

UNOPS

MIP
Medical Insurance Plan
Rules

Effective 1 January 2017

Table of Contents

Chapter I	5
General Observations	5
Name	5
Object	5
Third Party Administrator	5
Chapter II	6
Rules Governing the Medical Insurance Plan	6
1.0 General	6
Administration of MIP Claims	7
After-service participant	7
Appendix D beneficiary	7
Co-ordination of benefits	7
Emergency	8
Hospitalization	8
Mental and nervous care	8
MIP Reference Salary	8
Participating survivor	8
Physician	9
Reasonable and customary (RC) expenses	9
Recognized expenses	9
Subscriber	9
2.0 Participation	10
2.1 Automatic participation	10
Contract	10
Contributions	10
Enrolment	11
2.2 Voluntary participation	11
Coverage for eligible family members	11
Secondary Dependants	12
Death of a staff member	12
After-service coverage	12
2.3 Waivers for certain duty stations	12
Government or national health insurance	12
Other UN-recognized insurance	13
Individual waivers	13
Special leave without pay (SLWOP)	13
Effective commencement of coverage	13
2.4 Cessation of coverage	13
Effective date	13
Eligible family members	14
Withdrawal of eligible family members	14
3.0 Summary of Benefits	15
3.1 Reasonable and customary (RC) expenses	15
Definition	15
Medical expenses incurred outside the country	15
3.2 Hospital expenses	15

3.3 Professional services and medications	16
Services provided by a qualified physician	16
Obstetrical services	16
Laboratory tests	17
Drugs and medicines	17
Immunizations	17
3.4 Mental and nervous care	17
Out-Patient Mental Health	17
Treatment for Substance Abuse	17
3.5 Optical lenses and hearing aids	17
Waiting period	17
Routine Eye examinations	18
Corrective Optical lenses	18
Hearing aids	18
3.6 Dental care	18
Rate of reimbursement	18
Concept of reasonable expenses	18
Maximum reimbursement of all benefits	18
3.7 HIV and AIDS	19
3.8 Well Child Care (Routine Examinations for children)	19
a) newborn 1 routine in-hospital examination at birth	19
b) birth to Age 1 6 routine visits, i.e. every two months	19
c) age 1 through Age 2 3 routine visits, i.e. every six months	19
d) age 3 through Age 6 4 routine visits, i.e. every year	19
e) age 7 through 19th birthday 6 routine visits, i.e. every two years	19
3.9 Well Man Care (Routine Urological Examinations for Men)	19
3.11 Routine Physical	20
a) children 19+ and adults, every 24 months; <i>and</i>	20
3.13 Non-Reimbursable Items	20
3.14 Maximum reimbursement of expenses	21
MIP ceiling	21
Reimbursements	21
Amounts exceeding the MIP ceiling	21
3.15 Co-ordination of benefits	22
3.16 List of Reimbursable and Non-Reimbursable Items	22
3.17 Access to Medical Global Networks	22
4.1 Staff members	23
4.2 Eligible family members	23
Change in Family Status	23
4.3 After-Service Participants	24
4.4 Cessation of coverage of family members	25
5.0 Premiums	28
5.1 Contributory nature of the scheme	28
5.2 Premiums	28
5.3 Collection of contributions	28
6.0 Claims, Hospitalization and Direct Billing	29
6.1 Time Limit for Filing a Claim.	29
6.2 Forms and supporting documentation	29
Claim Form	29
Supporting documents	29
6.4 Screening of claims by the TPA	32
6.5 Referral to Headquarters	32
Screening of claims	32
Claims exceeding the MIP ceiling	32

6.6 Reimbursement of claims	32
Procedure	32
Concept of reasonable and customary expenses	32
Expenses incurred outside the country	33
Co-ordination of benefits	33
7.0 After-Service Health Insurance (ASHI)	37
7.1 General	37
Conditions	37
Secondary dependants	37
7.2 Eligibility conditions	37
Eligible Former Staff Members	37
Children	39
Children born After-service	39
Disabled child	39
Qualifying periods	39
7.3 Enrolment procedures and time-limits for after-service coverage	40
Applications	40
Delays for submission	40
Death of a former staff member	40
7.4 Contributions	40
7.5 Method of payment of contributions	40
7.6 Change in country of residence	41
Conditions	41
New country of residence	41
7.7 Type of benefits and currency of reimbursement	41
Definition	41
Currency of reimbursement	41
7.8 Cessation of coverage	41
After-service coverage for eligible former staff members ceases:	41
After-service coverage for eligible surviving family members ceases	42
8.0 Miscellaneous	43
8.1 Administrative aspects	43
Responsibility	43
Compliance to the rules	43
8.2 Queries	43
8.3 Forfeiture and suspension of benefits	43
8.4 Recourse	43
8.5 Abuse or Fraud	44
8.6 Service-incurred injuries	44
Chapter III	45
Stop-Loss Clause	45
Chapter IV	47
Hardship Provision	47
Appendix A - Second surgical opinion requirement	48
The 16 surgical procedures for which second opinions will be reimbursed at the rate of 100 per cent are:	48
Procedure	48
Explanation	48
1 Bunionectomy	48

Removal of bunions	48
2 Cholecystectomy	48
Removal of gall bladder	48
3 Dilation and curettage	48
Dilation of cervix and scraping of uterus	48
4 Excision of cataracts	48
Removal of cataracts	48
5 Haemorrhoidectomy	48
Removal of haemorrhoids	48
6 Hernia (inguinal) repair	48
Repair of hernia in the groin	48
7 Hysterectomy	48
Removal of uterus	48
8 Knee surgery	48
Knee operation	48
9 Laminectomy	48
Removal of part of spine	48
10 Mastectomy: partial or complete	48
Partial of complete removal of breast tissue	48
11 Prostatectomy	48
Removal of prostate	48
12 Septo-rhinoplasty	48
Nose surgery for functional improvement	48
13 Spinal fusion	48
Surgical welding of spine segments	48
14 Tonsillectomy and/or adenoidectomy	48
Removal of tonsils and/or adenoids	48
15 Varicose veins	48
Removal and tying of varicose veins	48
16 Coronary artery bypass	48
Heart surgery to bypass one or more blocked arteries feeding the heart	48
Appendix B - Methodology for contribution calculation	49
[Only relevant to enrolled Staff Members and enrolled former Staff Members under ASHI]	49
Appendix D – Excluded duty stations	49
Appendix E - List of Reimbursable and Non-Reimbursable Items	49

Chapter I

General Observations

Name

The “Medical Insurance Plan” (MIP) was established in 1987 by the General Assembly (GA) at its forty-first session in accordance with United Nations (UN) Staff Regulation 6.2 and replaced the Medical Expense Assistance Plan (MEAP).

Object

The object of the MIP is to assist subscribers¹ and their eligible family members in meeting expenses incurred for certain health services, facilities and supplies arising from sickness, accident or maternity and which should be reimbursed within the limits laid down in UNOPS MIP rules.

Third Party Administrator

The administration of UNOPS² MIP claims is outsourced to a Third Party Administrator who is an independent administration brokerage firm. UNOPS Headquarters will provide advice to the Third Party Administrator (hereinafter referred to as “the TPA”) upon request.

The TPA will have the responsibility for the day-to-day operation of the UNOPS MIP. This includes processing and reimbursement of claims, financial management and accounting of settled claims.

Underwriter

The underwriting of UNOPS MIP claims is outsourced to an insurer as detailed in the Contract and Appendix D to the MIP Rules.

1 Both UNOPS MIP subscribers and UN System MIP subscribers administered by UNOPS.

2 and claims from UN System subscribers administered by UNOPS.

Chapter II

Rules Governing the Medical Insurance Plan

1.0 General

1.1 Purpose

The Medical Insurance Plan (MIP) is a health insurance scheme operated by UNOPS for the benefit of their locally-recruited active staff members (both in the General Service and National Officer categories) and former staff members (and their eligible family members) serving or residing at designated duty stations away from headquarters.

A MIP participant may go to a hospital, physician or dentist of his/her choosing, whether an in-network or non-network provider (see MIP Rule 3.17). When a MIP participant goes to an in-network provider with whom the TPA has negotiated fees/discounts, the provider's billing and the TPA's settlement will reflect these preferential rates, which are to the benefit of both the subscriber and MIP.

1.2 Eligibility

Except in New York and designated duty stations, participation in MIP is automatic (see MIP Rule 2.1) for all UNOPS³ locally-recruited staff members⁴ who:

- a) hold a letter of appointment governed by the UN Staff Regulations and Staff Rules of *three months or more*; or
- b) have completed three months of continuous service under a letter of appointment governed by the UN Staff Regulations and Staff Rules.

The Plan provides also for:

- a) health insurance for eligible family members of locally-recruited UNOPS⁵ staff members on an *optional basis*; and
- b) after-service health insurance (ASHI) protection for eligible former UNOPS⁶ staff members and their eligible family members also on an *optional basis*.

3 or UN agencies on behalf of which UNOPS administers their locally-recruited staff members.

4 Both General Service and National Officer Categories.

5 or UN agencies on behalf of which UNOPS administers their locally-recruited staff members.

6 or UN agencies on behalf of which UNOPS administers their locally-recruited staff members.

1.3 Definitions

The following definitions are intended to clarify the meaning of certain terms which are used throughout these rules:

Administration of MIP Claims

The TPA will administer claims for all:

- a) UNOPS MIP subscribers; *and*
- b) UN System MIP subscribers administered by UNOPS.

After-service participant

This term is used for convenience to refer equally to retirees, participating survivors, disability pensioners and Appendix D of the UN Staff Rules beneficiaries.

Appendix D beneficiary

An Appendix D beneficiary is a former staff member or eligible family member in receipt of a periodic compensation benefit payable under Appendix D of the UN Staff Rules.

Co-ordination of benefits

Co-ordination of benefits refers to the settlement of reimbursable medical expenses where more than one medical insurance scheme covers a subscriber and/or his/her eligible family members.

With respect to MIP, co-ordination of insurance benefits will apply, as appropriate (i.e. if the insured patient is entitled to reimbursement by another insurer, reimbursement under MIP, will be applied to the difference between the costs actually incurred and reimbursement obtained from the other insurer).

Dental Services

Dental services are services performed by a dental practitioner, or a dentist who has completed a course of study at a university faculty of dentistry and is licensed to practice dentistry, i.e. perform dental services, in the country in which he/she practices the profession of dentistry.

Disability pensioner

A Disability Pensioner is a former staff member or eligible family member who is in receipt of a disability benefit from the United Nations Joint Staff Pension Fund (UNJSPF).⁷

Eligible family members

Eligible family members constitute the subscriber's spouse and children. The MIP recognizes only one spouse as eligible for coverage; the number of children covered under the Plan is ***unlimited as long as they are eligible for the Plan*** (see MIP Rule 2.2), or in the case of retired staff members, the spouse and children already enrolled at the time of retirement and any child born within 300 days of retirement.

Parents, brothers and sisters, whether or not secondary dependants, ***are not eligible for the Plan***.

Emergency

The sudden, unexpected onset of a medical condition which, if not treated immediately, could reasonably result in such deterioration of the patient's condition as to jeopardize life or seriously impair bodily function.

Hospitalization

Hospitalization is defined as any stay including at least one night in the establishment.

Mental and nervous care

Mental and nervous care constitutes medical treatment for emotional disturbance provided by a physician licensed in the specialty of psychiatry.

MIP Reference Salary

This term is used in the text for abbreviation purposes. It stands for the monthly net base salary at the top step of the highest regular General Service level of the duty station scale⁸. ***For this purpose any Extended General Services or National Officer levels are not taken into account nor are longevity or long-service steps.*** The MIP reference salary is based on the scale in use on ***1 January each year*** and is ***not*** revised on the basis of subsequent salary scale revisions unless such revisions have a retroactive effective date prior to the reference date, ***i.e. to 1 January***.

Participating survivor

A participating survivor is an eligible family member who survives a subscriber.

7 www.unjspf.org

8 The salary scales may be accessed at: http://www.un.org/Depts/OHRM/salaries_allowances/

Physician

A physician means a person who holds a medical degree from an accredited medical school of university level recognized by the Government of the jurisdiction in which he/she is licensed to practice medicine.

Reasonable and customary (RC) expenses

Reasonable and customary (RC) expenses refers to the prevailing pattern of charges for professional and other health services at the duty station where the service is provided, (staff member's duty station). This applies to services within the country of the staff member's duty station.

For services performed outside the country of the staff member's duty station, except on official duty travel (DT) and medical evacuation travel (MET), *only prevailing patterns of charges for the services within the country of the staff member's duty station are recognized.*

Recognized expenses

The expenses for services claimed provided they are found to be reasonable and customary at the duty station or, when obtained elsewhere in the country, at the place provided. If the expenses claimed are found to be above what is considered reasonable and customary, then the recognized amount for the purpose of calculating reimbursement is the reasonable and customary (RC) amount as determined by the TPA.

Subscriber

A subscriber is an active staff member, a former staff member enrolled in MIP or, upon the death of the former or the latter, the surviving spouse (if any) or the eldest eligible child.

2.0 Participation

2.1 Automatic participation

Contract

Except in New York and designated duty stations, participation in MIP is automatic for all UNOPS⁹ staff members who:

- a) hold a letter of appointment governed by the UN Staff Regulations and Staff Rules of *three months or more; or*
- b) under a letter of appointment governed by the UN Staff Regulations and Staff Rules, *have completed three months of continuous service.*

Contributions

All staff members governed under the UN Staff Regulations and Staff Rules, regardless of their length of contract, will have a deduction taken from their salary in respect of their participation in MIP. Subject to limited exceptions, UNOPS subsidizes the MIP premium for the appointee and his/her eligible family members by making contributions.

If a staff member who is not initially eligible remains in the employment of the Organization beyond three months, he/she may claim retroactively for assistance in reimbursement for MIP-covered services. If he/she leaves the Organization during the initial period of three months, he/she will not have been entitled to benefits and will be refunded the contributions deducted during that period.

9 or UN agencies on behalf of which UNOPS administers their locally-recruited staff members.

Enrolment

Notwithstanding that participation in MIP is automatic, a MIP Application/Request for Change Form ***must be completed*** by the staff member in respect of his/ her own participation, and, additionally, to provide an opportunity to enrol his/her eligible family members.

2.2 Voluntary participation

Coverage for eligible family members

Health coverage for family members is highly recommended as a protection against high health care costs. A staff member is therefore encouraged to enrol his/her spouse and children in MIP. However, enrolment of these family members ***is voluntary***.

Eligible family members of active staff ***must*** be enrolled ***within 30 days*** after the staff member joins the Organization, or within 30 days after the marriage¹⁰ of the staff member or birth/adoption¹¹ of a child. If eligible family members are not enrolled within 30 days after the staff member joins the Organization, or within 30 days after the marriage of the staff member or birth/adoption of a child, they may be enrolled during the annual enrolment campaign to be held between 1st and 15th June every year.

If eligible family members are at any time withdrawn from the Plan, they may only re-enter during the annual enrolment campaign to be held between 1st and 15th June every year, subject to fulfilling a minimum waiting period of two years counted as from the effective date of withdrawal from the plan.

Spouse

A recognized spouse is always eligible.

Children

A child is insurable under MIP until the end of the year in which he/she reaches the age of 25, provided all of the following conditions are met, namely that he/she is:

- a) a dependant of the subscriber;
- b) not married; *and*
- c) not engaged in full-time employment.

10 If the issuance of the marriage certificate takes longer than 30 days the staff member should still submit the enrolment form within 30 days. Upon submission of the marriage certificate, enrolment will become effective retroactive to date of marriage.

11 If the issuance of the birth/adoption certificate takes longer than 30 days, the staff member should still submit the enrolment form within 30 days. Upon submission of the birth/adoption certificate, enrolment will become effective retroactive to date of birth/adoption.

There is no limit on the number of children eligible for coverage, provided the subscriber concerned submits satisfactory evidence of parenthood or adoption.

Subject to consultation with the UN Medical Director, the above age limitation may be waived in the case of disabled children. If a child is disabled by reason of mental and/or physical handicap to the extent that he/she is unable to earn a living, coverage under MIP may be continued for as long as that incapacity lasts and his/her parent is a MIP subscriber or he/she is a surviving child. Evidence of such incapacity will have to be supplied in a manner satisfactory to, and at intervals required by the UN Medical Director. If the UNJSPF¹² continues to pay a child's benefit because of the child's incapacity, such payment may constitute satisfactory evidence of disability.

Secondary Dependants

Coverage is not available for secondary dependants (such as a parent, brother or sister).

Death of a staff member

If an insured staff member dies, the surviving eligible spouse (if any) or the eldest eligible child *becomes eligible to assume the role of the subscriber* and to continue to pay contributions in accordance with the appropriate category of coverage (see MIP Rule 7.4).

Coverage for surviving and eligible family members of a deceased former staff member is also available on a voluntary basis (see MIP Rule 7.2).

After-service coverage

After-service coverage for former staff members and their eligible family members is available on a voluntary basis (see MIP Rule 7.2).

2.3 Waivers for certain duty stations

Under certain circumstances, all staff at a duty station may be excluded by UNOPS from participating in MIP. The two main reasons justifying such exclusion are as follows:

Government or national health insurance

Where comparable and adequate health coverage is provided on a general basis by the Government or national health plan of the country concerned. In this case, it is up to the affected UN Organizations at the duty station to jointly present to the relevant headquarters their request that participation in MIP be waived for the entire duty station. In the case of UNOPS, requests should be submitted to the People and Change Group.

12 www.unjspf.org

Other UN-recognized insurance

Where staff at the duty station have traditionally had health insurance coverage through a UN-recognized plan other than MIP or its predecessor, MEAP. Staff members at the respective duty station will not be required to switch their enrolment to MIP, but may opt into the Plan as a group. Once a duty station opts into MIP and the exercise of that option has been approved by the relevant Headquarters¹³, subsequent withdrawal from MIP will not be permitted. In some instances, the UN and related Organizations, e.g., UNOPS, UNDP, UNICEF and UNHCR, may be operating different medical schemes.

Individual waivers

Where a waiver for the entire duty station has been approved on the basis of coverage provided by the Government or a national health plan and where certain individuals are excluded from the governmental coverage (for instance, for not being nationals of the country), individual enrolment will be permitted in MIP. Family members may not, however, be enrolled in MIP without the participation of the subscriber; the subscriber would therefore have to be enrolled in MIP in order for his/her eligible family members to qualify for coverage.

Special leave without pay (SLWOP)

Coverage under MIP may be continued during a period of special leave without pay (SLWOP) provided the staff member pays both his/her own contribution and that of the Organization (see MIP Rule 4.5).

Effective commencement of coverage

New coverage for a staff member newly enrolled in MIP commences on the first day of a qualifying contract (see MIP Rule 1.2). If the first day of a qualifying contract occurs later than the first day of the month, coverage commences on that day. In no event can coverage commence prior to the first day of the qualifying contract.

2.4 Cessation of coverage

Effective date

A staff member participating in MIP remains covered through the last day of the month in which the employment ceases. Therefore, if a contract terminates before the last day of a month, coverage will remain in place until the end of that month.

In cases of termination for disciplinary reasons, coverage will cease immediately.

In the case of retirement or disability, there are provisions for after-service coverage, which are explained under MIP Rule 7.0.

13 In the case of UNOPS, requests should be submitted to the People and Change Group.

Eligible family members

Eligible family members may remain covered as long as the staff member or former staff member remains covered, subject to payment of the required contribution, and until their eligibility (as defined in MIP Rule 2.2) ceases. Surviving family members who continue contributing to MIP will maintain their coverage until their eligibility ceases or until they elect to discontinue, whichever occurs first.

Withdrawal of eligible family members

Withdrawal of eligible family members from MIP must be done *in writing* and submitted to the UNOPS Global Shared Service Center (GSSC).

Once a staff member has elected to withdraw eligible family members, their re-entry into the plan will only be permitted during the annual enrolment campaign to be held between 1st and 15th June every year, subject to fulfilling a minimum waiting period of two years counted as from the effective date of withdrawal from the plan.

3.0 Summary of Benefits

3.1 Reasonable and customary (RC) expenses

Definition

MIP covers the benefits described below, subject to the stated limitations. The TPA will reimburse claims in line with these benefits on the basis of the reasonable and customary (RC) charges applicable at the duty station. RC refers to the prevailing pattern of charges for professional and other health services *at the duty station* where the service is provided. Fees for treatments, procedures or services which may be considered by the TPA to be excessive compared to prevailing fee levels will be reimbursed up to the reasonable and customary level. This applies for services within the country of the staff member's duty station.

Medical expenses incurred outside the country

Services and medication provided outside the country of the staff member's duty station, will be covered on the basis of the RC costs prevailing pattern *within* the country of the staff member's duty station. Expenses above these limits will not be reimbursed except in the cases indicated in the following paragraph.

In the case of medical expenses incurred while on:

- a) *official duty travel (DT)* expenses for an emergency treatment will be reimbursed based on the prevailing pattern of charges for professional and other health services in the country where incurred. Expenses for non-emergency treatments will be reimbursed based on the prevailing pattern in the country of the staff member's duty station; *and*
- b) *medical evacuation travel (MET)*, expenses will be reimbursed based on the prevailing pattern of charges for professional and other health services to where MET is authorized.

3.2 Hospital expenses

A MIP participant may go to a hospital of his/her choosing, whether an in-network or non-network provider (see MIP Rule 3.17). When a MIP participant goes to an in-network provider with whom the TPA has negotiated fees/discounts, the provider's billing and the TPA's settlement will reflect these preferential rates, which are to the benefit of both the subscriber and MIP.

Reimbursement at 100 per cent is provided for hospital services (excluding doctor's fees) and supplies, including such items as bed and board (semi-private accommodations), operating room and equipment, use of recovery room and equipment, intensive care, general hospital nursing care, laboratory equipment, x-ray examinations, as well as drugs and medicines administered in the hospital. Drugs and

medicines administered in the hospital include those provided by the hospital, provided by a physician for administration in the hospital, or provided privately in the absence of availability through the hospital. Where hospital accommodation is provided at rates for a private room with only one bed, then 70% of the costs of bed and board and general nursing care at the private rate or 100 per cent of the rate for semi-private accommodation, *whichever is greater*, is reimbursed.

Only under the following conditions, subject to the provision of documentation satisfactory to the TPA, will private-room care be reimbursed in full (i.e. 100 per cent):

- a) when the nature and gravity of the illness requires private-room care and the need for such care is substantiated by the attending physician; *or*
- b) when the patient is admitted on an emergency basis to a hospital that has semi-private accommodation but none is available at the time; *or*
- c) when the patient is admitted to a hospital that does not have any semi-private accommodation, that is, it has no standard of accommodation other than private rooms and general wards.

In the event of in-patient hospitalization, the TPA will normally provide direct settlement for the allowable expenses incurred (see MIP Rule 6.10).

3.3 Professional services and medications

A MIP participant may go to a provider of his/her choosing, whether in-network or non-network provider (see MIP Rule 3.17). When a participant goes to an in-network provider with whom the TPA has negotiated fees/discounts, the provider's billing will reflect these preferential rates, which are to the benefit of both the subscriber and MIP.

The following services are reimbursed at **80 per cent**:

Services provided by a qualified physician

Services provided by a qualified physician, whether at the office or in the hospital, including surgeon's fees, and other medical services.

Medical services rendered by a family member who is a physician will not be considered for reimbursement, only the materials used or medications prescribed will be considered.

Obstetrical services

Obstetrical services, including delivery and midwifery;

Laboratory tests

Laboratory tests and X-rays (provided on an out-patient basis);

Drugs and medicines

Drugs and medicines prescribed by a doctor as being necessary for the treatment of the illness; *and*

Immunizations

MIP will cover immunizations as determined by the Health Authorities of the country in which the subscriber resides. Immunizations for personal travel are not covered under MIP. Immunizations for official duty travel (DT) should be charged to the same funding source covering the travel costs and *not* claimed under MIP.

3.4 Mental and nervous care**Out-Patient Mental Health**

The cost of outpatient mental health treatment by a psychiatrist is covered, as are the services of a licensed psychoanalyst, a licensed psychologist or a licensed psychiatric social worker. The cost in respect of insured participants is reimbursable at the rate of 80 per cent of the reasonable and customary fee level and to a maximum reimbursement of one month at the MIP reference salary per insured person in a calendar year.

Treatment for Substance Abuse

The cost of treatment for substance (alcohol and/or drug) abuse is covered, under certain conditions. The coverage includes in-patient treatment (see MIP Rule 3.2) for detoxification and rehabilitation at a facility certified for such treatment, subject to the prior approval of the TPA. Such treatment will normally be limited to 30 days in a calendar year. In addition, the plan covers outpatient counselling for the purpose of diagnosis and treatment. The costs of outpatient counselling are reimbursable at the rate of 80 per cent and to a maximum reimbursement of one month at the MIP reference salary for not more than 50 visits per insured person in any calendar year. Of these 50 visits, up to 20 may be allocated to counsel covered family members of the participant undergoing treatment for the substance abuse problem.

3.5 Optical lenses and hearing aids**Waiting period**

In order to be entitled to these benefits, a subscriber or eligible family member will have to have been enrolled in the MIP scheme *for one year or more*.

Routine Eye examinations

One routine eye examination every two years, reimbursement is made at the 80 per cent rate (per eligible patient)

Corrective Optical lenses¹⁴

Subject to the one-year waiting period, reimbursement is made at the 80 per cent rate with a maximum of \$60 per lens and a maximum of two lenses in a period of two years (per eligible patient). These maxima (i.e. 80 per cent with a maximum of \$60 per eye) will also apply to surgical or laser treatment for the correction of refraction.

Hearing aids

Subject to the one-year waiting period, reimbursement is made at the 80 per cent rate with a maximum of \$300 per apparatus, including the related examination, and a maximum of one apparatus per ear in a period of three calendar years (per eligible patient).

3.6 Dental care

Rate of reimbursement

Reimbursement at *the 80 per cent* rate is provided for dental services, including:

- a) false teeth, crowns, bridges, other similar appliances; *and*
- b) dento-facial orthodontics (e.g. braces), if treatment is started before the patient is 15 years old (except in the case of an accident) and the treatment period is up to 4 years.

Dental services performed by a family member who is a dentist will not be considered for reimbursement, only the materials used or medications prescribed will be considered.

Concept of reasonable expenses

The general provision regarding RC charges (see MIP Rule 3.1) applies to dental expenses as well. For instance, a charge for a gold tooth or gold filling would be considered unreasonable when less expensive services are available for the same condition.

Maximum reimbursement of all benefits

The maximum benefit is subject to a limit in any calendar year (for each eligible patient) equivalent to one half of the MIP reference salary.

¹⁴ Including contact lenses, disposable lenses, bifocal or trifocal lenses or lenses of progressive focal length or any other corrective lens.

3.7 HIV and AIDS

MIP provides the same reimbursement for the diagnosis and treatment of HIV and AIDS as it provides for any other illness.

MIP also reimburses at 80 per cent the cost of two voluntary (i.e. no prescription required) blood tests (including pre- and post-counselling) per year for the human immunodeficiency virus. Additional tests during the same year require a prescription from a medical doctor.

3.8 Well Child Care (Routine Examinations for children)

MIP covers the following primary and preventive routine care services for covered dependent children at the rate of 100 per cent:

- | | | |
|----|-----------------------------|--|
| a) | newborn | 1 routine in-hospital examination at birth |
| b) | birth to Age 1 | 6 routine visits, i.e. every two months |
| c) | age 1 through Age 2 | 3 routine visits, i.e. every six months |
| d) | age 3 through Age 6 | 4 routine visits, i.e. every year |
| e) | age 7 through 19th birthday | 6 routine visits, i.e. every two years |

Covered services include a physical examination, medical history, developmental assessment, anticipatory guidance and laboratory tests ordered at the visit.

The plan also covers the following recommended immunizations: DPT (diphtheria, pertussis and tetanus), polio, MMR (measles, mumps and rubella), varicella (chicken pox), hepatitis B, hemophilus, tetanus, diphtheria, pneumococcal, meningococcal and tetramune. MIP will cover additional immunizations as determined by the Health Authorities of the country in which the subscriber resides.

3.9 Well Man Care (Routine Urological Examinations for Men)

One urological examination for per year, including one Prostate Specific Antigen (PSA) screening at the rate of 80 per cent.

3.10 Well Woman Care (Routine Gynaecological Examinations for Women)

One routine gynaecological examination per year, including one pap smear and one mammography, at the rate of 80 per cent.

3.11 Routine Physical

One routine physical examination at the rate of 80 per cent for:

- a) children 19+ and adults, every 24 months; *and*
- b) age 65+: every 12 months.

3.12 Second Surgical Opinion

Whenever feasible, participants are encouraged to seek a second surgical opinion, in particular for the 16 surgical procedures listed in Appendix A. For this reason, the TPA will reimburse at 100 per cent the cost of a second opinion rendered by a qualified physician in connection with these 16 surgical procedures. If the second opinion does not agree with the first, a third opinion may be sought and will also be fully reimbursed. Please note that the second (or third) opinion must be provided by a physician not associated or in practice with the physician who originally recommended or proposed to perform the surgery. There is no reimbursement penalty for failure to provide evidence or a second opinion in connection with any surgery.

3.13 Non-Reimbursable Items

The following will not be reimbursed under the Plan:

- a) eyeglass frames (as distinct from lenses);
- b) preventive health examinations, except those mentioned in MIP Rule 3.8 to 3.11.
- c) spa cures, rejuvenation cures, cosmetic treatment (cosmetic surgery is covered where it is necessary as the result of an accident for which coverage is provided);
- d) 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;
- e) injuries resulting from motor-vehicle racing or dangerous competitions in respect of which betting is allowed (normal sports competitions are covered);
- f) any portion of the expenses for medical services and supplies that exceeds the regular and customary charge for the services or supplies;
- g) home help, family help or similar household assistance, and fees of persons who are not qualified nurses;

- h) any charges for services or supplies that have not been prescribed or approved by a physician;
- i) hospital charges for telephone, television, or for persons other than the patient, etc.;
- j) elective plastic surgery;
- k) food and dietary products (other than those normally provided during hospitalization), cosmetics, toilet articles; *and*
- l) 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/she is injured by an accident or stricken by disease and the first hospital where treatment is given will not be excluded.

3.14 Maximum reimbursement of expenses

MIP ceiling

Under MIP, reimbursement of expenses at the rate described above will be allowed in respect of any eligible patient up to a limit in any calendar year equivalent to *six times the MIP reference salary in effect on 1 January and converted to United States dollars* (at the UN operational rate of exchange).

Reimbursements

In determining the totality of expenses in any calendar year, full account will be taken of all reimbursed amounts paid by MIP in respect of the eligible patient for services contemplated under MIP Rules 3.2 through 3.12.

Amounts exceeding the MIP ceiling

Under very exceptional circumstances, where demonstrated hardship is involved, the Plan may reimburse amounts in excess of the MIP ceiling described above. Individual claims which result in exceeding the annual limit of reimbursement expenditures, i.e. six times the MIP reference salary, will be submitted by the TPA to UNOPS People and Change Group for its decision (see Chapter IV).

3.15 Co-ordination of benefits

Co-ordination of benefits refers to the settlement of reimbursable medical expenses where more than one medical insurance scheme covers a subscriber and/or his/her eligible family members.

With respect to MIP, co-ordination of insurance benefits will apply, as appropriate (i.e., if the insured patient is entitled to reimbursement by another insurer, reimbursement under MIP, will be applied to the difference between the costs actually incurred and reimbursement obtained from the other insurer).

3.16 List of Reimbursable and Non-Reimbursable Items

A detailed list of reimbursable and non-reimbursable items may be provided by UNOPS. The current version of that list is available as Appendix E.

The list is not exhaustive. If an item is not listed and there are doubts on the coverage, subscribers should contact the TPA directly (see MIP Rule 8.2).

3.17 Access to Medical Global Networks

The TPA has a healthcare network which includes hospitals, physicians, and dentists, many of which have direct billing facilities and/or negotiated fees.

The TPA Medical network may be accessed from the TPA's website.

A MIP participant may go to a hospital, physician or dentist of his/her choosing, whether an in-network or non-network provider. When a participant goes to an in-network provider with whom the TPA has negotiated fees/discounts, the provider's billing will reflect these preferential rates, which are to the benefit of both the subscriber and MIP.

4.0 Enrolment

4.1 Staff members

Every staff member¹⁵ who participates in UNOPS MIP is required to complete a MIP Application/Request for Change Form and submit it to the UNOPS GSSC. New staff members must complete the form *within 30 days after joining the Organization*.

The MIP Application/Request for Change Form is available from the local UNOPS HR Manager/Administrator or may be downloaded from the intranet:

https://www.unops.org/SiteCollectionDocuments/HR/Recruitment/Form-MIP_Application_or_Request_For_Change.pdf

The GSSC must ensure that all information regarding subscribers and their eligible family members is timely inputted into OneUNOPS.

The MIP Application/Request for Change Form is also used to designate the eligible family members to be covered under the Plan.

4.2 Eligible family members

To enrol additional eligible family members (e.g. upon marriage, birth, adoption) or to delete family members (e.g. upon death), the staff member must, *within 30 days of the event*, complete a MIP Application/Request for Change Form and submit it to the GSSC.

Failure to apply for coverage within the 30 days period, will result in the staff member not being able to enrol his/her eligible family member(s) until the next annual enrolment campaign.

Change in Family Status

For all requests for changes in coverage (e.g. marriage or birth/adoption of children), the staff member must, *within 30 days of the change in family status*, complete a MIP Application/Request for Change Form and submit it to the GSSC.

Failure to request the change in coverage within 30 days period will result in the staff member not being able to enrol his/her eligible family member(s) until the next annual enrolment campaign.

The GSSC must ensure that any change is timely inputted into OneUNOPS.

Insurance enrolment resulting from loss of employment of spouse

15 UNOPS MIP subscribers and UN System MIP subscribers administered by UNOPS.

Loss of coverage of health insurance by a spouse as a result of loss of employment is considered to constitute a qualifying event for the purpose of their enrolment in the MIP. The staff member wishing to apply for enrolment in MIP under these circumstances must, ***within 30 days of the qualifying event***, complete a MIP Application/Request for Change Form and submit it to GSSC. In addition, application for coverage under this provision must be accompanied by an official letter from the spouse's employer, certifying the termination of employment and its effective date.

Annual Enrolment Campaigns

Staff members who have not enrolled their eligible family members within 30 days of the date of their entry on duty (EOD) have an opportunity once each year to do so. The annual enrolment period will take place between 1st and 15th June of each year.

The effective date of insurance coverage which is applied for during the annual enrolment campaign is the first day of the following month, i.e. 1st July.

Staff members who can demonstrate that they were on mission or annual/sick leave during the annual enrolment opportunity period may enrol within 30 days of their return to their duty station.

At times other than the annual enrolment periods referred to above, eligible family members may be enrolled in the MIP ***only*** if at least one of the following events occurs and application for enrolment is made within 30 days thereafter:

- a) upon return from special leave without pay (SLWOP); *or*
- b) upon marriage, birth or legal adoption of a child for coverage of the related family member.

Applications between enrolment opportunity periods based on circumstances other than those listed above or not received within 30 days of the event giving rise to eligibility, will not be accepted. In this regard, it should be noted that termination of health insurance coverage under a scheme not offered by UNOPS will in no case give rise to any right on the part of a family member to immediate enrolment in the Plan. If such termination occurs between annual enrolment opportunity periods, the staff member must wait until the next annual enrolment opportunity to enrol in the UNOPS MIP. Staff members who for any reason may be uncertain about the continuity of their outside coverage for family members are encouraged to consider enrolling in the UNOPS scheme during the established annual enrolment period.

If eligible family members are at any time withdrawn from the Plan, they may only re-enter during the annual enrolment campaign to be held between 1st and 15th June every year, subject to fulfilling a minimum waiting period of two years counted as from the effective date of the withdrawal from the Plan.

4.3 After-Service Participants

Retirees and other eligible former staff members, who wish after-service coverage, must complete a new MIP Application/Request for Change Form and submit it to the GSSC within 30 days of separation from service (see also MIP Rule 7.3).

4.4 Cessation of coverage of family members

Change in Family Status

When there are changes in the staff member's family that result in a family member's ceasing to be eligible (e.g. a spouse upon divorce, a child reaching the age of 25 years, marrying or taking up full-time employment), the staff member must immediately complete and submit a new MIP Application/Request for Change Form and submit it to the GSSC. The family member's TPA ID card (see MIP Rule 4.7) must also be returned to the GSSC.

The GSSC must ensure that any change is timely inputted into OneUNOPS.

Other Reasons

Staff members who wish to discontinue coverage of a family member under the MIP for any other reason may do so at any time, although this is strongly discouraged. The responsibility for initiating the resulting change in coverage rests with the staff member. It is in the interest of staff members to provide this notification promptly whenever changes in coverage occur in order to benefit from any reduction in premium contribution that may result. Any such change will be implemented on the first of the month following receipt of notification. No retroactive adjustments can be made as a result of failure to provide timely notification of any change.

4.5 Staff on Special Leave Without Pay (SLWOP)

For periods of SLWOP for a partial month, a full month's premium will be deducted and coverage under the insurance plans will not be interrupted.

For periods of SLWOP for one month or longer, the Organization will not subsidize insurance premium for the staff member. Continued participation is optional with full premium payment to be made by the staff member. Such payments are to be made in advance on a quarterly basis.

Insurance coverage maintained during special leave without pay (SLWOP)

If the staff member decides to retain coverage during the period of SLWOP, he/she must contact the GSSC and forward within the first five days of the month funds equivalent to the full amount of the quarterly premium due.

Insurance dropped while on SLWOP

If a staff member decides not to retain insurance coverage while on SLWOP, no action is required by the staff member upon commencement of the special leave.

Re-enrolment upon return to duty following SLWOP

Upon return from SLWOP, regardless of whether a staff member *decided to retain or drop insurance coverage* during the period of SLWOP, he/she must re-enrol in the plan within 30 days of return to duty. Failure to do so will mean that the family members will be unable to resume participation in the insurance plan until the following annual enrolment period.

4.6 Staff Member married to another Staff Member

Locally-Recruited Staff members governed by the UN Staff Regulations and Staff Rules and married to:

- a) *UN/UNOPS locally-recruited staff members governed by the UN Staff Regulations and Staff Rules*, the insurance coverage must be carried by the higher-salaried staff member and he/she must enroll his/her spouse;
- b) *UN/UNOPS internationally-recruited staff members governed by the UN Staff Regulations and Staff Rules*, the insurance coverage must be carried by the higher-salaried staff member and if the internationally-recruited staff member, he/she must enroll his/her spouse.

The period of contributory participation as a spouse of an active staff member, is counted towards in-service contributory participation for after-service health insurance (ASHI) purposes.

If one spouse separates from service with the Organization before the other spouse, the spouse who remains in active service must become the subscriber.

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.

4.7 ID Cards

All MIP subscribers¹⁶ and their eligible family members are issued ID cards within five days (plus delivery time) upon receipt of eligibility information from UNOPS to the TPA.

¹⁶ UNOPS MIP subscribers (including ASHI MIP subscribers) and UN System MIP subscribers (including ASHI MIP subscribers) administered by UNOPS.

The ID cards should be presented whenever requesting services from an in-network provider (see MIP Rule 3.16). The cards also provide details on how to contact the TPA.

The GSSC must ensure that all information regarding subscribers¹⁷ and their eligible family members is timely inputted into OneUNOPS.

Separation from Service. Upon separation from service, the ID cards must be returned unless an application for ASHI MIP coverage is submitted to the GSSC within 30 days of separation.

Safe-Keeping. The holder of a TPA ID card is responsible for its safe-keeping.

Loss or Theft. Holders of a TPA ID card should take every possible precaution to prevent its loss or theft. If loss or theft occurs, the GSSC should request the holder to report the incident to the local police or other appropriate government authority¹⁸ and send a copy of the report to the TPA (see MIP Rule 8.2). Upon receipt of the report, the TPA will issue a new ID card.

¹⁷ UNOPS MIP subscribers (including ASHI MIP subscribers) and UN System MIP subscribers (including ASHI MIP subscribers) administered by UNOPS.

¹⁸ Or follow the procedure established by the local UNOPS office for loss or theft of local UNOPS ID cards.

5.0 Premiums

5.1 Contributory nature of the scheme

MIP operates as a health insurance plan for which premiums are paid to remunerate the insurance provider for the bearing of the risk covered by the MIP.

5.2 Premiums

The premiums are detailed in Appendix B.

5.3 Collection of contributions

The contributions of staff members towards MIP premiums are collected by monthly payroll deductions. For periods of less than one month, a pro rata premium is due, with as minimum 1/3 of the monthly premium.

Staff members on SLWOP and ASHI subscribers. The contributions are ***billed quarterly***¹⁹ in advance by the GSSC.

¹⁹ Except for the initial period falling within a quarter, subscribers are billed as follows: a) for premiums for the period January to March, during the first five days of January; b) for premiums for the period April to June, during the first five days of April; c) for premiums for the period July to September, during the first five days of July; and d) for premiums for the period October to December, during the first five days of October.

6.0 Claims, Hospitalization and Direct Billing

6.1 Time Limit for Filing a Claim.

Claims must be submitted with the least possible delay but no later than **two years** from the date on which the medical expenses were incurred. Claims received by the TPA later than two years after the date on which the expense was incurred will not be eligible for reimbursement.

It is recommended to try to group small claims before submitting them in order to avoid reimbursements of small amounts.

6.2 Forms and supporting documentation

Claim Form

Out-patient expenses²⁰ are first to be settled by the staff member, who can afterwards claim reimbursement.

Claims for reimbursement must be submitted directly to the TPA on a TPA MIP Refund Claim Form

The subscriber²¹ fills out, signs and submits, in a sealed envelope, the TPA MIP Refund Claim Form, copies of which are available from the local UNOPS office or may be downloaded from the intranet.

Incomplete/unsigned claims will result in delays in their processing.

Signing the TPA MIP Refund Claim Form signifies the subscriber's certification of the truth and accuracy of the information provided. ***The subscriber will be held responsible and subject to disciplinary measures for any false or incorrect information submitted.*** Submission of fraudulent MIP claims is grounds for dismissal.

The TPA MIP Refund Claim Form may be submitted in Arabic, Chinese, English, French, Russian or Spanish.

In case of an in-patient hospitalization, subscribers are not required to complete/submit a TPA MIP Refund Claim Form when the TPA arranges for direct billing with the hospital/clinic (see MIP Rule 6.10).

Supporting documents

20 and in-patient hospitalization, when the TPA is unable to arrange for direct billing.

21 Both UNOPS MIP subscriber and UN System MIP subscribers administered by UNOPS.

In addition to the TPA MIP Refund Claim Form, the subscriber must submit proper supporting documentation consisting of:

- a) **for Professional Services.** A duly completed and signed TPA MIP Refund Claim Form with the Attending Physician/Dentist's statement of services. Alternatively, original receipted bills may be submitted provided they show:
 - i) the name of the patient;
 - ii) the nature of the services rendered;
 - iii) the dates of the services rendered; *and*
 - iv) detailed costs of the services rendered.

If the local Health Authorities have specific requirements regarding receipts for services, these must be fulfilled in respect of the claims submitted under MIP to the TPA.

- b) **for Drugs, Medicines, Optical Lenses and Hearing Aids.** Original²² prescriptions, detailed invoices and proof of payment for drugs, medicines, optical lenses and hearing aids.

A prescription may cover up to a one-year drug treatment provided the attending physician clearly and specifically indicates that the drug is required for any period up to one whole year. Reimbursement is limited to up to a three-month supply at a time. If the duration of the treatment exceeds one year, the attending physician must reassess the treatment and issue a new prescription. When a drug prescription is to be used more than once, a photocopy may be submitted in lieu of the original which must be submitted with the claim covering the last refill of the prescription.

22 Photocopy if local Health Authorities require original receipt to be retained by dispensing provider.

Copies

Subscribers should take the precaution of making copies of all documentation before sending them to the TPA. The TPA will not entertain any requests for copies.

Language

Supporting documentation may be submitted in any language, although preferably in Arabic, Chinese, English, French, Russian or Spanish.

Screening by UNOPS personnel

Neither the claim nor the supporting documentation may be screened/viewed by UNOPS personnel.

Co-ordination of Benefits

If the patient is covered by a social security system or another group/individual insurance contract which intervenes as his/her “primary insurer“, he/she must first obtain the reimbursement to which he/she is entitled under this scheme. The subscriber must send the TPA the original settlement note together with copies of all supporting documents in order to obtain an additional reimbursement.

Accident

In the event of an accident, the subscriber must specify place and circumstances of its occurrence. It is important to mention the details of the third party involved (name, address, address and policy number of his/her insurance company), and of any witnesses or legal authorities.

Detailed procedures for submission of claims are indicated on the back of the TPA MIP Refund Claim Form.

6.4 Screening of claims by the TPA

The TPA is responsible for ensuring the completeness and correctness of each claim, and that the claim conforms to the requirements of MIP rules and is consistent with reasonable and customary costs for similar services in the locality. They may request additional documentation or seek advice from any source in respect of any claim that appears unreasonable or questionable, whether in terms of the institution or professional services concerned, the nature or treatment of the illness or the costs incurred.

6.5 Referral to Headquarters

Screening of claims

Claims may be referred by the TPA to the People and Change Group for advice. Guidance may also be sought in case of doubt as to the interpretation of the rules.

Claims exceeding the MIP ceiling

Individual claims, which result in exceeding the annual limit of reimbursement expenditures, i.e. six times the MIP reference salary, will be assessed by the TPA and referred to the People and Change Group for consideration under the MIP Hardship (see Chapter IV).

6.6 Reimbursement of claims

Procedure

Duly completed, signed and documented claims which are in line with the requirement of these rules, will be processed by the TPA and the appropriate amount reimbursed to the subscriber within an average of three working days (excluding mail delivery and bank or OneUNOPS payment processing time).

Concept of reasonable and customary expenses

One of the fundamental principles of MIP is the concept of reasonable and customary (RC) charges. This means that the Plan will take into account and reimburse on the basis of charges for medical services and medicines which are at a reasonable cost and which are typical for the locality. MIP, therefore, does not automatically reimburse medical claims irrespective of the costs which have been charged by the doctor, dentist, hospital or pharmacy, and will not reimburse charges which are excessive (i.e. unreasonably high, abnormally expensive).

Example: If a first visit to a doctor for an illness would typically cost between 30 and 50 pesos, a charge of 150 for a similar service would be unreasonable.

Example: A medicine costs 20 schillings in most pharmacies in town, however, another pharmacy is charging 40 schillings which should be considered to be unreasonably priced.

If the claim includes charges for any service found to be in excess of RC costs, the TPA will calculate the reimbursement on the basis of the RC charges in the locality for similar services and the subscriber will be so informed.

Expenses incurred outside the country

Services and medication provided outside the country of the staff member's duty station, will be covered on the basis of the RC costs prevailing pattern *within* the country of the staff member's duty station. Expenses above these limits will not be reimbursed.

In the case of medical expenses incurred while on:

- a) *official duty travel (DT)* expenses for an emergency treatment will be reimbursed based on the prevailing pattern of charges for professional and other health services in the country where incurred. Expenses for non-emergency treatments will be reimbursed based on the prevailing pattern in the country of the staff member's duty station; *and*
- b) *medical evacuation travel (MET)*, expenses will be reimbursed based on the prevailing pattern of charges for professional and other health services to where MET is authorized.

Co-ordination of benefits

Co-ordination of benefits refers to the settlement of reimbursable medical expenses where more than one medical insurance scheme covers a subscriber and/or his/her eligible family members.

With respect to MIP, co-ordination of insurance benefits will apply, as appropriate (i.e., if the insured patient is entitled to reimbursement by another insurer, reimbursement under MIP, will be applied to the difference between the costs actually incurred and reimbursement obtained from the other insurer).

6.7 Payment

Currency of reimbursement

Payment is made to the insured person, but if the staff member is no longer alive, payment will be made to his/her beneficiary as per P-2 Form "Designation of Beneficiaries".

The currency of reimbursement will be the same as that in which the subscriber contributes to MIP. If the medical services are paid in a different currency, reimbursement is to be made in the currency of contribution to MIP. Payments in hard currency *may exceptionally* be reimbursed in that currency. The rate of exchange used will be that of the UN, as applicable, *on the date the expenses were reimbursed*.

Method

Wherever possible, payments will be made by the TPA directly to the subscriber. Patient confidentiality will be protected. In cases where the TPA cannot pay directly to the subscriber, alternate arrangements may be used as described in Annex C to the Contract. Any payments made via UNOPS or OneUNOPS will not indicate the nature of the medical services provided.

6.8 Explanation of Benefits (EOB)

Once the claim is screened, the TPA will send an Explanation of Benefits (EOB) to the subscriber by:

- a) *email*, if the subscriber has opted for this means of communication; *or*
- b) *postal mail*, if the subscriber has not opted for electronic means of communication.

6.9 In-Patient Hospitalization and Direct Billing

A MIP participant may go to a hospital of his/her choosing, whether in-network or non-network provider (see MIP Rule 3.17).

Except in emergencies, any in-patient hospitalization (i.e. a hospital admission including at least one overnight stay) requires the prior agreement of the TPA. This applies whether the MIP participant opts to go to an in-network or non-network hospital/clinic.

The main reasons for such prior agreement are that it:

- a) assures the patient whether the related expenses will be covered under the Plan;
- b) permits a hospitalization case to be medically monitored from the first day; *and*
- c) ensures a smooth admission and avoids deposit requirements by allowing administrative and financial aspects to be arranged in advance.

In the event of an in-patient hospitalization, the TPA normally arranges for direct settlement for the allowable expenses incurred.

When the TPA arranges for direct billing with the hospital, the subscriber is not required to complete/submit a TPA MIP Refund Claim Form. The hospital is requested to send all invoices directly to the TPA for direct settlement of reimbursable expenses, which leaves only the balance of non-reimbursable expenses at the MIP subscriber's charge. The subscriber will be informed of the latter amount by means of the TPA's Explanation of Benefits (see MIP Rule 6.8).

Planned Hospitalizations²³. As indicated above, except in emergencies, any hospitalization is subject to prior agreement by the TPA. The TPA MIP Prior Agreement Form must be completed by the attending physician/hospital and signed by the patient²⁴ and sent **10 working days** (or as soon as planned if within less than 10 working days) before the scheduled date of admission directly to the TPA either by mail, fax or email.

a)

Emergency Hospitalizations²⁵. In the event of emergencies, the TPA MIP Prior Agreement Application Form must be completed by the attending physician/hospital and signed by the patient²⁶ and sent by fax within **three working days** following admission directly to the TPA by mail, fax or email.

The TPA's Medical Board's Review and Direct Billing

If after review of the TPA Prior Agreement Application Form, the TPA's Medical Board:

- a) **approves** the application for taking responsibility, the TPA's concerned Claims Unit sends a Letter of Guarantee²⁷ to the hospital/clinic, specifying the standard level of coverage for direct payment from the TPA. The patient²⁸ will be informed accordingly;
- b) **partially approves** the application for taking responsibility (e.g. limitation of the stay, limitation of fees, etc), the TPA's concerned Claims Unit sends a Letter of Guarantee⁴⁵ to the hospital/clinic, specifying the restrictions of coverage and

23 Including planned hospitalizations on medical evacuation travel (MET).

24 If a minor, a parent or guardian. If unable to complete/sign a) his/her spouse or an adult family member; or b) a UNOPS officer but only if there is no spouse or adult family member present to complete/sign.

25 Including emergency hospitalizations on medical evacuation travel (MET).

26 If a minor, a parent or guardian. If unable to complete/sign a) his/her spouse or an adult family member; or b) a UNOPS officer but only if there is no spouse or adult family member present to complete/sign.

27 The Letter of Guarantee will request the hospital to send all invoices to the TPA for direct settlement of reimbursable expenses, which leaves only the balance of non-reimbursable expenses at the MIP subscriber's charge. The subscriber will be informed of the latter amount by means of the TPA's Explanation of Benefits (see MIP Rule 6.8).

28 If a minor, a parent or guardian.

the amount that will be accepted within the direct payment procedure from the TPA. The patient²⁹ will be informed accordingly; *or*

- c) **requires additional information** concerning the patient's condition or the estimate, the TPA's Medical Advisory Board contacts the patient³⁰ and requests the desired information by fax³¹ or email; *or*
- d) **rejects** the application for taking responsibility (e.g. specific procedure not covered by MIP, etc.), the TPA's Medical Advisory Board informs the patient³² and provides him/her with full particulars on the negative decision.

Salary Advances

In the event the TPA is unable to arrange for direct billing, the staff member may request a salary advance. The salary advance will be recovered in full at the end of the fourth month (earlier if separated from service) after the advance has been made, or upon settlement of the MIP Claim, whichever is earlier.

29 If a minor, a parent or guardian.

30 If a minor, a parent or guardian.

31 MIP subscribers (including ASHI MIP subscribers) may use the office fax services. MIP subscribers may **not** be required to submit copies of the faxes.

32 If a minor, a parent or guardian. If unable to complete/sign a) his/her spouse or an adult family member; or b) a UNOPS officer but only if there is no spouse or adult family member present to complete/sign.

7.0 After-Service Health Insurance (ASHI)

7.1 General

Conditions

After-service health insurance (ASHI) is available under the conditions described below for former locally-recruited staff members³³ at designated duty stations (and for their eligible family members) who, at the time of separation from the service, were covered by MIP.

Secondary dependants

After-service coverage is optional and is allowed only as a continuation of in-service coverage. "*Secondary dependants*" **are not** eligible for after-service coverage.

7.2 Eligibility conditions

Eligible Former Staff Members

The following categories of former staff members **are eligible** for after-service coverage:

- a) a former staff member who has left the service **on or after the age of 55** and, who at the time of separation, had at least five years of cumulative³⁴ in-service contributory participation in MIP, its predecessor, MEAP, or, prior to that in a health insurance plan recognized by the UN.

Such former staff members are entitled to a subsidy from the Organization provided they had at least 10 years of cumulative⁵² in-service contributory participation in MIP, MEAP, another UN qualifying plan or a combination thereof; entitlement to a subsidy resulting from less than 10 years of in-service participation will be recognized only if the former staff member pays the entire premium until he/she has fulfilled the 10-year requirement;

- b) effective 1 January 1995, a former staff member who separates, **below age 55**, on agreed termination or abolition of post, who is at least 50 years old at the time of separation and, who has at the time of separation, completed a minimum of 15 years of cumulative⁵² in-service contributory participation in MIP, its predecessor, MEAP, or, prior to that in a health insurance plan recognized by the UN.

33 Both UNOPS staff members and UN System staff members administered by UNOPS.

34 It is not necessary that the in-service participation be continuous.

The cost of after-service participation is met through joint contributions by the organisation and the subscribers. Given the longer period of insurance coverage expected in respect of former staff members and their survivors covered by this scheme (from age 50) as compared with those covered under the normal after-service plan (from age 55), the subsidy paid by the organisation will be lower than that applicable to the normal after-service coverage;

- c) former staff members who retired ***prior to 1 September 1987*** are eligible to participate under the conditions specified below:

- i) **former staff members (and their eligible family members) who separated between 1 January 1984 and 1 January 1987:**

If they separated from service at age 55 or after, provided that at the time of separation they had participated for at least five years in MEAP, or another UN recognized plan or a combination thereof; *and*

Such former staff members will be entitled to a subsidy from the Organization provided they had at least 10 years of in-service participation in MEAP, another UN recognized plan or a combination thereof; entitlement to a subsidy resulting from less than 10 years of in-service participation will be recognized only if the former staff member pays the entire premium until he or she has fulfilled the 10-year requirement; *and*

- ii) **former staff members (and their eligible family members) who separated prior to 1 January 1984:**

If they separated from service at age 55 or after, provided that at the time of separation they had participated for at least 10 years in MEAP, another UN recognized plan or a combination thereof;

Such former staff members will be entitled to a subsidy from the Organization; *and*

- d) a former staff member who is eligible for a ***periodic disability benefit*** from the UNJSPF³⁵ and/or a periodic benefit under Appendix D of the UN Staff Rules (which govern compensation for service-incurred illness, injury or death) ***provided he/she was covered under MIP at the time of his/her separation. No minimum qualifying period of in-service coverage is necessary.***

Eligible Family Members.

The following family members ***are eligible*** for after-service coverage:

- a) the ***spouse and children*** of a former staff member who is eligible for and who has opted to be covered under the ASHI MIP ***provided that they were insured at the time of the staff member's separation from service;***

35 www.unjspf.org

- b) the *surviving spouse and children* of a staff member who dies at any age while still in service, *provided that they were insured under MIP at the time of the staff member's death. No minimum qualifying period of in-service coverage is necessary; and*
- c) the *surviving spouse and children* of a former staff member who dies after leaving the service of the UN or who dies at any age while still in the service, *provided that they were insured under ASHI MIP at the time of the former staff member's death.*

Children

A child is insurable under the after-service coverage until the end of the year in which *he/she reaches the age of 25*, provided he/she is:

- a) a dependant of the subscriber;
- b) not married; *and*
- c) not engaged in full-time employment.

There is no limit on the number of children eligible for after-service coverage, provided the parent concerned provides satisfactory evidence of parenthood or adoption

Children born After-service

After-service coverage is also available for a child born within 300 days of the death or separation from the service of the insured former staff member.

Disabled child

If a child is disabled by reason of a mental and/or physical handicap to the extent that he or she is unable to earn a living, after-service insurance may be continued for as long as that incapacity lasts. Evidence of such incapacity will have to be supplied in a manner satisfactory to, and at intervals required by the UN Medical Director. If the UNJSPF³⁶ continues to pay a child's benefit because of the child's incapacity, such payment may constitute satisfactory evidence of disability.

Qualifying periods

If, before joining UNOPS, the insured former staff member had been covered under any of the other contributory health insurance plans of the UN system, the periods of such coverage will count towards the required minimum qualifying period of in-service coverage. It is not necessary that the required minimum qualifying period of in-service coverage be single, continuous periods. Two or more periods of in-service coverage that are interrupted by periods of non-coverage will count towards the required minimum period concerned.

36 www.unjspf.org

The period of contributory participation as a spouse or an active staff member, is counted towards in-service contributory participation for ASHI purposes.

7.3 Enrolment procedures and time-limits for after-service coverage

Applications

Applications³⁷ for after-service coverage should be made by completing the MIP Application/Request for Change Form within 30 days of separation from service and submitting it to the GSSC. After the application has been approved, the applicant will be informed of the amount of the contribution and method of payment.

The local GSSC must ensure that all information regarding ASHI MIP subscribers and their eligible family members is timely inputted into OneUNOPS.

Delays for submission

Separating staff members who are eligible for after-service coverage should normally arrange for their enrolment ***within 30 days of their separation from service.*** When potential after-service participants elect not to enrol in the after-service coverage when they first become eligible, neither they nor their eligible family members will be permitted to enrol in MIP at a later date should a potential after-service participant elect not to have after-service coverage, a signed note stating this decision must be put into the staff member's file at the time of separation.

If a separated staff member at any time withdraws him/herself and/or his/her eligible family members from the Plan, they are not permitted to enter the Plan at a later date.

Death of a former staff member

If an insured former staff member dies, the surviving spouse (if any) or the eldest eligible child becomes eligible to assume the role of the subscriber and to continue to pay contributions in accordance with the appropriate category of coverage. He/she must complete the MIP Application/Request for Change Form and submit to the local UNOPSHR Manager/Administrator within 30 days of the death of the former staff member.

7.4 Contributions

The premiums are detailed in Appendix B.

7.5 Method of payment of contributions

37 From UNOPS ASHI MIP subscribers and UN System ASHI MIP subscribers administered by UNOPS.

Those eligible for, and who wish, after-service health insurance under the conditions set out above will be required to pay their contributions *in advance on a quarterly basis*. Contributions must be made in currency acceptable to the UN, normally the currency of the subscriber's country of residence. Insurance protection will become effective on the first day of the month immediately following the date of enrolment.

7.6 Change in country of residence

Conditions

Any subscriber who is eligible for after-service health insurance and who changes his/her country of residence after separation is responsible for informing the TPA and the appropriate UNOPS office in the new country of residence.³⁸ Participation in the after-service coverage will continue, provided the subscriber pays a contribution appropriate for the new country of residence.

New country of residence

The contribution will be in the currency of the new country of residence. The UNOPS office will take steps to see that the insured persons were up-to-date in their contributions for after-service coverage in their previous country of residence.

7.7 Type of benefits and currency of reimbursement

Definition

The benefits available under the after-service arrangements are the same as those for in-service coverage.

Currency of reimbursement

Currency of reimbursement will be governed by the provisions of MIP Rule 6.7.

7.8 Cessation of coverage

After-service coverage for eligible former staff members ceases:

- a) upon his/her death; *or*
- b) upon his/her failure to make timely contributions; *or*
- c) upon his/her giving written notice of withdrawal to UNOPS (i.e. the local UNOPS HR Manager/Administrator); *or*

38 If there is no UNOPS office, the subscriber should contact GSSC and IPAS Admin.

- d) when his/her periodic disability or periodic compensation benefits stop (unless he/she returns to service or he or she qualifies for after-service coverage).

After-service coverage for eligible surviving family members ceases

After-service coverage for insured surviving spouses and insured children ceases upon death of subscriber, upon failure to make timely contributions or upon their giving written notice of withdrawal for such coverage or, as the case may be, upon the remarriage of a surviving spouse, or when an insured child no longer qualifies for in-service coverage because of age, marriage or full-time employment.

8.0 Miscellaneous

8.1 Administrative aspects

Responsibility

UNOPS GSSC is responsible for enrolling subscribers and their eligible family members and for collecting subscribers' contributions.

The TPA will be responsible for the screening and processing their claims. Additionally, they will keep appropriate records on those matters, for consultation or auditing purposes.

Compliance to the rules

The TPA will also be responsible for ensuring compliance by subscribers with these rules and avoiding unreasonable or abusive use of the Plan. They may seek advice at the local and Headquarters levels or refer difficult or doubtful cases to UNOPS People and Change Group for guidance.

8.2 Queries

Queries regarding eligibility and enrolment should be addressed to the GSSC.

All other queries (e.g. coverage, claims, etc.) should always be addressed directly to the current TPA.

When contacting the TPA the patient's name and the TPA Identification Number must be mentioned.

8.3 Forfeiture and suspension of benefits

A participant's entitlement to certain benefits and/or further participation in MIP may be forfeited or suspended:

- a) if he/she does not comply with MIP Rules;
- b) if it is determined that he/she fraudulently attempted to obtain benefits to which he/she was not entitled; *and*
- c) if he/she is delinquent in the payment of contributions to the Plan.

8.4 Recourse

When the TPA denies a claim, wholly or partly, the TPA will send written notice of the reason for the denial.

If the TPA denies a claim in whole or in part, the subscriber has the right to appeal the decision. The subscriber can submit a written request for review within 60 days of receiving the TPA's notice. The TPA will send a written decision with an explanation within 60 days of receiving the appeal. If special circumstances require more time, the TPA can extend the review period up to 120 days from the date the appeal was received.

A request for review must be sent to the the current TPA.

8.5 Abuse or Fraud

Neither abuse or fraud will be tolerated. The subscriber will be held responsible and subject to disciplinary measures for any false or incorrect information submitted. *Submission of fraudulent MIP claims is grounds for dismissal.*

8.6 Service-incurred injuries

In the event of illness or accident which may be attributed to the performance of the official duties, the resulting medical and related expenses are payable under Appendix D to the UN Staff Rules (rules governing compensation in the event of death, injury or illness attributable to the performance of official duties on behalf of the UN). When this is the case, medical expenses can be paid initially under MIP, subject to offset by any amounts payable under the provisions of Appendix D to the UN Staff Rules.

Chapter III

Stop-Loss Clause

1. The plan reimburses, at 100 per cent, recognized professional medical services and medications once a participant along with his/her family members have collectively incurred in a calendar year out-of-pocket expenses equivalent to one month of his/her net base salary.
2. In the case of a retiree, the one-month net base salary requirement is substituted by 50 per cent of the current net salary corresponding to the grade/step of the former staff member at the date of his/ her separation. Effective 1 July 2003, future increases in the amount of net salary will correspond to the global cost-of-living increase declared by UNJSPF³⁹. This increase will become effective on 1 July following such announcement by the UNJSPF.
3. The stop loss clause will not be considered so long as the total non-reimbursed medical and hospital expenses incurred by the subscriber and enrolled family members (for reasonable and customary care) have not exceeded in a calendar year one month of the subscriber's monthly net base salary.
4. In calculating the "total non-reimbursed expenses", it is important to note the following:
 - a) only the non-reimbursed portion of recognized professional medical services and medications (see MIP Rule 3.3) and hospital expenses (see MIP Rule 3.2) are taken into account. Thus non-reimbursed portions in respect of dental care, outpatient mental and nervous care, eyeglasses and hearing aids are *not* taken into account in determining out-of-pocket expenses; neither are any expenses for medical and hospital services which are not considered recognized expenses. (For instance, the difference between semi-private and private accommodation in the hospital would not be taken into account);
 - b) what is taken into account is the 20 per cent portion of professional medical services and medication which MIP does not reimburse and any amounts either for hospital expenses or professional medical services and medications which were not reimbursed because the patient had reached the annual limit of reimbursement of six times the MIP Reference Salary;
 - c) for the TPA to determine whether a subscriber has reached the one month "out of pocket" requirement in a calendar year, the subscriber should be alerted to keep track (and retain receipts, prescriptions, etc.) of hospital expenses and expenses for professional medical services and medications, once the annual limit for one of the individuals in the family has been reached. If a case for application of the stop-loss clause is to be made, and if it takes into account expenses incurred which were not submitted for reimbursement under MIP, then it is imperative that such expenses, and the relevant receipts, prescriptions,

39 www.unjspf.org

and the like be submitted for screening by the TPA. The expenses must be screened, as is done for claims for reimbursement, in order to be taken into account; *and*

- d) in arriving at a total of non-reimbursed expenses for the purpose of the stop-loss clause, all enrolled members of the subscriber's family are taken into account.
5. In considering the reimbursement of expenses under the stop loss clause, the TPA will only take into account expenses that are considered to be reasonable and customary (RC) for the duty station of the staff member.

Services and medication provided outside the country of the staff member's duty station, will be covered on the basis of the RC costs prevailing pattern *within* the country of the staff member's duty station. Expenses above these limits will not be reimbursed except in the cases described in the following paragraph.

In the case of medical expenses incurred while on:

- a) *official duty travel (DT)* expenses for an emergency treatment will be reimbursed based on the prevailing pattern of charges for professional and other health services in the country where incurred. Expenses for non-emergency treatments will be reimbursed based on the prevailing pattern in the country of the staff member's duty station; *and*
- b) *medical evacuation travel (MET)*, expenses will be reimbursed based on the prevailing pattern of charges for professional and other health services to where MET is authorized.

Chapter IV

Hardship Provision

1. MIP provides for reimbursement of most medical expenses up to a defined annual limit. That limit is established at six times the MIP Reference Salary. This limit applies to the maximum reimbursement per individual (not per family) in a calendar year, and is referred to in MIP Rule 3.14 of these guidelines.
2. It is expected that most medical expenses will fall within these limits. If an individual incurs expenses beyond the limits, then the subscriber and his/her family is expected to meet those expenses. In the event of major illness or very major medical expenses, the situation could occur that the staff member or after-service participant is faced with expenses which are so significantly over and above the normal limits payable under the Plan that they would cause undue financial hardship to the staff member or after-service participant concerned. As stated in the MIP Rules 3.14, the Plan *may* reimburse under such very exceptional circumstances amounts in excess of the regular limit of six times the MIP Reference Salary.
3. *In these instances each case will be considered on its merits by the TPA and the People and Change Group.*
4. Undue financial hardship will not be considered so long as the total non-reimbursed medical and hospital expenses incurred by the subscriber and enrolled family members (for reasonable and customary care) have not exceeded one month of the subscriber's monthly net base salary in the respective calendar year.

Appendix A - Second surgical opinion requirement

The 16 surgical procedures for which second opinions will be reimbursed at the rate of 100 per cent are:

Procedure	Explanation
1 Bunionectomy	Removal of bunions
2 Cholecystectomy	Removal of gall bladder
3 Dilation and curettage	Dilation of cervix and scraping of uterus
4 Excision of cataracts	Removal of cataracts
5 Haemorrhoidectomy	Removal of haemorrhoids
6 Hernia (inguinal) repair	Repair of hernia in the groin
7 Hysterectomy	Removal of uterus
8 Knee surgery	Knee operation
9 Laminectomy	Removal of part of spine
10 Mastectomy: partial or complete	Partial or complete removal of breast tissue
11 Prostatectomy	Removal of prostate
12 Septo-rhinoplasty	Nose surgery for functional improvement
13 Spinal fusion	Surgical welding of spine segments
14 Tonsillectomy and/or adenoidectomy	Removal of tonsils and/or adenoids
15 Varicose veins	Removal and tying of varicose veins
16 Coronary artery bypass	Heart surgery to bypass one or more blocked arteries feeding the heart

Appendix B - Methodology for contribution calculation

[Only relevant to enrolled Staff Members and enrolled former Staff Members under ASHI]

Appendix D – Excluded duty stations

The MIP Rules do not apply to staff members in the following duty stations: Switzerland, the United States of America and Uruguay.

Appendix E - List of Reimbursable and Non-Reimbursable Items