co-pay for generic/brand, 30-day supply
VISION CARE PROGRAM	
Through a designated group of providers	100% for 1 exam every 12 months 100% after $45 co-pay for frames and lenses from a select group every 24 months
OTHER HEALTH CARE	
Acupuncture/Yoga/Massage	Discounted rates
Chiropractic Care (no referral needed)	100%

Annex IV: CIGNA Dental PPO

Plan outline

The dental PPO programme offers a large network of participating providers in the Greater New York Metropolitan area and nationally. A dental PPO functions like a medical PPO: the network of dentists who participate in the CIGNA dental PPO plan accept as payment a fee schedule negotiated with CIGNA. When covered services are rendered by an in-network provider, CIGNA reimburses the dentist according to the schedule and the participant normally has no out-of-pocket expense.

One may also choose a dentist who is not a participating practitioner in the CIGNA plan. Covered dental services rendered by out-of-network providers are reimbursed as a percentage of reasonable and customary allowances as follows:

- Diagnostic & Preventive Care: 90% after the deductible;
- Restorative Care: 80% after the deductible;
- Major Services: 80% after the deductible
- Orthodontic care for children under age 19: 70% after the deductible.

CIGNA Dental Members enrolled in the DPPO can now receive discounts from DPPO network dentists on most non-covered services when they exceed their annual maximums and other plan limitations. Members must receive care from CIGNA in-network DPPO providers. Claims will be processed utilizing CIGNA's standard operating procedures and reimbursement will be based on the provider's contracted fee instead of usual, customary and reasonable fees. The member will then pay the provider the contracted fee. **Providers are not allowed to balance bill members beyond their CIGNA dental PPO contracted fees.**

Premium

Effective 1 July 2012, overall premiums for the CIGNA dental plan increased by 7.35 per cent. The premium rates and related percentages of salary contribution are shown in the table entitled "Headquarters medical and dental insurance schedule of monthly premiums and contribution rates".

Benefits

Effective 1 July 2012, a plan enhancement called "Progressive Regressive Maximum" programme will be introduced. Members will have an opportunity to increase their per participant per year (1 July through 30 June) maximum by receiving a Class I Preventive Service each year. For each year a member receives a Class I Preventive Service, the annual maximum will increase in increments of $100 at the next policy year. If a member does not receive consistent Class I Preventive Services each year, they will regress to the prior year's annual maximum. However, the annual maximum will not be less than the base maximum of $2,250. The maximum for orthodontic services are subject to a separate, lifetime maximum of $2,250.

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, it is recommended that you ask your dentist to file with CIGNA a description of the procedures to be performed and an estimate of the charges before the course of treatment begins. The dentist should include the American Dental Association procedure code for each procedure. This process will inform the participant as to exactly how much will be reimbursed. Please note the Health and Life Insurance Section has no information in regard to reasonable and customary charge norms.

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 the United States.

CIGNA website

Access to CIGNA's nationwide network of participating dentists is available through the Insurance home page of the Health and Life Insurance Section on the United Nations Intranet. In addition, the CIGNA dental provider directory can be accessed directly from the CIGNA Internet website at: http://www.cigna.com/. To find a dentist, go to www.cigna.com, Click "Find a Doctor". This will bring you to "Health Care Professionals Directory". Click "Dentist" and complete the remaining fields to begin your search.

Summary of benefits

The CIGNA dental PPO summary of benefits is found in the chart below.

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:

CIGNA Dental Appeals
P.O. Box 188044
Chattanooga, TN 37422

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 Limitations

Exams	Three per Plan year
Prophylaxis (Cleanings)	Three per Plan year (plus two periodontal cleanings)
Fluoride	1 per Plan year for people under 19
Histopathologic Exams	Various limits per Plan year depending on specific test
X-Rays (routine)	Bitewings: 3 per Plan year
X-Rays (non-routine)	Full mouth: 1 every 36 consecutive months. Panorex: 1 every 36 consecutive months
Model	Payable only when in conjunction with Ortho workup and extensive Perio treatment
Minor Perio (non-surgical)	Various limitations depending on the service
Perio Surgery	Various limitations depending on the service
Crowns and Inlays	Replacement every 5 years
Bridges	Replacement every 5 years
Dentures and Partials	Replacement every 5 years
Relines, Rebases	Covered if more than 6 months after installation
Adjustments	Covered if more than 6 months after installation
Repairs — Bridges	Reviewed if more than once
Repairs — Dentures	Reviewed if more than once
Sealants	Limited to posterior tooth, under age 14. One treatment per tooth every three years
Space Maintainers	Limited to non-Orthodontic treatment
Prosthesis Over Implant	One per 60 consecutive months is unserviceable and cannot be repaired. Benefits are based on the amount payable for non-precious metals. No porcelain or white/tooth colored material on molar crowns or bridges
Alternate Benefit	When more than one covered Dental Service could provide suitable treatment based on common dental standards, CG will determine the covered Dental Service on which payment will be based and the expenses that will be included as Covered Expenses

Benefit Exclusions

- Services performed primarily 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 accepted 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
- 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

- Charges made by a hospital which performs services for the U.S. Government if the charges are directly related to a condition connected to a military service
- 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
- To the extent that payment is unlawful where the person resides when the expenses are incurred
- Procedures performed by a Dentist who is a member of the covered person's family (covered person's family is limited to a spouse, siblings, parents, children, grandparents, and the spouse's siblings and parents)
- For charges which would not have been made if the person had no insurance
- For charges for unnecessary care, treatment or surgery
- To the extent that you or any of your Dependents is in any way paid or entitled to payment for those expenses by or through a public program, other than Medicaid
- To the extent that benefits are paid or payable for those expenses under the mandatory part of any auto insurance policy written to comply with a "no-fault" insurance law or an uninsured motorist insurance law. Connecticut General Life Insurance Company will take into account any adjustment option chosen under such part by you or any one of your Dependents
- In addition, these benefits will be reduced so that the total payment will not be more than 100% of the charge made for the Dental Service if benefits are provided for that service under this plan and any medical expense plan or prepaid treatment program sponsored or made available by your Employer.

CIGNA DENTAL PPO SUMMARY OF BENEFITS

BENEFITS	IN-NETWORK		OUT-OF-NETWORK	
Plan Year Maximum — 1 July 2012-30 June 2013 (Class I, II and III expenses) Maximum amounts in Years 2-4 are dependent on Class I services being rendered.	Year 1: $2,250 Year 2: $2,350 Year 3: $2,450 Year 4: $2,550		$2,250	
Plan Year Deductible — 1 July 2012-30 June 2013	$0		$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 Routine Cleanings Full Mouth X-rays Bitewing X-rays Panoramic X-ray Periapical X-rays Fluoride Application Sealants Space Maintainers Emergency Care to Relieve Pain Histopathologic Exams	100%	No Charge	90%	10%
Class II — Basic Restorative Care Fillings Root Canal Therapy/Endodontics Osseous Surgery Periodontal Scaling and Root Planning Denture Adjustments and Repairs Oral Surgery — Simple Extractions Oral Surgery — all except simple extractions Anesthetics Surgical Extractions of Impacted Teeth Repairs to Bridges, Crowns and Inlays	100%	0%	80%	20%
Class III — Major Restorative Care Crowns Surgical Implants Dentures Bridges Inlays/Onlays Prosthesis Over Implant	100%	0%	80%	20%
Class IV — Orthodontia Lifetime Maximum	100% $2,250 Dependent children up to age 19	0%	70% $2,250 Dependent children up to age 19	30%

This benefit summary highlights some of the benefits available under the proposed plan. A complete description regarding the terms of coverage, exclusions and limitations, including legislated benefits, will be provided in your insurance certificate or plan description. Benefits are insured and/or administered by Connecticut General Life Insurance Company. CIGNA Dental refers to the following operating subsidiaries of CIGNA Corporation: Connecticut General Life Insurance Company, and CIGNA Dental Health, Inc., and its operating subsidiaries and affiliates. The CIGNA Dental Care plan is provided by CIGNA Dental Health Plan of Arizona, Inc., CIGNA Dental Health of California, Inc., CIGNA Dental Health of Colorado, Inc., CIGNA Dental Health of Delaware, Inc., CIGNA Dental Health of Florida, Inc., a Prepaid Limited Health Services Organization licensed under Chapter 636, Florida Statutes, CIGNA Dental Health of Kansas, Inc. (Kansas and Nebraska), CIGNA Dental Health of Kentucky, Inc., CIGNA Dental Health of Maryland, Inc., CIGNA Dental Health of Missouri, Inc., CIGNA Dental Health of New Jersey, Inc., CIGNA Dental Health of North Carolina, Inc., CIGNA Dental Health of Ohio, Inc., CIGNA Dental Health of Pennsylvania, Inc., CIGNA Dental Health of Texas, Inc., and CIGNA Dental Health of Virginia, Inc. In other states, the CIGNA Dental Care plan is underwritten by Connecticut General Life Insurance Company or CIGNA HealthCare of Connecticut, Inc. and administered by CIGNA Dental Health, Inc. The term "DHMO" is used to refer to product designs that may differ by state of residence of enrolee, including but not limited to, prepaid plans, managed care plans, and plans with open access features. The CIGNA Dental PPO is underwritten and/or administered by Connecticut General Life Insurance Company with network management services provided by CIGNA Dental Health, Inc. For Arizona/Louisiana residents the dental PPO plan is known as CG Dental PPO. In Texas, CIGNA Dental's network-based indemnity plan is known as CIGNA Dental Choice. The CIGNA Traditional plan is underwritten or administered by Connecticut General Life Insurance Company. In Arizona and Louisiana, the CIGNA Traditional plan is referred to as CG Traditional.

BSD21039 © 2010 CIGNA

Annex V: FrontierMEDEX

FrontierMEDEX is a facility available to Aetna and Empire Blue Cross subscribers. The 2011 monthly cost per subscriber is $0.20 and is built into the premium schedule for Aetna and Empire Blue Cross as set out in the table entitled "Headquarters medical and dental insurance schedule of monthly premiums and contribution rates".

FrontierMEDEX is a programme providing emergency medical assistance management — including coordinating emergency evacuation and repatriation — and other travel assistance services when the staff member is 100 or more miles from home. Below is a summary of the management coordination services provided.

Medical assistance services

Worldwide Referrals: Worldwide medical and dental referrals are provided to help the participant locate appropriate treatment or care.

Monitoring of treatment: FrontierMEDEX Assistance Coordinators will continually monitor the participant's case and FrontierMEDEX Physician Advisors will provide the participant with consultative and advisory services, including the review and analysis of the quality of medical care being received.

Facilitation of hospital payment: Upon securing payment or a guarantee to reimburse, FrontierMEDEX will either wire funds or guarantee the required emergency hospital admittance deposits.

Transfer of insurance information to medical providers: FrontierMEDEX will assist the participant with hospital admission, such as relaying insurance benefit information, to help prevent delays or denials of medical care. FrontierMEDEX will also assist with discharge planning.

Medication, vaccine and blood transfers: In the event medication, vaccine or blood products are not available locally, or a prescription medication is lost or stolen, FrontierMEDEX will coordinate their transfer to the participant upon the prescribing physician's authorization, if it is legally permissible.

Replacement of corrective lenses and medical devices: FrontierMEDEX will coordinate the replacement of corrective lenses or medical devices if they are lost, stolen, or broken during travel.

Dispatch of doctors/specialists: In an emergency where the participant cannot adequately be assessed by telephone for possible evacuation, or cannot be moved, and local treatment is unavailable, FrontierMEDEX will send an appropriate medical practitioner to the participant.

Medical records transfer: Upon the participant's consent, FrontierMEDEX will assist with the transfer of medical information and records to the participant or to the treating physician.

Continuous updates to family, employer and physician: With the participant's approval, FrontierMEDEX will provide case updates to appropriate individuals designated in order to keep family, employer and physicians informed.

Hotel arrangements for convalescence: FrontierMEDEX will assist with the arrangement of hotel stays and room requirements before and after hospitalization.

Medical evacuation and repatriation services

Emergency medical evacuation: If the participant sustains an injury or suffers a sudden and unexpected illness and adequate medical treatment is not available locally, FrontierMEDEX will arrange for a medically supervised evacuation to the nearest medical facility capable of providing appropriate medical treatment. The participant's medical condition and situation must be such that, in the professional opinion of the health-care provider and FrontierMEDEX, the participant requires immediate emergency medical treatment, without which there would be a significant risk of death or serious impairment. **Please note that the cost of the evacuation is not covered by FrontierMEDEX.**

Transportation to join a hospitalized member: If the participant is travelling alone and is or will be hospitalized for more than seven days, FrontierMEDEX will coordinate round-trip airfare for a person of the participant's choice to join the participant. **Please note that the cost of the airfare is not covered by FrontierMEDEX.**

Return of dependent children: If the participant's dependent child(ren) age 18 or under are present but left unattended as a result of the participant's injury or illness, FrontierMEDEX will coordinate for one-way airfare to send them back to the participant's home country. FrontierMEDEX will also arrange for the services and transportation expenses of the participant's qualified escort, if required. **Please note that the costs of the airfare and escort services are not covered by FrontierMEDEX.**

Transportation after stabilization: Following emergency medical evacuation and stabilization, FrontierMEDEX will coordinate for one-way airfare to the participant's point of origin. If following stabilization FrontierMEDEX determines that hospitalization or rehabilitation should occur in the participant's home country, FrontierMEDEX will alternatively coordinate for the participant's transportation there. **Please note that the cost of the transportation is not covered by FrontierMEDEX.**

Repatriation of mortal remains: If the participant sustains an injury or suffers a sudden and unexpected illness that results in death, FrontierMEDEX will assist in obtaining the necessary clearances for the participant's cremation or the return of the participant's remains. FrontierMEDEX will coordinate the expenses for preparation and transportation of the participant's mortal remains to the participant's home country. **Please note that the cost of the transportation is not covered by FrontierMEDEX.**

THE FOLLOWING SERVICES DO NOT FALL WITHIN THE PURVIEW OF HEALTH INSURANCE, BUT ARE, NEVERTHELESS, INCLUDED IN THE MONTHLY FrontierMEDEX FEE PAID BY PARTICIPANTS IN THE AETNA AND BLUE CROSS PLANS:

Travel assistance services

Emergency travel arrangements: FrontierMEDEX will make new reservations for airlines, hotels, and other travel services in the event of an illness or injury.

Transfer of funds: FrontierMEDEX will provide an emergency cash advance subject to FrontierMEDEX first securing funds from the participant or participants.

Replacement of lost or stolen travel documents: FrontierMEDEX will assist in taking the necessary steps to replace passports, tickets and other important travel documents.

Legal referrals: Should legal assistance be required, FrontierMEDEX will direct the participant to an attorney and assist in securing a bail bond.

Interpretation services: FrontierMEDEX's multilingual Assistance Coordinators are available to provide immediate verbal interpretation assistance in a variety of languages in an emergency; otherwise FrontierMEDEX will provide referrals to local interpreter services.

Message transmittals: The participant may send and receive emergency messages toll-free, 24 hours a day, through the FrontierMEDEX Emergency Response Center.

Personal security services

Security evacuation services: In the event of a threatening situation, FrontierMEDEX will assist in making evacuation arrangements, including flight arrangements, securing visas, and logistical arrangements such as ground transportation and housing. In more complex situations, FrontierMEDEX will assist in making arrangements with providers of specialized security services. **Please note that the cost of the evacuation is not covered by FrontierMEDEX.**

Transportation After Security Evacuation: Following a Security Evacuation and when safety allows, FrontierMEDEX will coordinate for one-way airfare to the participant's home country or host country. **Please note that the cost of the evacuation is not covered by FrontierMEDEX.**

Online services

Member Center: Participants have access to FrontierMEDEX's Member Center, which includes detailed information on the FrontierMEDEX programme, as well as medical and security information for more than 230 countries and territories around the world. To activate the Member Center account:

1. Visit https://members.medexassist.com.
2. In the Log In box, select "Create User".
3. Enter the FrontierMEDEX ID Number for the United Nations (33211).
4. Accept the User Agreement.
5. Enter in your personal account information to designate yourself a unique username and password.

FrontierMEDEX 360°m Global Medical Monitor: The participant will have online access to continuous updates on health information pertinent to your destination(s) of travel such as immunizations, vaccinations, regional health concerns, entry and exit requirements, and transportation information. Risk Ratings are provided for each country and rank the severity of risk concerning disease, quality of care, access to care, and cultural challenges.

World Watch® Global Security Intelligence: The participant will have online access to the latest authoritative information and security guidance for over 170 countries and 280 cities. Information includes the latest news, alerts, risk ratings, and a broad array of destination information including crime, terrorism, local hospitals, emergency phone numbers, culture, weather, transportation information, entry and exit requirements, and currency.

The FrontierMEDEX global security and medical databases are continuously updated and include intelligence from thousands of worldwide sources. This information is also available upon request by calling the FrontierMEDEX Emergency Response Center.

Custom Travel Reports: Using the 360°m Global Medical Monitor and World Watch® online intelligence tools, the participant is able to create customized, printable health and security profiles by destination.

Hot Spots Travel Alerts: Subscribe through the Member Center to receive this free weekday e-mail snapshot of security events from around the world. Listed by region and destination, this bulletin provides a quick review of events that could have a significant impact on travellers. Each event summary includes country threat levels and significant dates.

Conditions and limitations

The services described above are available to the participant only during the participant's enrolment period and only when the participant is 100 or more miles away from his/her residence.

HOW TO USE FrontierMEDEX ACCESS SERVICES 24 HOURS A DAY, 7 DAYS A WEEK, 365 DAYS A YEAR

If participants have a medical problem, call the toll-free number of the country you are in (see list below), or call collect the 24-hour FrontierMEDEX Emergency Response Center in Baltimore, Maryland

Phone: +1-410-453-6330
Internet: http://www.FrontierMEDEX.com
E-mail: operations@FrontierMEDEX.com

A multilingual assistance coordinator will ask for your name, your company or group name, the UN FrontierMEDEX ID number — 33211 — and a description of your situation.

If the condition is an emergency, go immediately to the nearest physician or hospital without delay and then contact the FrontierMEDEX Emergency Response Center. It will then take the appropriate action to provide assistance and monitor care.

INTERNATIONAL TOLL-FREE TELEPHONE ACCESS NUMBERS[a]

Listed below are the telephone numbers for the worldwide FrontierMEDEX Assistance network. If you have a medical or travel problem, call FrontierMEDEX. Printed on your ID card are the telephone numbers for the worldwide FrontierMEDEX network. Call the toll-free number for the country you are in if one is available. If you are in a country that is not listed, or if the call will not go through, please call the Baltimore, Maryland, coordination center *collect*. Be prepared to give FrontierMEDEX your name, identification number, organization's name, and a brief description of your problem.

[a] The asterisk (*) indicates that the caller should dial the first portion of the phone number, wait for the tone, and then dial the remaining numbers.

Australia, including Tasmania	1-800-127-907
Austria	0-800-29-5810
Belgium	0800-1-7759
Brazil	0800-891-2734
China (Northern)*	108888 (wait for tone) 800-527-0218
China (Southern)*	10811 (wait for tone) 800-527-0218
Dominican Republic	1-888-567-0977
Egypt (inside Cairo)*	2-510-0200 (wait for tone) 877-569-4151
Egypt (outside of Cairo)*	022-510-0200 (wait for tone) 877-569-4151
Finland	0800-114402
France and Monaco	0800-90-8505
Germany	0800 1 811401
Greece	00-800-4412-8821
Hong Kong	800-96-4421
Indonesia	001-803-1471-0621
Israel	1-809-41-0172
Italy, Vatican City and San Marino	800-877-204
Japan	00531-11-4065
Mexico	001-800-101-0061
Netherlands	0800-022-8662
New Zealand	0800-44-4053
Philippines	1-800-1-111-0503
Portugal	800-84-4266
Republic of Ireland (Eire)	1-800-409-529
Republic of South Africa	0800-9-92379
Singapore	800-1100-452
South Korea	00798-1-1-004-7101
Spain and Majorca	900-98-4467
Switzerland and Liechtenstein	0800-55-6029
Thailand	001-800-11-471-0661
Turkey	00-800-4491-4834

United Kingdom of Great Britain and Northern Ireland, Isle of Jersey, the Channel Isles and Isle of Man	0800-252-074
United States of America, Canada, Puerto Rico, US Virgin Islands, Bermuda	1-800-527-0218

FrontierMEDEX ASSISTANCE COORDINATION CENTER (*call collect*)

United States: Baltimore, Maryland [1]-410-453-6330

Notes

When a toll-free number is not available, travellers are encouraged to call FrontierMEDEX collect. The toll-free numbers listed are only available when physically calling from within the country. We strongly encourage you to note this in your printed material to avoid confusion.

The toll-free ISRAEL line is not available from payphones and there is a local access charge.

The toll-free ITALY, VATICAN CITY and SAN MARINO number has a local charge for access.

In ITALY operator assisted calls can be made by dialling 170. This will give you access to the international operator.

The toll-free JAPAN line is only available from touchtone phones (including payphones) equipped for International dialling.

If calling from MEXICO on a payphone, the payphone must be a La Date payphone.

When calling the CHINA phone numbers please dial as follows:

Northern regions — First dial 10888, then wait a second to be connected. After being connected, dial the remaining numbers.

Southern regions — First dial 10811, then wait a second to be connected. After being connected, dial the remaining numbers.

When calling the EGYPT phone numbers please dial as follows:

Inside Cairo — First dial 510-0200, then wait a second to be connected. After being connected, dial the remaining numbers.

Outside Cairo — First dial 02-510-0200, then wait a second to be connected. After being connected, dial the remaining numbers.

International callers who are unable to place toll-free calls to FrontierMEDEX:

Many telephone service providers, such as cell phone, payphone and other commercial phone venues, charge for, or outright bar, toll-free calls on their networks. These callers should be instructed to try calling collect. If that is not an option, they will need to dial our number directly and provide a number to which FrontierMEDEX may immediately call back.

Annex VI: ActiveHealth Wellness Programme

The ActiveHealth programme was implemented in December 2008 as a health management service that provides confidential disease management and wellness programmes to Aetna and Empire Blue Cross health insurance plan participants. Disease Management and Wellness programmes work to reduce preventable conditions which are often precursors to more serious and chronic conditions. ActiveHealth provides important care considerations to participants and their doctors and assists in managing the health concerns of participants through the services noted below. Staff members may be contacted by ActiveHealth, or can elect to participate in this programme through self-referral by calling ActiveHealth at 1-800-778-8351, or by enrolling at www.myactivehealth.com/unitednations.

- CareEngine and Care Considerations: Personalized and confidential communications to patients and physicians to improve the quality of care;
- Nurse Care Program: Nurse coaching for members with chronic conditions;
- MyActiveHealth: Online Personal Health Record;
- 24-hour Informed Health Line;
- NuVal™: Nutritional Scoring System.

Care Engine and Care Considerations

ActiveHealth is “powered” by the CareEngine® System that applies thousands of evidence-based clinical rules to aggregated member medical, pharmacy, and lab claims along with self-reported data to uncover potential errors and instances of sub-optimal care. The rules are applied on a continuous basis to all members of a covered population to find clinical improvement opportunities. For each potential opportunity identified, a “Care Consideration” is generated that identifies the clinical issue(s) found, and suggests a change in treatment that the evidence-based literature and treatment guidelines indicate would improve the patient’s care. These Care Considerations are communicated to treating physicians each time a potential care improvement opportunity is identified by the CareEngine system. Since the physician may have information about the patient that is not available to ActiveHealth, the decision of whether to implement a Care Consideration is up to the physician.

Nurse Care Programme

Members participating in the Disease Management program are assigned to a Nurse Care Manager who acts as their “personal health coach” around their specific conditions. The Nurse Care Manager provides one-on-one education and support to the member in understanding his/her health needs and how to best leverage physician visits through informed communication.

Disease Management provides comprehensive support for more than 30 chronic conditions that:

- Focuses on both physicians and patients in effecting behaviour changes leading to improved clinical and financial outcomes.

- Identifies and targets impactable clinical issues that are communicated to physicians and patients with specific actions that can be taken to improve patient care.
- Customizes member engagement and education activities and intensity according to the member's specific clinical issues and medical needs.
- Creates a strong value proposition in that it targets resources to those members most likely to benefit from disease management interventions.
- Designs interventions and plans of care around the member's complete set of conditions and co-morbidities in order to maximize care and anticipate potentially harmful interactions between disease states.

The following is a list of the 34 conditions included in ActiveHealth Nurse Care Programme:

Vascular

- Peripheral Artery Disease
- Cerebrovascular Disease/Stroke
- Congestive Heart Failure (CHF)
- Coronary Artery Disease (CAD)
- Hypertension — Adult & Paediatrics
- Hyperlipidemia Hypercoagulable State (Blood Clots)

Diabetes — Adult & Paediatrics

Pulmonary

- Asthma — Adult & Paediatrics
- Chronic Obstructive Pulmonary Disease (COPD)

Orthopedic/Rheumatologic

- Rheumatoid Arthritis (RA)
- Osteoporosis
- Osteoarthritis (OA)

Gastrointestinal

- Gastro Esophageal Reflux Disease (GERD)
- Chronic Hepatitis B or C
- Peptic Ulcer Disease
- Inflammatory Bowel Disease (Crohn's Disease and Ulcerative Colitis)

Neurologic Conditions

- Seizure Disorders
- Migraines
- Parkinsonism
- Geriatrics

Geriatrics

Cancer

- Cancer (General)
- Breast Cancer
- Lung Cancer
- Lymphoma/Leukemia
- Prostate Cancer
- Colorectal Cancer

Renal

- Chronic Kidney Disease
- End Stage Renal Disease

Other

- Cystic Fibrosis — Adult & Paediatrics
- HIV
- Chronic Back/Neck Pain
- Sickle Cell Disease — Adult & Paediatrics
- Weight Management (Obesity) — Adult & Paediatrics

MyActiveHealth^{SM}: Personal Health Record

MyActiveHealth is a simple yet powerful online tool that identifies opportunities for improvements in care. It also identifies prescriptions and over-the-counter drugs that should not be mixed and provides alerts to alternative treatment opportunities to you and your family. The online tool allows you to:

- Store and easily retrieve information about doctor visits, prescriptions, test results, immunizations and even family medical history.
- Access to your medical files securely anywhere the Internet is available — at home, at work, or even in the doctor's office.
- Share information with doctors, family members or caregivers by either printing out the records or granting online access.
- Provide doctors with a more complete picture of your health (if you choose to share it) and promotes better interaction with your doctor.

- Give each family member his or her own personal record to help keep things organized.

You can access the MyActiveHealth website at www.myactivehealth.com/unitednations.

24-hour Informed Health Line

- 24/7 telephone access to registered nurses by calling 1-800-556-1555
- Audio Library on thousands of health topics such as common conditions/ diseases, gender/age-specific issues, dental care, mental health, weight loss and much more!
- IHL Nurses will work in tandem with the Disease Management program as well as other coverages the UN has in place and will make referrals when appropriate.

NuVal

- Nutritional Scoring System, available via through the MyActiveHealthSM. portal, is a unique food labelling system which ranks all foods between 1 and 100; the higher the score, the higher the food's overall nutrition. Members can compare scores within a food category, such as cereals, or across categories, such as beef burgers to veggie burgers.
- This tool enables ActiveHealth members to create personalized shopping lists and meal plans. ActiveHealth nurse care program coaches will also have access to the database as a tool for reinforcing better eating habits.

Annex VII: Vanbreda Insurance Benefits Summary

1. The Vanbreda insurance programme indemnifies members, within the limits of the plan, for reasonable and customary charges in respect of medical, hospital and dental treatment for illness, an accident or maternity. The aggregate reimbursement in respect of the total expenses covered by the plan that are incurred by an insured participant shall not exceed $250,000 in any calendar year. The provisions set forth below shall be subject to this limitation. In addition to the maximum reimbursement per calendar year, certain maxima per treatment, procedure, supplies or other services may also apply, depending on the type of service, as described in the paragraphs below.

2. The programme reimburses only treatment, supplies or other services that are widely and generally accepted as medically necessary and appropriate for the condition being treated, and when such treatment, supplies or other services are prescribed by a licensed, qualified medical professional. Vanbreda International has the fiduciary duty and discretionary authority to determine, on behalf of the United Nations, what constitutes a covered service or plan benefit under the programme.

3. Prior approval from Vanbreda medical consultants is required for all non-emergency hospitalizations. Prior approval means that reimbursement is guaranteed only in cases where, on the basis of the medical justification, as well as a cost estimate furnished by the beneficiary at least one week prior to the admission date of the hospitalization in question, Vanbreda medical consultants grant explicit approval for the treatment. In the case of a medical emergency, approval can be obtained post factum, on the basis of the same medical criteria. Other benefits that require the prior approval of Vanbreda medical consultants include acupuncture, speech therapy, home health care, durable medical equipment or orthopaedic appliances, and vitamins, minerals and food/nutritional supplements.

4. The United Nations health insurance plan provides for two levels of coverage each, namely, the Basic Medical Benefit Plan (BMBP) and the Major Medical Benefits Plan (MMBP) in two different geographic areas, namely the United States and the rest of the world. Both the BMBP and the MMBP coverage periods run from 1 January until 31 December. Medical expenses are reimbursed under BMBP and MMBP. Services rendered by a licensed paramedical professional or, in case of maternity, by a licensed midwife can be considered for reimbursement, but only upon the prescription of a licensed, qualified medical professional.

5. For services received in countries other than the United States, the major medical component does not apply in the case of outpatient mental health treatment that are medically necessary and preauthorized by Vanbreda based on a detailed medical prescription (see Outpatient mental health care under No. 8.4 of Annex I), treatment for substance abuse (alcohol and/or drug), expenses for hearing aids, or expenses for optical lenses, nor does MMBP apply for costs that are reimbursed at 100 per cent under BMBP (for example, other hospital expenses and hospital stay), as there is no balance left on these charges. Also, expenses that are subject to a maximum reimbursement (for example, dental care for illnesses not related to an accident, optical care, psychotherapy, etc.) are also not subject to a reimbursement under the MMBP component. MMBP covers 80 per cent of the difference between the accepted costs and the amount reimbursed under BMBP. In order to be entitled to any reimbursement under MMBP, an OOP maximum of $200 per insured person

or $600 per family has to be satisfied. All payments under MMBP are applied automatically and do not require submission of a claim by the United Nations staff member.

6. For services received in the United States, a deductible of $200 per insured person or $600 per family has to be satisfied before any reimbursement is made under the under the programme. The programme will reimburse 80 per cent of all medically necessary treatment under the BMBP and the participant will pay the 20 per cent residual cost after the deductible is satisfied. Treatment received under the major component will also be reimbursed at 80 per cent after the deductible is met, and will continue to be reimbursed at the 80 per cent level until the participant's out-of-pocket cost (the $200 deductible and the 20 per cent share) total $1,200, or $3,600 for the family. At this point, the MMBP will reimburse an additional 80 per cent of the participant's 20 per cent share.

7. **Reimbursement rates outside of the United States**

(a) Under the basic medical component, reimbursement in respect of medical treatment prescribed by qualified doctors is calculated at the rate of 80 per cent of the reasonable and customary charges involved, including inpatient and outpatient doctors' fees (see para. 23 (h) below for information about reasonable and customary charges);

(b) Under the major medical component, 80 per cent of the residual unpaid reasonable and customary charges are paid, subject to a calendar-year maximum co-payment of $200 per participant and $600 per family. The calendar-year maximum co-payment is sometimes called the out-of-pocket (OOP) maximum, requiring that the participant pay the 20 per cent residual out-of-pocket, up to the calendar-year maximum co-payment of $200, or $600 in the case of family coverage. When covered expenses exceed the calendar year maximum co-payment amount, the 80 per cent basic component still applies, and the major medical component automatically reimburses 80 per cent of the residual 20 per cent for the remainder of that calendar year.

8. **Example: medical expense reimbursement.** The following example illustrates how reimbursement is determined for an individual in respect of basic and major medical coverage (figures are in United States dollars):

(a) Basic coverage (BMBP)

Reasonable and customary charges for medical treatment	5,600
Reimbursement at 80 per cent	4,480
Residual 20 per cent	1,120

(b) Major medical coverage (MMBP)

20 per cent residual not reimbursed by basic coverage	1,120
Less calendar year maximum co-payment (deductible)	-200
= Basis for major medical coverage	920
x 80 per cent = major medical reimbursement	736

(c) Total reimbursement (recapitulation of (a) and (b))

Basic medical coverage	4,480
Major medical coverage	+736
Total insurance reimbursement	5,216
Participant's total out-of-pocket expense	384
Total original expense	5,600

9. **Reimbursement rates in the United States**

(a) Under the basic medical component, reimbursement in respect of medical treatment prescribed by qualified doctors is calculated at the rate of 80 per cent, after deductible, of the reasonable and customary charges involved, including inpatient and outpatient doctors' fees (see para. 11 below for information about reasonable and customary charges);

(b) Under the major medical component, 80 per cent of the residual unpaid reasonable and customary charges are paid, subject to a calendar-year maximum co-payment of $200 per participant and $600 per family and an out-of-pocket maximum payment of $1,200 per participant and $3,600 per family;

(c) When covered expenses reach the annual deductible amount, the 80 per cent basic component still applies. The major medical component automatically reimburses 80 per cent of the residual 20 per cent for the remainder of that calendar year when the dollar amount of the deductible and residual 20 per cent cost total $1,200 per participant or $3,600 per family.

10. **Example: medical expense reimbursement.** The following example illustrates how reimbursement is determined for an individual in respect of basic and major medical coverage (figures are in United States dollars):

(a) Basic coverage (BMBP)

Reasonable and customary charges for medical treatment	5,600
Less calendar year maximum co-payment (deductible)	-200
= Basis for basic medical coverage	5,400
Reimbursement at 80 per cent	4,320
Residual 20 per cent	1,080

(b) Major medical coverage (MMBP)

20 per cent residual not reimbursed by basic coverage	1,080
Plus calendar year maximum co-payment (deductible)	+200
= Participant's out-of-pocket to date	1,280
Less out-of-pocket maximum (OOP)	1,200
= Basis for major medical coverage	80
x 80 per cent = major medical reimbursement	64

(c) Total reimbursement (recapitulation of (a) and (b))

Basic medical coverage	4,320
Major medical coverage	+64
Total insurance reimbursement	4,384
Participant's total out-of-pocket expense	1,216
Total original expense	5,600

Vanbreda dedicated website/Vanbreda identification cards/official designation

11. Vanbreda has dedicated web pages (see http://www.vanbreda-international.com) in respect of the United Nations worldwide Vanbreda plan. The pages can be accessed by logging on with a personal reference number indicated on the Vanbreda membership card. The website provides details regarding:

(a) Benefits;

(b) How to arrange for direct billing;

(c) How to submit a claim and how to receive your settlement online;

(d) Provision for the downloading of forms, for example, claim forms;

(e) Contact information at Vanbreda;

(f) A provider list enabling a participant to select medical providers based upon location and medical specialization;

(g) Information on symptoms and treatment of some chronic diseases (diabetes, HIV/AIDS, Parkinson's disease, asthma, chronic obstructive pulmonary disease (COPD), cardiovascular disease (CVD)). If UN staff need personal advice, they are encouraged to contact Vanbreda's panel of international medical doctors through an online form;

(h) Plan members and HR administrators will be able to print a personal insurance certificate using a simple tool available on Vanbreda's website.

12. The Vanbreda identification card which is mailed to all participants enables a hospital or clinic to contact Vanbreda in order to set up a direct billing arrangement in respect of hospitalization or high-cost outpatient treatment. Participants who do not have an identification card should contact Vanbreda.

Basis for claim reimbursement in United States dollars

14. The default currency for claim reimbursement is United States dollars, converted from the currency in which the hospital, medical or dental expenses have been incurred. Vanbreda International will also reimburse members in another currency for costs incurred and/or payments made in that currency. The list of currencies is USD, EUR, AUD, CAD, CHF, DKK, EGP, GBP, HKD, IDR, JOD, MAD, NZD, PHP, SEK, SGD, THB, TND and XOF.

Please note that:

– reimbursement in a non-USD currency always has to be combined with a reimbursement by bank transfer;

– only one currency per claim form will be allowed;

– if no reimbursement currency is selected on the claim form or if data are insufficient to provide the payment selected, reimbursement will, by default, be made in United States dollars.

15. Reimbursements are based on the United Nations operational rate of exchange in effect on the date that the medical and dental expenses are incurred and, in the case of hospital expenses and doctors' fees incurred during the hospitalization, on the date that the hospital bill is rendered.

16. In order to guarantee a smooth processing of their claims, Vanbreda International would like to encourage all plan participants to use the settlement details online together with electronic fund transfers (direct deposit into the member's bank account).

17. The latest version of the claim form and more information on settlement details online can be found under "Plan members" on the Vanbreda International dedicated web pages (see http://www.vanbreda-international.com).

Conversion privileges

18. A "conversion" privilege is part of the United Nations group contract with Vanbreda. This privilege allows staff members (subscribers) who cease employment with the United Nations and do not qualify for after-service health insurance benefits to "convert" their group medical insurance with Vanbreda to an individual short-term health insurance policy. The individual conversion policy is guaranteed-issue. This means that no proof of the subscriber's good health is required; the insurer cannot refuse to insure an eligible subscriber who applies in a timely manner for a conversion policy. Application for an individual policy under the conversion privilege must be made within 31 days of termination of coverage under the United Nations group policy. The availability of this 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 the individual health insurance policy. The conversion privilege is designed to provide coverage during a period of transition to more permanent health insurance coverage. The Vanbreda conversion privilege grants coverage up to a maximum of 36 months and is not subsidized by the United Nations.

19. Staff members (subscribers) may apply for a policy of individual coverage under the conversion privilege for themselves only or for themselves and their covered eligible dependants. Moreover, eligible dependants may apply on their own behalf in the following circumstances:

(a) Children whose eligibility for insurance ceases as the result of reaching age 25 are eligible to apply for a health insurance conversion policy provided that they are financially dependent on their parent(s), are unmarried, and are not employed full-time;

(b) A staff member's spouse whose eligibility for insurance ceases as the result of divorce and who is not employed full-time may also apply.

The application for an individual conversion policy **must** be submitted within 31 days of termination of coverage under the United Nations group medical programme;

(c) Details concerning conversion to an individual insurance policy may be obtained by communicating directly with Vanbreda at the following address:

Vanbreda International
Plantin en Moretuslei 299
2140 Antwerp, Belgium
Tel: +32 3 217 5742
Fax: +32 3 272 3969
E-mail: gp1@vanbreda.com

General administration

20. The existing rules and terms governing eligibility and enrolment for the Vanbreda plan are summarized in paragraphs 19 to 41.

21. General Rules

Benefits	**Description**
Overall maximum	Maximum of 250,000 USD per person per calendar year
Aim	The plan covers reasonable and customary expenses of medical, hospital and dental treatment resulting from sickness, accident or maternity. The plan only reimburses treatment, supplies or other services that are widely and generally accepted as medically necessary and appropriate for the condition being treated, and when such treatment, supplies or other services are prescribed by a licensed, qualified medical professional. Vanbreda International has the fiduciary duty and discretionary authority to determine, on behalf of the United Nations, what constitutes a covered service or plan benefit under the programme. Additionally, the plan provides coverage for some aspects of preventive care.
Reasonable and customary	Only reasonable and customary expenses are covered. This means that only fees and prices which are commonly charged for the treatment or purchase in question can be considered for reimbursement, taking into account the geographical area where the treatment is given or the item is purchased. Furthermore, the treatment or purchase must also be reasonable and customary from a medical point of view. This means, for example, that the number of treatment sessions/days of admission/dosage of medication should be medically justified. Any excess in this regard will be limited to the reasonable and customary level.

Eligibility	The plan provides coverage for staff members and former staff members who reside in all parts of the world, **except** the United States. Staff members, former staff members and their dependants **who reside in the United States are not eligible for coverage under this plan.** The sole exception to this exclusion arises in the case of a dependent child attending school or university in the United States, who will be required to enrol in the health insurance plan offered by the educational institution. In this case, the student's health insurance plan at the school or university will be primary and the Vanbreda International coverage will be secondary.
Currency of reimbursement	By default, claims will be reimbursed in USD. Upon request, reimbursement in other currencies is possible: – if expenses were incurred in that specific currency – and provided that the payment can be made by bank transfer. The extended list of currencies is USD, EUR, AUD, CAD, CHF, DKK, EGP, GBP, HKD, IDR, JOD, MAD, NZD, PHP, SEK, SGD, THB, TND and XOF.
Validity of prescriptions	One year (even for prescriptions mentioning 'permanent use')
Claim submission deadline	All claims must be received at Vanbreda International within two years after the date on which the expenses were incurred.
Outpatient treatment/outpatient surgery/day case	Treatment given on an outpatient basis, where the date of admission is the same as the date of discharge.
Inpatient treatment/ hospitalization	Treatment given on an inpatient basis, where the date of admission differs from the date of discharge.
Insurance year	An insurance year is equal to a calendar year.
Prior approval	Prior approval from Vanbreda International's medical consultant is required for all non-emergency hospitalizations. Prior approval means that reimbursement is guaranteed only in cases where Vanbreda's medical consultants grant explicit approval for the treatment, on the basis of the medical justification, as well as a cost estimate furnished by the beneficiary at least one week prior to the planned admission. In case of a medical emergency, approval can be obtained *post factum*, on the basis of the same medical criteria. Other benefits that require prior approval from Vanbreda International's medical consultants include acupuncture, speech therapy, home health care, durable medical equipment or orthopaedic appliances, and vitamins, minerals and food/ nutritional supplements.

22. Summary of Benefits

22.1 In the hospital

GENERAL RULE

All treatments and medicines must be prescribed by a qualified and registered medical doctor. The items below are reimbursed at 80% + Major Medical Benefits Plan (MMBP), unless indicated otherwise in the remarks.

Item	Remarks
Prior approval from Vanbreda International's medical consultant is required for all non-emergency hospitalizations. Notification of such hospitalizations should be given at least 1 week prior to the admission date.	
Bed and board (Western Europe)	As of 1 January 2012 • semi-private room or ward: 100% up to 900 USD per day • private room: 100% of semi-private room rate up to 900 USD per day Note: 100% of a private room is exceptionally reimbursable up to 900 USD per day: • when the hospital does not have semi-private accommodation (only private room and general wards); • if there is a medical necessity for a private room; • in case of medical emergency and no semi-private room is available; • if the patient is obliged to stay in a private room as a foreigner. Note: For Western Europe countries, see footnote on rate page in section IV.
Bed and board (Chile + Mexico)	As of 1 January 2012 • private, semi-private room or ward: 100% up to 450 USD per day

Item	Remarks
Bed and board (Canada, Israel and Australia)	• private room: 100% of semi-private room rate up to 750 USD per day Note: 100% of a private room is exceptionally reimbursable up to 750 USD per day: • when the hospital does not have semi-private accommodation (only private room and general wards); • if there is a medical necessity for a private room; • in case of medical emergency and no semi-private room is available; • if the patient is obliged to stay in a private room as a foreigner.
Bed and board (USA)	• semi-private room or ward: 100% up to 600 USD per day • private room: 100% of semi-private room rate up to 600 USD per day Note: 100% of a private room is exceptionally reimbursable up to 600 USD per day: • when the hospital does not have semi-private accommodation (only private room and general wards); • if there is a medical necessity for a private room; • in case of medical emergency and no semi-private room is available; • if the patient is obliged to stay in a private room as a foreigner. Note: For admissions in the United States the 600 USD limit does not apply in three specific circumstances: • medical evacuation approved by the UN Medical Director; • a medical emergency arising while in the USA; • necessary treatment can only be given at a hospital in which the daily semi-private room rate exceeds 600 USD (Prior approval is required).
Bed and board (in the rest of the world)	Private, semi-private room or ward: 100% up to 330 USD per day
Stay in the Intensive Care Unit (ICU)	100%
Doctor's fees (surgeon, treating physician, assistant, anaesthetist, midwife)	80% + MMBP

Item	Remarks
Other hospital expenses (e.g. use of operating theatre and equipment, lab, x-rays, medication for use during the hospital admission)	100%
Accompanying person	Not covered, except when the patient is under the age of 12 or when it is required by local legislation.
Outpatient surgery (where an operation theatre is required)	• doctor's fees: 80% + MMBP • other hospital expenses: 100%
Chemotherapy, radiotherapy, haemodialysis, etc.	• doctor's fees: 80% + MMBP • other hospital expenses: 100%
Admission related to alcohol and drug abuse	Covered if medically necessary and preauthorized by Vanbreda
Fertility treatment: • Artificial Insemination (AI); • Intra-Uterine Insemination (IUI); • Micro-Epididymal Sperm Aspiration (MESA); • Percutaneous Epididymal Sperm Aspiration (PESA); • Testicular Sperm Aspiration (TESA); • Testicular Sperm Extraction (TESE).	A total of 3 attempts per lifetime are covered. IVF and related pharmaceuticals are not covered.
In Vitro Fertilization (IVF)	Not covered
Cryopreservation of stem cells/umbilical cord (= preservation by cooling to low sub-zero temperatures)	Prior approval is required. Please provide us with a detailed medical report including: • a diagnosis and description of the current treatment with prognosis; • the motivation to conserve stem cells/umbilical cord.
Abortion	See Outpatient surgery
Sterilization/Vasectomy/Tubal ligation	See Outpatient surgery
Reversal of sterilization/Vaso-vasectomy	Not covered

Item	Remarks
Blepharoplasty (= eyelid surgery)	Prior approval is required. Please provide us with a detailed medical report including: • the results of a visual field test measuring the field of vision by an ophthalmologist; • pre-operative photographs.
Corrective eye surgery to change the dioptre/LASIK	Covered under the available maximum for glasses/lenses
Rehabilitation/convalescence after surgery	Prior approval is required.
Home for the elderly/nursing home	Not covered
Institution for the disabled	Not covered
Cures	Not covered
Cosmetic surgery	Not covered
Reconstructive surgery	Prior approval is required.
Breast reduction	Prior approval is required. Please provide us with a detailed medical report including: • an estimation of the amount of body tissue to be removed; • the patient's weight and length; • the bra cup size; • the placement of the nipples and areolas; • description of functional complaints; • pre-operative photographs.
Circumcision for preventive or religious reasons	Covered. See outpatient surgery.
Rhinoplasty (= plastic surgery of the nose)/ Septoplasty (= surgical procedure to correct the shape of the nasal septum, the separation between the 2 nostrils)	Prior approval is required. Please provide us with a detailed medical report including: • the result of a nasal endoscopy; • a CT or other appropriate imaging documenting the degree of nasal obstruction.

22.2 Ambulance and transportation expenses

GENERAL RULE

All treatments and medicines must be prescribed by a qualified and registered medical doctor. The items below are reimbursed at 80% + Major Medical Benefits Plan (MMBP), unless indicated otherwise in the remarks.

Item	**Remarks**
General transportation costs	Not covered
Ambulance	Transportation between the place where you are injured by an accident or stricken by sickness and the first hospital where treatment is given.
Repatriation	Not covered
Evacuation	Not covered

22.3 At the General Practitioner's

GENERAL RULE

All treatments and medicines must be prescribed by a qualified and registered medical doctor. The items below are reimbursed at 80% + Major Medical Benefits Plan (MMBP), unless indicated otherwise in the remarks.

Item	**Remarks**
Consultation	80% + MMBP
Annual subscription fees	Not covered
Minor surgical intervention in a doctor's office	80% + MMBP
Vaccination	All vaccinations given in the context of Well-child care (for members up to age 19) are covered at 80% + MMBP; For members 19 years and older, Influenza, Hepatitis A, Hepatitis B, Hepatitis A+B, Yellow Fever, Tetanus (diphtheria), and Pneumococcal vaccines are covered at 80% + MMBP.
Routine physical exam	One routine physical exam per person per calendar year reimbursed at 100% up to 750 USD (no MMBP). Includes related x-rays, laboratory and any other charges, urologic examinations and prostate specific antigen (PSA) screening, gynaecological exams, mammography screening and Pap smears.
Well-child care	Covered for members up to age 19 in addition to the routine physical exams at the rate of 80% + MMBP in accordance with the following schedule: • well-child care up to the age of 7: - 6 visits per year between 0 to 1 year old; - 2 visits per year between 1 to 2 years old; - 1 visit per year between 2 to 7 years old; • 1 visit every 24 months from the age of 7 to 19. All vaccinations administered in the context of well-child care visits are reimbursed up to midnight before turning 19.
Testing for the HIV virus	• 100% • Unlimited blood tests per year

22.4 At the specialist's

GENERAL RULE

All treatments and medicines must be prescribed by a qualified and registered medical doctor. The items below are reimbursed at 80% + Major Medical Benefits Plan (MMBP), unless indicated otherwise in the remarks.

Item	Remarks
Consultation	Covered
Treatment	Covered
Second surgical opinion	100%
Outpatient mental health care	Covered at 80% up to a $1,000 ceiling per plan year. The following conditions are covered at 80% upon prior approval, with no ceiling: Anorexia Nervosa, Psychosis, Bipolar Disorder, Obsessive Compulsive Disorder, Severe Depression with suicidal risk, Severe Personality Disorders (Paranoid, Schizoid), Neuropsychiatric affections of comparable severity, Post-Traumatic Stress Disorder (PTSD).
Immunotherapy	Prior approval is required. Please provide us with your allergy test results.
IUD (intrauterine device)	Covered
Check-ups (mammography, Pap smear etc.)	– If preventive: covered at 100% under the maximum of routine physical exam (see 8.3) – If diagnostic (in case of an illness or suspicion of an illness): 80% + MMBP
Hearing test	Covered under the maximum available for hearing aids
Eye test to determine the dioptre by an ophthalmologist, optometrist or optician	Maximum one test per 24-month period
Eye examination due to a medical condition (i.e. not routine or to determine the dioptre)	Covered at 80% + MMBP

22.5 At the licensed qualified medical service provider's (other than doctor)

GENERAL RULE

All treatments and medicines must be prescribed by a qualified and registered medical doctor. The items below are reimbursed at 80% + Major Medical Benefits Plan (MMBP), unless indicated otherwise in the remarks.

Item	Remarks
A doctor's prescription is required for care given by a person holding a paramedical degree (e.g. nurse, physiotherapist).	
Medical act (e.g. dressing wounds, giving injections) and supervision by a nurse	Prior approval is required. Please provide us with a detailed medical report including: • the patient's medical condition for which the attention of a home nurse is required; • the period during which the attention of a home nurse is required; • the treatment plan, including a list of tasks the home nurse is expected to perform and the approximate amount of time required for each individual task.
Nursing assistance for activities of daily living (e.g. dressing, feeding, supervision)	Not covered
Home health care	100% if it is provided as an alternative equal in cost to, or cheaper than, a medically required inpatient hospitalization. Prior approval is required. Approval will be given for limited time periods only. Note: Custodial care or assistance with activities of daily living (for example, feeding, bathing, dressing, providing companionship) is not covered.

12-41270

Item	Remarks

Dietician and nutritional counselling	• 80% + MMBP for one dietary-oriented consultation per calendar year.
	• Up to ten sessions per lifetime for patients with:
	  • a chronic disease (namely: cardiovascular disease, diabetes mellitus, hypertension, kidney disease, eating disorders and gastrointestinal disorders);
	  • a BMI (Body Mass Index) higher than 30.
	For these patients, dietary adjustment is medically necessary and has a therapeutic role.
	
	The nutritional counselling must be prescribed by a physician and furnished by a medical service provider (e.g. a registered dietician, licensed nutritionist or other qualified licensed health professional).

Education programmes for diabetes/ asthma/serious allergy patients, …	Covered
Prenatal and postnatal exercises guidance	Covered
Physiotherapy	Covered if given to improve or restore physical functions that have been lost or are debilitated as a result of an illness, accident or congenital disorder. Therapy aimed at preventing deterioration of bodily functions is not reimbursable. The doctor’s prescription should mention the number of sessions required. The invoice should mention: • the medical service provider’s medical degree; • the date(s) of treatment; • the type of treatment given.
Alternative medicine	Covered if there is sufficient scientific proof of its therapeutic effectiveness. Requesting prior approval for alternative medicine is recommended.
Acupuncture	Covered if the treatment is given in order to alleviate pain or to treat orthopaedic ailments.

Item	Remarks

Chiropractic treatment	Prior approval is required.
	
	Please provide us with a detailed medical report including:
	• the reason for the treatment;
	• the nature of the treatment, including the required number of sessions;
	
	Please submit the following documents with your claim form:
	• a doctor's prescription mentioning the diagnosis and the prescribed number of sessions.
	• the official original invoice mentioning:
	  • the medical service provider's medical degree;
	  • the date(s) of treatment;
	  • the type of treatment.

Podotherapy	Covered if it is medically necessary. The doctor's prescription should clearly indicate the diagnosis and the number of sessions prescribed.
Speech therapy	Covered if it is provided to remedy a medical condition. Social or educational concerns are not grounds for reimbursement. Prior approval is required. Please provide us with a speech therapist's evaluation report and a detailed medical report including: • the cause of the speech disorder; • the reason for the treatment; • the nature of the treatment including the required number of sessions.

Item	Remarks

Psychological treatment given by a
• psychiatrist;
• licensed psychologist;
• licensed psychoanalyst;
• licensed psychiatric social worker;
• neurologist.
	Covered at 80% up to a $1,000 ceiling per plan year.
	The following conditions are covered at 80% upon prior approval, with no ceiling:
	Anorexia Nervosa, Psychosis, Bipolar Disorder, Obsessive Compulsive Disorder, Severe Depression with suicidal risk, Severe Personality Disorders (Paranoid, Schizoid), Neuropsychiatric affections of comparable severity, Post-Traumatic Stress Disorder (PTSD).
	Please provide us with:
	• a confirmation of the diagnosis (i.e. the reason for the treatment);
	• the official original invoice mentioning:
	  • the medical service provider's medical degree;
	  • the date(s) of treatment;
	  • the type of treatment.

Custodial care	Not covered
Hospice care	Not covered
Relationship therapy	Not covered
Alcohol and drug abuse — Outpatient treatment	Covered at 80% if medically necessary and preauthorized by Vanbreda. 40% of allowable visits may be allocated to counsel covered family members of the participant undergoing treatment for the substance abuse problem.

22.6 At the optician's

GENERAL RULE

All treatments and medicines must be prescribed by a qualified and registered medical doctor. The items below are reimbursed at 80% + Major Medical Benefits Plan (MMBP), unless indicated otherwise in the remarks.

Item	Remarks
Eye test to determine the dioptre by an ophthalmologist, optometrist or optician	Maximum one test per 24-month period
Corrective glasses and contact lenses	Participation of 12 months in the Vanbreda International scheme is required. 80% up to 250 USD per 24 months. The 24-month period starts on the first date of purchase of the optical device. Replacement in case of dioptre change is allowed. For claiming purposes, please send the following information and documentation: • the dioptre of the optical devices; • a detailed official invoice stating the separate prices per item purchased.
Frames	Covered under the limit set for corrective glasses and contact lenses
Fluid for contact lenses	Not covered

22.7 At the dentist's

GENERAL RULE

All treatments and medicines must be prescribed by a qualified and registered medical doctor. The items below are reimbursed at 80%, unless indicated otherwise in the remarks.

Item	Remarks
General cover for dental care	80% up to 1,000 USD with a one-year carry-over of unspent annual balance. As of 01/01/2011, any unspent balance can be carried over to the next year. In practice, this means that in case there is an unspent balance for dental care on 31/12/2011, this can be carried over and used in 2012.
Half-yearly dental exam	Included in the General cover for dental care
Dental x-rays	Included in the General cover for dental care
Prostheses (including bridges, implants, dentures)	Included in the General cover for dental care
Orthodontic care (including the orthodontic device)	Treatment has to start before the patient's 15th birthday; The maximum treatment period is 4 years. Never reimbursable for adults over the age of 18 unless the treatment is medically necessary as a result of an accident; Included in the General coverage for dental care
Dental surgery performed in hospital for which a hospital theatre is required (e.g. surgical tooth extraction)	The doctor's fees and the cost of the dental items are included in the General coverage for dental care. For other expenses (e.g. use of an operating theatre, bed and board in case of an inpatient admission), see hospital coverage.
Orthodontic treatments/surgeries after accidents	Reimburse doctor's fees at 80% + MMBP Reimburse other hospital expenses, if any, at 100%
Toothbrush, toothpaste, mouthwash	Not covered
Tooth whitening	Not covered

22.8 At the pharmacist's

GENERAL RULE

All treatments and medicines must be prescribed by a qualified and registered medical doctor. The items below are reimbursed at 80% + Major Medical Benefits Plan (MMBP), unless indicated otherwise in the remarks.

Item	Remarks

General coverage of prescribed pharmaceutical products
• containing active medical components; and
• generally medically recognised and fully approved by the relevant legislation in force; and
• required as a result of illness, accident or maternity.
	For claiming purposes, please provide us with the following documents together with your Claim form:
	• doctor's prescription stating:
	  • the name of the patient:
	  • the diagnosis:
	  • the name of the medication:
	  • the dosage;
	• the official original invoice clearly mentioning:
	  • the date of purchase;
	  • the name(s) of the medication;
	  • the price paid for each product.

Over-the-counter (OTC) drugs	OTC drugs are only covered in case they are an essential part of a treatment and when the following conditions are met: • the medication must be generally medically accepted as medicine (containing enough active pharmaceutical components). This means that there has to be enough scientific proof of its effectiveness in the peer reviewed medical literature; • the medication needs to be prescribed by a doctor for a well specified diagnosis and this diagnosis needs to be mentioned on the claim or prescription; • the dosage and the quantity purchased need to be reasonable and customary for the specified diagnosis. The following products are not reimbursable: • cosmetics such as creams/lotions to remove wrinkles, Retin A products (unless for diagnosed severe acne) body washes/soaps, moisturizers/barrier creams, skin cleansers; • non-medicated eye drops, hypo tears; eye lubricants.

Item	Remarks
Food/nutritional supplements	Not covered
Vitamins and minerals	Not covered, unless when the vitamin/mineral in question is taken to cure an existing deficit. Please send the results of the relevant laboratory test so that our medical consultant can ascertain whether this is the case.
Vitamin D	Only covered for patients with osteoporosis or osteopenia.
Multivitamins	Not covered
Calcium	Only covered for patients with osteoporosis or osteopenia.
Homeopathy	Covered
Phytotherapy, herbal products	Not covered
Traditional Chinese medicines (TCM)	TCM are reimbursable if there is a medical condition that requires the treatment; if the treatment is provided by a licensed medical doctor in the country where the treatment is rendered; and if the treatment is recognized as a valid treatment modality by the competent health authorities in the country of treatment.
Appetite inhibitors aimed at weight loss/ dietary products	Not covered
Drugs for obesity management (Xenical, Meridia and Reductil)	For patients with a Body Mass Index (BMI) greater than or equal to 30, in conjunction with any of the following severe co-morbidities: • coronary heart disease; • type II diabetes mellitus; • clinically significant obstructive sleep apnoea; • medically refractory hypertension; • well-documented and serious orthopaedic problems. Prior approval is required. Please provide us with a detailed medical report confirming your BMI (Body Mass Index) and any relevant medical disorders. Approval can be granted for a period of maximum six months, but can be prolonged based on an updated evaluation report documenting the treatment’s effectiveness (percentage of weight loss).

Item	Remarks
Products aimed at quitting smoking	Not covered
Bifosfonates/Medication to treat osteoporosis (Fosamax, Evista etc)	Prior approval is required. Please provide us with the result of the BMM (Bone Mass Measurement) taken before the treatment started mentioning the T- and Z-scores. This type of medication will only be covered if the BMM results show that the patient is suffering from osteoporosis (i.e. if the T-score is -2.5 or below and the Z-score is -1.0 or below). Reimbursement of such products is limited to a period of five years.
HIV/AIDS medication	Covered
Daily care products (soap, shampoo etc)	Not covered
Contraceptives	Over the counter drugs and devices are not covered. Birth control drugs and devices are covered when prescribed by a medical doctor
Glucosamine, chondroitin sulfate	Not covered
Hair and nail growth stimulating products	Not covered
Medication to (temporarily) treat impotence (e.g. Viagra, Levitra)	Only covered if the product is prescribed by a doctor • following a prostatectomy (= surgical removal of all or part of the prostate gland); • in case of diabetic neuropathy (= nerve damage as a result of high blood sugar levels). The prescription must include the patient's diagnosis. Maximum reimbursement for 6 tablets per month. Erectile dysfunction as a result of ageing and psychogenic impotence are no valid conditions.
Malaria prophylaxis (= prevention of malaria)	Not covered
Nicotine substitutes	Not covered
Preventive vaccinations for children (well-child care)	See Well-child care
Vaccines	Not covered, except for Influenza, Hepatitis A, Hepatitis B, Hepatitis A+B, Yellow Fever, Tetanus (diphtheria), and Pneumococcal vaccinations, and inoculations for children up to 19 years of age (see Well-child care).

Item	Remarks
Tami flu	Not covered if used for preventive reasons. Covered if the patient has been diagnosed with the flu or when there is an immediate real threat.
HPV vaccine (e.g. Gardasil, Cervarix)	Not covered for members 19 years and over
Insulin, syringes for diabetics	Covered
Lactometer, insulin pump, blood testing strips for insulin-dependant diabetics	Prior approval is required.
Lactometer, insulin pump, blood testing strips for non-insulin-dependant diabetics	Not covered
Strips for urine testing for diabetics	Covered
Hormonal treatment to stimulate fertility	Covered, insofar it is not related to IVF treatment

22.9 At the specialised supplier's office

GENERAL RULE

The plan covers the rental of medical appliances at 80 per cent + MMBP (or the purchase thereof when purchase is more economical than rental or when it is impossible to rent the appliance in question), if considered medically necessary by Vanbreda International's medical consultant.

Item	Remarks
Orthopaedic devices in general	Prior approval is required. Please provide us with a medical prescription indicating the diagnosis and the device prescribed and a Cost estimate.
Orthopaedic shoes	Prior approval is required. Please provide us with a detailed medical report justifying its need and a Cost estimate.
Inlay soles	
Hearing aids	Participation of 12 months in the health plan is required. Prior approval is required. Please provide us with a detailed medical report and audiogram. Covered at 80% up to 750 USD per hearing apparatus (including the cost of the relevant hearing exam) and with a maximum of one hearing aid per ear per 36 months period (no MMBP). The date of the hearing test or the date of purchase, whichever comes first, is considered when determining the eligibility for reimbursement for the expenses in question.
Rental of an aerosol/nebulizer	Prior approval is required. Please provide a detailed medical report justifying its need.
Rental of a CPAP appliance	Prior approval is required. • Please provide a detailed medical report including the results of a sleep study that confirm the existence of a sleep apnoea and a Cost estimate.
Rental of sphygmomanometer (= a blood pressure meter)/blood pressure gauge	Not covered, except for the following persons: • diabetics (both type I and type II, provided that the patient is taking medicines to control the illness, namely, insulin and/or oral antidiabetics);

Item	Remarks
	• pregnant women who present a clinical risk for developing toxicosis or pre-eclampsia; • elderly people suffering from multiple co-morbidities; • patients on home dialysis; • patients with cerebrovascular malformations. Prior approval is required. Please provide a detailed medical report and a Cost estimate.
Wheelchair	Prior approval is required. Please provide a detailed medical report justifying its need and a Cost estimate.
Crutches	Prior approval is required. Please provide a detailed medical report justifying their need and a Cost estimate.
Rollator	
Standing frame	
Support stockings for varicose veins	Prior approval and confirmation of the number of pairs reimbursable is required.
Anti-allergic eiderdown cover, mattress cover, pillow cover	Not covered

22.10 In the laboratory/medical imaging facility

GENERAL RULE

All treatments and medicines must be prescribed by a qualified and registered medical doctor. The items below are reimbursed at 80% + Major Medical Benefits Plan (MMBP), unless indicated otherwise in the remarks.

Item	**Remarks**
X-rays	Covered
Magnetic Resonance Imaging (MRI)	Covered
Ultrasound	Covered
Electrocardiogram (ECG)	Covered
Preventive routine mammography	See Routine physical exam
Preventive routine mammography for persons with a prior history of breast cancer or whose mother or sister has had a prior history of breast cancer	Covered
Mammography for diagnostic purposes	Covered
Laboratory tests	Covered
Amniocentesis	Covered
HIV testing	100%
PSA testing	See Routine physical exam
Pap smear	See Routine physical exam

23. **Exclusions**. The insurance programme does not cover:

(a) Insured participants who are mobilized or who volunteer for military service in time of war;

(b) Injuries resulting from motor-vehicle racing or dangerous competitions in respect of which betting is allowed (normal sports competitions are covered);

(c) The consequences of insurrections or riots if, by taking part, the insured participant has broken the applicable laws; and the consequences of brawls, except in cases of self-defence;

(d) Spa cures, rejuvenation cures or cosmetic treatment (reconstructive surgery is covered where it is necessary as the result of an accident for which coverage is provided);

(e) The direct or indirect results of explosions, heat release or irradiation produced by transmutation of the atomic nucleus or by radioactivity or resulting from radiation produced by the artificial acceleration of nuclear particles;

(f) Expenses for, or in connection with, travel or transportation, whether by ambulance or otherwise, except that charges for professional ambulance service used to transport the insured participant between the place where he or she is injured by an accident or stricken by disease and the first hospital where treatment is given will not be excluded;

(g) In vitro fertilization;

(h) Expenses that are not deemed to be reasonable and customary. The determination of the reasonable and customary charge for each service is made by Vanbreda, based on the prevailing charges for the service at the place where treatment is rendered and considering the complexity of the treatment, including related services or supplies. Fees for treatments, supplies or services that are determined by Vanbreda to be excessive compared with prevailing fee levels will be reimbursed up to the reasonable and customary level for the geographical area in which such medical services are received;

(i) Medical care that is not medically necessary or medical care that is not medically recognized as a treatment for the diagnosis provided;

(j) Products, the effectiveness of which has not been sufficiently proved scientifically and which are not generally medically recognized in the medical world, are not covered under the health plan. One example of this exclusion is products containing glucosamine or chondroitin sulphate;

(k) Elective surgery not resulting from illness, an accident or maternity.

Filing of Claims

24. Members are reminded that claims for reimbursement must be submitted to Vanbreda no later than **two years** from the date on which the medical expenses were incurred. **Claims received by Vanbreda later than two years after the date on which the expense was incurred will not be eligible for reimbursement.**

Provisions pertaining to hospitalization in the United States of America

25. Staff members covered under the Vanbreda Worldwide programme should not seek medical service in the US because the plan does not offer adequate medical protection due to the annual reimbursement limit of $250,000. Medical treatments obtained in the US will be subject to all restrictions and limitations of the Vanbreda plan and staff members will be responsible to reimburse all amounts that exceed benefit limits and annual maximums. Participants who seek admission to a hospital in the United States of America will have to provide prior notification to Vanbreda. **Reimbursement for such hospitalization will be subject to a limit of $600 in respect of the daily semi-private room rate.** Thus, if a participant chooses a hospital at which the daily semi-private room rate exceeds $600, the cost of the daily room rate above $600 will be borne entirely by the participant. There will be no change in the reimbursement for other services. Please note that hospital costs vary considerably throughout the United States and may exceed the $600 reimbursement ceiling, particularly in parts of California, Florida, Massachusetts, New York, Texas and Washington, D.C. Hospital costs also vary by institution and may be much higher in certain hospitals.

26. The **$600 limit will not apply** to semi-private hospital accommodation in three specific circumstances:

(a) In connection with medical evacuation to any hospital in the United States where there is prior authorization by the United Nations Medical Director;

(b) In cases of **bona fide** medical emergency arising while in the United States;

(c) In situations where the necessary medical treatment can be provided only at a hospital where the daily semi-private room rate exceeds $600. In such cases, reimbursement above the $600 will be made if Vanbreda is informed before the hospital admission that the daily semi-private room rate exceeds $600.

27. Please note that staff members, former staff members and their eligible dependants who **reside** in the United States are not eligible for coverage under the Vanbreda plan.

Direct deposit of reimbursements of claims into member bank accounts

28. Members are reminded of the option to have their reimbursements of claims deposited directly into their personal bank accounts. Please note that only one currency per claim form will be allowed and that if no reimbursement currency is selected on the claim form, or data are insufficient to provide the payment selected, reimbursement will, by default, be made in United States dollars. Election of this option can be made on the claim form that is posted on Vanbreda's dedicated website for United Nations participants (see http://www.vanbreda-international.com). Use of the claim form available on the Vanbreda website is recommended since it facilitates the settlement of claims by printing the participant's name and Vanbreda reference number as well as a corresponding bar code on the form. Although there is a Vanbreda claim form also posted on the United Nations insurance website (see http://www.un.org/insurance), it does not have the unique reference number or bar code.

29. Enter the following bank information on the Vanbreda claim form. Your bank can provide you with the information in (d) and (e):

(a) Bank name and full address;

(b) Bank account number;

(c) Account holder's name;

(d) International Bank Account Number (IBAN) code: mandated for cross-border payments within the European Union and Switzerland. If the IBAN is not available, provide the corresponding local bank code: for example, ABI/CAB for Italy, Bankleitzahl for Germany, sorting code for United Kingdom, and so on;

(e) Bank identification code: either the BIC/SWIFT code, or the ABA code in the United States.

30. Please note that the direct deposit option is not available for deposits into bank accounts in the following countries: Cuba, Iran (Islamic Republic of), Myanmar, North Korea, Syria and the Sudan.

Vanbreda International toll-free telephone numbers

31. UIFN (universal international free phone number)

Please dial the access number for international calls in the country you are calling from and then dial the 800 number assigned for that country. For example, if you are in the United States, you would dial 011 (access number for international calls) plus 80082468866 (the number for the United States).

Country or area	*Type*	*Number*
Argentina	UIFN	+80059089101
Australia	UIFN	+80082468866
Austria	UIFN	+80082468866
Belgium	UIFN	+80082468866
Brazil	UIFN	+80082468866
Canada	UIFN	+80082468866
China	UIFN	+80082468866
Colombia	UIFN	+80082468866
Costa Rica	UIFN	+80059089101
Cyprus	UIFN	+80059089101
Denmark	UIFN	+80082468866
Finland	UIFN	+80082468866
France	UIFN	+80082468866
Germany	UIFN	+80082468866
Hong Kong, China	UIFN	+80082468866
Hungary	UIFN	+80082468866
Iceland	UIFN	+80082468866
Ireland	UIFN	+80082468866
Israel	UIFN	+80082468866
Italy	UIFN	+80082468866
Japan	UIFN	+80082468866
Malaysia	UIFN	+80082468866
Malta	UIFN	+80082468866
Netherlands	UIFN	+80082468866
New Zealand	UIFN	+80082468866
Norway	UIFN	+80082468866
Philippines	UIFN	+80082468866
Portugal	UIFN	+80082468866
Russian Federation	UIFN	+80082468866
South Africa	UIFN	+80082468866
Spain	UIFN	+80082468866
Sweden	UIFN	+80082468866
Switzerland	UIFN	+80082468866
Thailand	UIFN	+80082468866
United Kingdom of Great Britain and Northern Ireland	UIFN	+80082468866

ITFS (international toll-free service)

32. Please dial the number.

Country	*Type*	*Number*
Belarus	ITFS	8002030939
Bulgaria	ITFS	008001154464
Chile	ITFS	12300208432
Dominican Republic	ITFS	18002030939
El Salvador	ITFS	8006589
India	ITFS	0008004401303
Indonesia	ITFS	001-803440600
Jamaica	ITFS	18009884829
Lithuania	ITFS	880030830
Mauritius	ITFS	8020440052
Mexico	ITFS	018001231680
Nicaragua	ITFS	8002030939
Panama	ITFS	008000444843
Paraguay	ITFS	0098004410036
Peru	ITFS	080053970
Sri Lanka	ITFS	2473018
United States of America	ITFS	18772961908
United Arab Emirates	ITFS	80004415344
Uruguay	ITFS	0004110023296

TFD (toll-free direct)

33. How does it work?

AT&T Direct® Toll-Free Service is a two-step dialing process:

a) The caller first dials the AT&T Direct® Access Code for the country from which he or she is calling. The caller reaches an English-speaking (or selected in-language support, including Spanish) AT&T operator or voice prompt and hears the following announcement: “AT&T”. Please enter the number you are calling now.

b) The caller enters the toll-free number. The AT&T Operator Services responds: “Thank you for using AT&T” and completes the call to the toll-free number location.

Country	Type	Toll-free direct access code	Toll-free number	Footnote
Albania	TFD	00-800-0010	800 203 0939	A
Angola	TFD	808 000 011	800 203 0939	
Bangladesh	TFD	157-0011	800 203 0939	
Belize	TFD	811	800 203 0939	
Belize (Hotels Only)	TFD	555	800 203 0939	
Bulgaria	TFD	00-800-0010	00800 1154464	
Cambodia	TFD	1-800-881-001	800 203 0939	D
Ivory Coast (English)	TFD	00-111-11	800 203 0939	A
Ivory Coast (French)	TFD	00-111-12	800 203 0939	
Cuba	TFD	2935	800 203 0939	
Ecuador – Andinatel	TFD	1-999-119	800 203 0939	
Ecuador – Pacifictel (English)	TFD	1-800-225-528	800 203 0939	
Ecuador – Pacifictel (Spanish)	TFD	1-800-999-119	800 203 0939	
Egypt Cairo	TFD	510-0200	800 203 0939	A
Egypt outside Cairo	TFD	02-510-0200	800 203 0939	
Fiji	TFD	004-890-1001	800 203 0939	
Guatemala	TFD	999-9190	800 203 0939	B
Haiti	TFD	183	800 203 0939	
Haiti Fr. Creole	TFD	181	800 203 0939	
Honduras	TFD	800-0123	800 203 0939	
Jordan	TFD	1-800-0000	800 203 0939	
Kazakhstan	TFD	8 800-121-4321	800 203 0939	A
Lebanon Beirut	TFD	426-801	800 203 0939	B
Lebanon outside Beirut	TFD	01-426-801	800 203 0939	C
Macedonia	TFD	99-800-4288	800 203 0939	B
Pakistan	TFD	00-800-01-001	800 900 44014	
Senegal English	TFD	810-3072	800 203 0939	
Senegal French	TFD	810-3073	800 203 0939	
Zimbabwe	TFD	110-98990	800 203 0939	

A Public phones require coin or card deposit.

B Public phones may require local coin payment during call duration.

C Collect calling only.

D Available from payphones in Phnom Penh and Siem Riep only.

* Circulated under the symbol ST/AI/2007/3.

Annex VIII: Provider Contact Directory

Internet websites

Online provider directories	*Instructions*
Aetna http://www.aetna.com/docfind/index.html	1. Click on “Find a doctor”. 2. Select the search criteria to be used and enter the geographical information. 3. Select a search category, such as “Specialists”, “Aetna Vision Discount locations” or “Medical Hospitals”. 4. Under “Select a Plan” choose “Aetna Standard Plans”. Then select “Open Choice PPO” from the Health Plan menu. 5. Click on the “start search” 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 http://www.empireblue.com	1. Click on “Visitors” or “Members” at the top of the menu in the upper left-hand corner of the home page. 2. Select “Find a Doctor” on the left of the page. This selection allows you to find a doctor or hospital locally or across the country. 3. Follow the prompts depending on your selection.
HIP Health Plan of New York https://www.hipusa.com/employers/allforms.asp	1. Click on “Log In” at center of page. 2. Choose Find Doctor on top of page. 3. Choose HIP on right side of page. 4. Select “Member” or Visitor and then a “provider type” (PCP, Specialist or Hospital) and select “Continue”. 5. Under the title “Select Plan” choose “HIP Prime” and under “Network”, select “Prime”. 6. You may refine your search by entering the name of a provider, or by proximity: zip code; languages spoken, area of specialization or hospital affiliation.
CIGNA http://www.cigna.com/	1. Select “Provider Directory” at the top of the home page. 2. Select “Dentist” on “What type of provider are you looking for?” 3. Select “Language spoken” preference. 4. Select “Search by name” and “Enter zip code OR city and state” if you already know the dentist’s name. 5. For a new dentist, select “Enter zip code OR city and state” and select the distance you are willing to travel. 6. Click on “Next” button. 7. On “Select your plan” choose “CIGNA Dental PPO or CIGNA Dental EPO (an in-network only DPPO product) 8. Select “CORE NETWORK” in the next drop-down menu. 9. Select “Specialty” on drop-down menu (i.e., Endodontics, General Dentistry, etc.). 10. Click on “Search” button to view search results.

Online provider directories	*Instructions*
Vanbreda International http://www.vanbreda-international.com	1. Select “Plan Members” 2. Enter your Personal Reference Number and Date of Birth (or password) 3. Select “Provider list” 4. Select a Continent and a Country 5. If desired, refine your search (specialty, city, …) 6. Click “Search”

Staff members are strongly encouraged to establish usernames and passwords to access the insurance carriers’ member websites to obtain information on the status of claims, view benefits, request ID cards and print temporary ID cards, among other things.

US-based insurance carriers addresses and telephone numbers for claims and benefit enquiries

I. Aetna PPO/POS II	**Aetna Inc.** **P.O. Box 981106** **El Paso, TX 79998-1106**
Tel.: (800) 784-3991	Member Services (benefit/claim questions)
Tel.: (800) 333-4432	Pre-registration of hospital/institutional services
Tel.: (610) 336-1000 ext. 3317763	Aetna PPO/POS II members on travel
Tel.: (800) 784-3991	Participating pharmacy referral
Tel.: (866) 612-3862	Aetna Rx Home Delivery (mail order drugs) P.O. Box 417019, Kansas City, MO 64179-9892
Tel.: (866) 612-3862	Maintenance drug automated refills (credit card)
Tel.: (800) 424-1601	Aetna Behavioral Health
Tel.: (800) 793-8616	Vision One
Tel.: (800) 422-6600	Discount Information on Lasik Surgery

II. Aetna International PPO	**Aetna International/Aetna** **P.O. Box 981543** **El Paso, TX 79998-1543 USA**
Tel.: 1-800-231-7729 or 1-813-775-0190 (call collect from outside USA)	Member Services (benefit/claim questions)
Tel.: 1-800-231-7729 or 1-813-775-0190 (call collect from outside USA)	Pre-registration of hospital/institutional services
Tel.: 1-800-231-7729 or 1-813-775-0190 (call collect from outside USA)	Participating pharmacy referral
Other numbers	Same as for Aetna PPO/POS II above

III. Empire Blue Cross PPO	**Empire Blue Cross Blue Shield** **PPO Member Services** **P.O. Box 1407** **Church Street Station** **New York, NY 10008-1407**
Tel.: (855) 519-9537	Member Services (benefit/claim questions)
Tel.: (800) 982-8089	Medical Management Program (precertification for hospital admissions, elective surgery, home care, skilled nursing facilities, second opinion referrals)
Tel.: (855) 519-9537	Empire Behavioral Health Services (prior approval of mental health/substance abuse care)
Tel.: (804) 673-1177-Collect	Empire World Wide (International Benefits Svs) Claims

Tel.: (888) 613-6091	Empire Pharmacy Management Program/NextRx (prescription card programme and pharmacy network and maintenance drug mail order drug information)
IV. Empire Blue Cross (International Benefits & Claims)	**BlueCard Worldwide Service Center P.O. Box 72017 Richmond, VA 23255-2017**
Tel.: (800) 810-2583 (804) 673-1177 (collect)	Empire World Wide (International Benefits & Claims Services)
Tel.: 866-723-0515	Blue View Vision Attn: Out Of Network (OON) Claims P.O. Box 8504 Mason, OH 45040
V. HIP	**HIP Member Services Department 7 West 34th Street New York, NY 10001**
Tel.: (800) HIP-TALK {(800) 447-8255}	HIP Member Services Dept. (walk-in service available) 6 West 35th Street New York, NY 10001
Tel.: (888) 447-4833	Hearing/Speech Impaired
Tel.: (877) 774-7693	Chiropractor Hotline
Tel.: (888) 447-2526	Mental Health Hotline
Tel.: (800) 290-0523	Dental Hotline
Tel.: (800) 743-1170	Lasik Surgery (Davis Vision) Hotline
VI. CIGNA Dental PPO Plan	**CIGNA Dental P.O. Box 188037 Chattanooga, TN 37422-8037**
Tel.: (800) 747-UNUN or (800) 747-8686	Claim Submission, ID Card Requests and Customer Service
Tel.: (888) DENTAL8	for participating provider referrals
VII. FrontierMEDEX	**FrontierMEDEX Assistance Corporation P.O. Box 19056 Baltimore, MD 21284**
Tel.: (800) 527-0218	Within the United States
Tel.: (410) 453-6330	FrontierMEDEX Emergency Response Center, Baltimore, MD (*collect call*)
International toll-free access numbers	See detailed listing contained in annex V

VIII. ACTIVEHEALTH	**ActiveHealth Management** **102 Madison Ave** **New York, NY 10016**
Tel.: (212) 651-8200	Corporate Headquarters
Tel.: (800) 778-8351	ActiveHealth Nurse Care Manager Program
Tel.: (800) 556-1555	24 Hour Nurse Line
www.activehealthphr.net/unitednations	ActivePHR Website

International insurance carrier addresses and telephone numbers for claims and benefit enquiries

You can reach Vanbreda 24 hours a day, 7 days a week, 365 days a year. In case of emergency or if you simply have a question, you can contact our multilingual staff in several ways. Our contact details are also mentioned on your personal webpages and on your membership card.

	Antwerp office	Kuala Lumpur office	Miami office
www	www.vanbreda-international.com		
@	mcc001@vanbreda.com		
Phone	+ 32 3 217 68 42	+ 60 3 2178 05 55	+ 1 305 908 91 01
Mail	Vanbreda International NV P.O. Box 69 2140 Antwerpen Belgium	Vanbreda International P.O. Box 10612 50718 Kuala Lumpur Malaysia	Vanbreda International P.O. Box 260790 33126 Miami, FL USA

Toll-free numbers

Wherever feasible, you can call us for free through a toll-free number. If there is no toll-free number available for your country of stay, you can use the UN dedicated phone number, which is also mentioned on your membership card. You can find the full list of available toll-free numbers per country on your personal webpages.

DISCLAIMER: This circular provides only a summary of the benefits covered under the UNHQ insurance programme. Detailed benefit description can be obtained from the insurance carriers of the United Nations.