

UN MIP

BENEFITS DESCRIPTION















January 2023



CONTENT

This document contains a general description of the medical cover provided by UN through its Medical Insurance Plan (MIP) for local staff outside the U.S.A. Should you have any questions about an item that is not listed below or need additional information, please contact Cigna or consult your personal webpages at www.cignahealthbenefits.com.

Our services	3
Your coverage	7
1. In general	6
2. Summary of benefits	10
2.1.  In the hospital.....	10
2.2.  Ambulance and transportation expenses.....	11
2.3.  At the General Practitioner's.....	12
2.4.  At the specialist's	13
2.5.  At the licensed qualified health care provider's (other than doctor)	14
2.6.  At the optician's.....	16
2.7.  At the dentist's	18
2.8.  At the pharmacist's	18
2.9.  At the specialised supplier's office.....	19
2.10.  In the laboratory/medical imaging facility.....	20
2.11.  Pregnancy and childbirth.....	20
2.12.  Fertility treatment.....	20
3. Special situations	22
3.1. Countries with inadequate medical facilities	22
3.2. Official Duty Travel (DT).....	23
3.3. Medical Evacuation Travel (MET)	23
3.4. Stop Loss Clause and Out-of-pocket maximum.....	24
3.5. Hardship provision.....	24
4. Exclusions	25

OUR SERVICES





24/7 Availability

You can reach us anytime, anywhere in your preferred language. If you want to know how to submit a claim or have any other questions, or in case of emergency, you can contact us by phone, email, fax or post. Our contact details are mentioned on your membership card and on your personal webpages.

Tip: Keep your membership card in your wallet or purse so you have our contact information at hand in case of emergency!

Our contact details

You can reach us 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 mentioned on your membership card and on your personal webpages.

Your region	Europe, CIS, Middle East and Algeria, Egypt, Libya, Morocco, Tunisia and Western Sahara	Sub-Saharan Africa i.e. all Africa except for Algeria, Egypt, Libya, Morocco, Tunisia and Western Sahara	Asia-Pacific	Latin America and the Caribbean
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Please note that the insurance contract is the only authentic text.

Toll-free numbers

Wherever feasible, you can call us for free through a toll-free number. You can consult the list of available toll-free numbers on [your personal webpages](#). If there is no toll-free number available for the country of your duty station, you can use the dedicated phone numbers of our offices listed above. They are also mentioned on your membership card.

Your personal webpages – Access to online information and services

All information regarding your plan is gathered on your personal webpages. Basically, everything you need to know is easily available in one place that is accessible at any time from anywhere in the world. Here you can also access our online services: you can search our worldwide health care provider network for a particular provider, download fillable forms and consult your settlement details.

Tip: We master all major languages in-house, so there is no need for you to translate any of the documents you wish to send us.

Access to quality health care at preferential rates

Wherever you are, you have access to our worldwide network of health care providers. We make sure you benefit from health care services at preferential rates. To find a health care provider that best suits your needs, search our provider list by location, type of facility and/or specialty on your personal webpages.

Free choice of health care provider

You have free choice of health care provider worldwide. However, if you seek medical treatment outside the country of your duty station, reimbursement will be limited to the [reasonable and customary expenses level](#) applicable to the country of your duty station.

Consulting a health care provider from our network is beneficial to you as we have negotiated advantageous rates with most of our health care providers. This will also have a positive impact on your patient share (co-payment).

Let us pay your medical bills

By simply showing your membership card prior to and upon admission to a hospital in our network you do not have to advance your medical expenses first and submit a claim for reimbursement afterwards. You will only have to pay your patient share (co-payment).

Prior approval: no surprises by notifying us in advance

For all non-emergency hospitalisations, MRIs, PET scans, CT scans, and major dental treatment you must request prior approval by our Medical consultant. By contacting us before a planned admission, you will benefit from our direct payment service and pre-negotiated prices. This means a lower patient share (co-payment) and no unpleasant surprises when you receive your medical bill.

Information on serious illnesses and possibility to contact our Medical consultant

We help raise awareness about the risk of developing serious or chronic diseases like diabetes, cardiovascular disorders or cancer. If you would like personal advice, feel free to contact our Medical consultant through your personal webpages.

Swift processing of your medical claims

As we have claims processing offices in four time zones (Antwerp, Nairobi, Miami and Kuala Lumpur), we can quickly process your claims and handle your queries. Thanks to our high-quality services, we have a customer satisfaction rate of 98%.

Cigna Global Telehealth

Cigna's Global Telehealth service – available through the Cigna Wellbeing App – connects patients to licensed doctors around the world (by telephone or video) for non-emergency health issues. The service can be accessed 24 hours a day, seven days a week, and appointments with general practitioners are set within 48 hours. Within five days of the initial consultation, the general practitioner can schedule a follow-up consultation with a specialist, when and where appropriate.

The Cigna Wellbeing application can be downloaded for free from the App Store (IOS) and Google Play (Android).

The Global Telehealth doctor is assigned on the basis of the date, time and language preference in your time zone. Currently, video consultations are available in English and Spanish while telephonic consultations are available in English, Spanish, French, German, Portuguese, Mandarin Chinese, Japanese, Hindi and Arabic.

To ensure the shortest waiting period for appointments, a plan participant may be paired with a different doctor for each consultation. However, all doctors will be able to review notes from previous Global Telehealth consultations, allowing for a shared and comprehensive patient file, which provides consistency and ensures that all users receive optimal care.

How can Global Telehealth help you?

Global Telehealth doctors will listen to your specific concerns and provide clear advice and guidance on the best steps to take. You will be able to share documents, images and files to help explain your symptoms and condition. The doctors can also help you to understand the local health-care system. They'll tell you how to organize any potential upcoming doctor appointments.

What services are provided through Global Telehealth?

Global Telehealth provides access to clinical guidance from doctors by phone or video. You may:

- Access a trusted doctor, including specialists, for a medical consultation, even when based in a remote location
- Discuss pressing medical symptoms, such as a fever, a rash and aches and pains
- Receive a working diagnosis when enough medical information is available
- Discuss a medical report, test results or treatment plans
- Prepare for upcoming consultations, treatment and hospitalizations
- Get support for navigating the local health-care system
- Obtain referrals to in-network Cigna health-care providers

What if there is an emergency?

Cigna's Global Telehealth is not for medical emergencies. In those cases, patients are advised to reach out to their local emergency service.

YOUR COVERAGE

1. In general

Benefits	Description
Aim	The UN Medical Insurance Plan (MIP) is a health insurance scheme provided to locally-recruited active and former staff members (and their eligible family members) serving or residing at designated duty stations away from the headquarters.
Overall maximum	The overall maximum equals 6 times the MIP Reference Salary per individual person (not per family) in a single calendar year. The MIP Reference Salaries are updated on a yearly basis.
Eligibility	Automatic enrolment for: <ul style="list-style-type: none">- Staff members holding appointment of three (3) months or more Optional enrolment for: <ul style="list-style-type: none">- Eligible family members of staff members- After-service health insurance (ASHI) protection for eligible former staff members and their eligible family members

<p>Reasonable and customary</p>	<p>Reasonable and customary expenses refer to the prevailing pattern of charges for professional and other health services provided at the duty station where the service is provided (staff member's duty station). This applies to services provided within the country of the staff member's duty station.</p> <p>For services provided outside the country of the staff member's duty station, only the prevailing pattern of charges for the services provided within the country of the staff member's duty station is accepted.</p> <p>Exception only in case of:</p> <ul style="list-style-type: none"> - emergency during official travel (DT); - approved medical evacuation travel (MET); - services provided in countries with inadequate medical facilities. <p>In these cases reimbursement is considered up to the limits of the country where care is provided or up to the limits of the country for which Cigna has granted its prior approval.</p> <p>To avoid unpleasant surprises it is hence recommended to request Cigna's approval beforehand.</p> <p>See also 3.1. Countries with inadequate medical facilities and 0 Official Duty Travel (DT) and 3.3 Medical Evacuation Travel (MET).</p>
<p>Currency of reimbursement</p>	<p>By default, claims will be reimbursed in the currency of the MIP participant's salary/pension.</p>
<p>Validity of prescriptions</p>	<p>One year</p> <p>For continuous medication, the physician has to indicate that the drug is required for a longer period, and specify that period.</p>
<p>Claim submission deadline</p>	<p>All claims must reach Cigna within 12 months after the date when the expenses were incurred.</p>
<p>Outpatient treatment/outpatient surgery/day case</p>	<p>Treatment given on an outpatient basis, where the date of admission is the same as the date of discharge.</p>
<p>Inpatient treatment/hospitalisation</p>	<p>Treatment given on an inpatient basis, where the date of admission differs from the date of discharge (minimum one overnight stay).</p>
<p>Insurance year</p>	<p>An insurance year is equal to a calendar year.</p>

<p>Prior approval</p>	<p>Prior approval from Cigna's Medical consultant is required for all non-emergency hospitalisations and for the following services:</p> <ul style="list-style-type: none">• MRIs, PET scans, CT scans;• major dental treatment;• sub-acute and long-term acute care admissions;• inpatient rehabilitation;• residential treatment;• transplants;• mental health treatment and substance abuse rehabilitation. <p>Prior approval means that reimbursement is guaranteed only in cases where Cigna's Medical consultant grants his explicit approval for the treatment, on the basis of the medical justification, as well as a cost estimate provided by the MIP participant at least one week before the planned admission. In case of medical emergency, approval can be obtained <i>post factum</i>, on the basis of the same medical criteria.</p>
<p>Coordination of benefits</p>	<p>The MIP does not reimburse costs for medical services that have been or are expected to be reimbursed under another insurance, social security or similar arrangement (whether government-run or private).</p> <p>The MIP participant is therefore requested to claim under that applicable arrangement first and then to submit a claim under the MIP in case of any non-reimbursed amount.</p> <p>Claims for such non-reimbursed amount will not be reimbursed at 100% but will be processed and reimbursed according to the conditions set out by the plan.</p>

Appeal process

First-level appeal

Review of a benefit determination needs to be requested from Cigna through the regular communication channels (see Our contact details) within 60 days following receipt of the corresponding settlement note. Plan members are encouraged to submit any additional information that can support their appeal.

Cigna will review and make a decision within 60 days following receipt of the appeal request, except if special circumstances require an extension of time.

The review is based on the following parameters:

- applicable plan design or contract language;
- claims and utilisation management guidelines and policies;
- relevant medical and dental records;

In case the appeal is denied, Cigna will send the Plan member a written notice that includes all specific reasons for the denial.

Second-level appeal: external review

If the claim dispute remains open after the first-level appeal and the value of the disputed claim is at least 500 USD, a review by an external arbitrator may be requested within 60 days following receipt of the denial of the first-level appeal.

The external review will be performed by an independent medical expert designated jointly by Cigna's Medical consultant and the Plan member's attending physician. The decision made by this arbitrator shall be considered final and shall be binding on both parties to the dispute.

Each party shall pay its own medical doctor. The cost of arbitration and fees payable to the medical arbitrator shall be borne half by the plan member and half by the plan except where the arbitrator settles the dispute in favour of the Plan member, in which case the fees will be payable solely by the plan.

Please note that the insurance contract is the only authentic text.

2. Summary of benefits

For elements that are not listed below, we kindly refer you to the [UN MIP List of reimbursable and non-reimbursable items](#).

2.1. In the hospital

GENERAL RULE

Insurance coverage is valid within the country of your duty station. While you may decide to seek medical care outside the country of your duty station, reimbursement will be limited to the reasonable and customary expenses level applicable to the country of your duty station.

You are covered for all generally accepted medical and surgical procedures (up to the limits of reasonable and customary expenses), including the latest medical technologies.

The UN MIP offers a free choice of physician and care provider. You are therefore entitled to be treated by the physician of your choice and in the medical facility of your choice.

Item	Remarks
Prior approval from Cigna's Medical consultant is required for all non-emergency hospitalisations. Notification of such hospitalisations should be given at least 1 week prior to the admission date.	
Bed and board	<ul style="list-style-type: none">Private room (least expensive): 70% of the rate for a private room (least expensive) rate OR 100% of the rate for a semi-private room (whichever is higher)Semi-private room: 100%General ward: 100%ICU: 100%
Doctor's fees during a hospitalisation (i.e. including an overnight stay)	100%
Outpatient consultations in hospital	80%
Other hospital expenses	100%
Emergencies	100%
Extra bed for accompanying adult for enrolled children under 13	80%
Personal expenses	Not covered
Home for the elderly/nursing home	Not covered
Spa cures	Not covered

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Item	Remarks
Drug and alcohol abuse	<u>Inpatient</u> : see Hospitalisation Maximum 90 days per person per calendar year, provided it is carried out at facility certified for detoxification and rehab. <u>Outpatient</u> : 80% up to limit for psychotherapy, which is equal to 1 month MIP Reference Salary per calendar year (per patient).
Outpatient surgery	Doctor's fees: 100% Other hospital expenses: 100%
Outpatient chemotherapy, radiotherapy,	100%
Outpatient haemodialysis	80%
Second surgical opinion	80%

2.2. Ambulance and transportation expenses

GENERAL RULE

All treatments and medicines must be prescribed by a qualified and registered medical doctor.

Item	Remarks
General transportation costs	Not covered
Ambulance - ground	80% Transportation from the place where you fell ill or got injured by an accident to the nearest hospital.
Ambulance – air	Not covered For provisions for medical evacuations, see the administrative instructions 'ST/AI/2000/10' and the information circular 'ST/IC/2000/70' on medical evacuation.
Evacuation	Not covered <ul style="list-style-type: none"> - For provisions for medical evacuations, see administrative instructions 'ST/AI/2000/10' and the information circular 'ST/IC/2000/70' on medical evacuation: - Active staff: via HR in duty station - Retired staff: not foreseen
Repatriation of deceased person	Not covered

2.3. At the General Practitioner's

GENERAL RULE

All treatments and medicines must be prescribed by a qualified and registered medical doctor.

Item	Remarks
Consultation	80%
New! Virtual consultation (by video or telephone)	80%
Annual subscription fees	Not covered
Routine examinations for children until 19 years old Well-child care	100% <ul style="list-style-type: none"> • New-born: 1 routine examination at birth, in the hospital • 0- 1 year old: 6 routine visits per year • 1-2 years old: 2 routine visits per year • 3-19 years old: 1 routine visit per year
Routine physical examinations for adults	For children up to 19 years old: see Well-child care For adults from 20 years old: 80% with a maximum of 1 exam per person per calendar year: <ul style="list-style-type: none"> • Blood analysis: <ul style="list-style-type: none"> ○ Haematology; ○ Sedimentation rate; ○ Blood sugar; ○ Creatinine, urea; ○ SGPT, SGOT, Gamma – GT, bilirubin; ○ Cholesterol – Total, LDL, HDL, triglyceride. • Urine analysis: <ul style="list-style-type: none"> ○ Microscopic evaluation; ○ Glucose; ○ Albumin. ○ Stool/faecal analysis: occult blood. ○ Hepatitis B: once a year from 21 years old. • Chest x-rays: <ul style="list-style-type: none"> ○ Once every two years. ○ Once every year if a smoker or 45 years of age or older • Static and exercise electro cardiogram (ECG): <ul style="list-style-type: none"> ○ Once every two years;

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Item	Remarks
	<ul style="list-style-type: none"> ○ Once every year if 45 years of age or older. ● Colonoscopy: <ul style="list-style-type: none"> ○ Women between the ages of 50 and 75: once every 5 to 10 years; ○ Men between the ages of 45 and 75: once every 5 to 10 years. ● For women: <ul style="list-style-type: none"> ○ Pap smear: once a year; ○ Mammography: once a year if 40 years of age or older; ○ Bone Mineral Density (BMD) test: once a year if 60 years of age or older. ● For men: <ul style="list-style-type: none"> ○ Urological examination: once every 2 years if 55 years of age or older; ○ Prostate specific antigen (PSA): once a year if 50 years of age or older; ○ Abdominal ultrasound for aortic aneurysm: once a year if 60 years of age or older.
HIV test & counselling	100% 2 voluntary blood tests per year without prescription
Vaccinations/preventive medication/immunisations	<p><u>For adults:</u> 100% for immunisations for adults that are recommended by the local health authorities and/or the World Health Organization</p> <p>Immunisations for official duty travel (DT) should be claimed under the funding source covering your travel expenses and not claimed under the MIP.</p> <p><u>For children</u> (well-child care): the MIP covers immunisations as determined by the local health authorities and/or the World Health Organization.</p>
Seasonal flu vaccination	100%

2.4. At the specialist's

GENERAL RULE

All treatments and medicines must be prescribed by a qualified and registered medical doctor.

Item	Remarks
Consultation	80%
Routine examination for women (children smear, mammography, gynaecology)	80% 1 PAP smear and 1 mammography per calendar year
Routine urological examination for men (PSA-test)	80% 1 PSA-test per calendar year

2.5. At the licensed qualified health care provider's (other than doctor)

GENERAL RULE

A doctor's prescription is required for care given by a person holding a paramedical degree (e.g. nurse, physiotherapist).

Renewal of the prescription is required for treatments taking longer than 3 months, unless indicated otherwise in the remarks.

Item	Remarks
Psychiatrist - psychotherapy	80% up to the equivalent of one month's MIP Reference Salary per calendar year (per patient)
Physiotherapy	80%, only if the treatment aims at improving or restoring bodily functions Not covered in case the treatment is provided preventively If the duration of the treatment exceeds 6 months , the attending physician must reassess the treatment and issue a new prescription. Treatments requiring more than 60 sessions per calendar year are subject to prior approval by Cigna's Medical consultant.
Osteopathic treatment	80%, only if the treatment aims at improving or restoring bodily functions Not covered in case the treatment is provided preventively
Chiropractic treatment	80%, only in case of treatment of chronic pain syndrome AND provided that: <ul style="list-style-type: none"> - the treatment is recognised as valid by the competent health authorities of the country, AND - the treatment is provided by a qualified medical doctor or a licensed chiropractor

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Item	Remarks
Acupuncture	80%, only if: <ul style="list-style-type: none"> - the treatment is recognised as valid by the competent health authorities of the country, AND - the treatment is provided by a qualified medical doctor or a licensed chiropractor
Private home duty nurse	80%, only if these are medical acts (wound dressing, injections, etc.) and if they are provided by a qualified nurse
Home health care	80%, only if prescribed as medically necessary and as an alternative to either hospitalisation or a stay in a skilled nursing facility
Alternative medicine	<ul style="list-style-type: none"> - In general: not covered but there are exceptions: - Chinese medicine is accepted for staff members assigned to a duty station located in China. - Ayurveda is accepted for staff members assigned to a duty station located in India provided the treatment is given in Bangladesh, India, Nepal, Pakistan, Sri Lanka, or Malaysia. - Some treatments are covered at 80% (see List of reimbursable and non-reimbursable items), under the following conditions: <ul style="list-style-type: none"> • the patient suffers from a medical condition that requires treatment, AND • the treatment is recognised as valid by the competent health authorities of the country, AND • the treatment is given by a qualified medical doctor.
Speech therapy	80%, only if the treatment aims at improving or restoring speech functions Not covered in case the treatment is given preventively
Homeopathy	80%, under the following conditions: <ul style="list-style-type: none"> • the patient suffers from a medical condition that requires treatment, AND • the treatment is recognised as valid by the competent health authorities of the country, AND • the treatment is provided by a qualified medical doctor.

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2.6. At the optician's

GENERAL RULE

See the [General rule for care given at the general Practitioner's \(2.3.\)](#), unless indicated otherwise in the remarks.

Item	Remarks
Eye test to determine dioptre by ophthalmologist	80% with a maximum of 100 USD every 12 months 
Lenses	<p>80% up to 75 USD/lens; maximum 2 lenses in a period of 12 months (the date of the 1st purchase determines the start of the 12-month period)</p> <p>A waiting period of 12 months applies from the enrolment into the MIP.</p> <p>For periods starting after 1st of January 2023: 80% with a maximum of 90 USD/lens and maximum 2 lenses every 12 months (the date of the purchase determines the start of the 12-month period)</p> <p>A waiting period of 12 months applies from the enrolment into the MIP.</p>
Frames	<p>80% up to 50 USD per frame; maximum 1 frame in a period of 24 months (the date of the 1st purchase determines the start of the 24-month period)</p> <p>A waiting period of 12 months applies from the enrolment into the MIP.</p> <p>For periods starting after 1st of January 2023: 80% with a maximum of 60 USD per frame and maximum one frame every 24 months (the date of the purchase determines the start of the 24-month period)</p> <p>A waiting period of 12 months applies from the enrolment into the MIP.</p>
Contact lenses	See Lenses
Fluid for contact lenses	Not covered
Disposable lenses	See Lenses
Prescription sunglasses with dioptre	See Lenses and Frames above

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Item	Remarks
Lasik/keratotomy and other procedures to change the dioptre	<p>80% up to 150 USD per eye</p> <p>A waiting period of 12 months applies from the enrolment into the MIP.</p> <p>As from 1st of January 2023: 80% up to maximum of 180 USD per eye</p> <p>A waiting period of 12 months applies from the enrolment into the MIP.</p>

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2.7. At the dentist's

GENERAL RULE

All dental treatments, including dental surgery, are covered and reimbursed as 'Ordinary dental care'.

Item	Remarks
Ordinary dental care	80% up to 50% of the MIP Reference Salary per person per calendar year
Major dental treatment (e.g. prosthesis, bridges, implants...)	80% subject to the limit for 'Ordinary dental care' Prior approval is required. Please provide us with the following documents: <ul style="list-style-type: none">• treatment plan;• OPG (panoramic x-ray of the mouth) taken before the treatment. An OPG taken after the treatment may also be required..
Orthodontics (e.g. braces, dento-facial orthodontics)	80% subject to the limit for 'Ordinary dental care', only if the treatment was started before the age of 15 Maximum treatment period: 4 years
Dental surgery	80% subject to the limit for 'Ordinary dental care' Some oral surgery procedures are not subject to the ceiling for dental care (see List of reimbursable and non-reimbursable items)
Dental care after an accident	80% up to one time the MIP Reference Salary per person per calendar year

2.8. At the pharmacist's

GENERAL RULE

All medicines must be prescribed by a qualified and registered medical doctor.

Item	Remarks
General	80%, only if the medicines are prescribed, medically necessary and contain pharmaceutical components to treat a specified diagnosis.
Medication for emergency care and for use in hospital	100%
Contraceptive devices and medication	80% Condoms are not reimbursable.

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Item	Remarks
Vitamins	<ul style="list-style-type: none"> - Multivitamins: not covered - Specific vitamins/minerals: not covered, unless when the vitamin/mineral in question is taken to cure an existing deficit. <p>Please send the results of the relevant laboratory test so that our Medical consultant can ascertain whether this is the case.</p>

2.9. At the specialised supplier's office

GENERAL RULE

The services listed below are normally reimbursable at 80% provided they are prescribed by the attending physician as medically necessary.

Item	Remarks
Orthopaedic devices	80% for rental (Purchase is acceptable if it turns out to be cheaper than rental or if the equipment cannot be rented.)
Hearing aids	80% up to 300 USD per apparatus, including the related examinations and batteries Maximum of 1 apparatus per period of 36 months
Batteries for hearing aids	See Hearing aids
Adaptation to the patient's accommodation (shower, elevator, lavatory, etc.)	Not covered
Orthopaedic shoes/insoles	80%

2.10. In the laboratory/medical imaging facility

GENERAL RULE

In general, tests and medical imaging are done on an outpatient basis. Test and imaging carried out during a hospitalisation are covered at 100% (see [Hospitalisation](#)).

Item	Remarks
Diagnostic medical imaging	Outpatient: 80% Inpatient: 100%
MRI, PET scan, CT scan	Outpatient: 80 % Inpatient: 100 % Prior approval is required.
Lab tests	Outpatient: 80% Inpatient: 100%

2.11. Pregnancy and childbirth

GENERAL RULE

Outpatient care given during pregnancy and at childbirth is reimbursable at 80%.
Inpatient care given during pregnancy and at childbirth is reimbursable at 100%.

Item	Remarks
Delivery in hospital	See Hospitalisation
Outpatient delivery	See Outpatient surgery
Home delivery	80%
Visits by a licensed midwife	80%
Pre- and postnatal exercises	80%
Sterilisation	see Outpatient surgery
Reversal of sterilisation	Not covered
Hormonal treatment to stimulate fertility	80%, only if meant to stimulate natural fertility
IVF (in-vitro fertilisation)	Not covered
ICSI (intra-cellular sperm injection)	Not covered
AI (artificial insemination)	Not covered
MESA (microchirurgical epididymal sperm-aspiration)	Not covered
TESE (testicular sperm-extraction)	Not covered

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Item	Remarks
Cryopreservation	Not covered

2.12. Fertility treatment

GENERAL RULE

80% up to lifetime ceiling of 15,000 USD per family (hardship provision and stop loss do not apply). A total of three attempts per lifetime is covered, limited to women younger than 45 when the treatment is started.

Prior approval is mandatory. The following documents must be submitted:

- Medical report with information on reproductive health, how long conception has been attempted, information on miscarriages and/or treatments
- Lab test results with hormone levels of female partner, and sperm analysis results of male partner
- List and price of treatments and tests

Hormonal treatment to stimulate fertility	80% Up to a life time ceiling of 15,000 USD per family
IVF (In-Vitro Fertilisation)	80% Up to a life time ceiling of 15,000 USD per family
ICSI (intra-cellular sperm injection)	80% Up to a life time ceiling of 15,000 USD per family
AI (artificial insemination)	80% Up to a life time ceiling of 15,000 USD per family
MESA (microchirurgical epididymal sperm-aspiration)	80% Up to a life time ceiling of 15,000 USD per family
PESA (Percutaneous Epididymal Sperm extraction)	80% Up to a life time ceiling of 15,000 USD per family
TESE (testicular sperm-extraction)	80% Up to a life time ceiling of 15,000 USD per family
TESA (testicular sperm aspiration)	80% Up to a life time ceiling of 15,000 USD per family
Laboratory test related to fertility treatment	80% Up to a life time ceiling of 15,000 USD per family
Cryoconservation	Not covered

3. Special situations

3.1. Countries with inadequate medical facilities

For each country with inadequate medical facilities, the UN MIP has established a 'regional area of care', i.e. a specific neighbouring country or region designated by the UN, where staff members can seek medical treatment without requesting approval for a medical evacuation. Medical expenses incurred in such areas will be reimbursed up to the limits of reasonable and customary expenses of the country where the treatment or service is provided.

For medical evacuations, the current procedures remain in place.

Duty station	Regional area of care
Afghanistan	Pakistan and India; Turkey and Kazakhstan as from 3 September 2021
Bhutan	India
Burundi	Rwanda, Uganda and Kenya (only when services are not available in Uganda)
Cambodia	Thailand Expenses incurred at the Bumrungrad Hospital will be strictly reimbursed on the basis of reasonable and customary limits applicable in Thailand. Please note that MIP participants will be responsible for all charges exceeding the reasonable and customary limits applicable in Thailand.
Central African Republic	Cameroon
Comoros	Mayotte, Réunion and Mauritius
Democratic Republic of Congo	Burundi, Rwanda and Uganda (for staff members and their family members located near the Eastern borders of Congo)
East Timor	Australia (Darwin)
Eritrea	Sudan, Egypt (only when services are not available in Sudan)
Guinea Bissau	Senegal
Haiti	Dominican Republic
Iraq	Jordan and Lebanon; Turkey since 02/08/2021
Kosovo	Albania, Bosnia, Croatia, Macedonia, Montenegro, Serbia, Slovenia
Laos	Thailand Expenses incurred at the Bumrungrad Hospital will be strictly reimbursed on the basis of reasonable and customary limits applicable in Thailand. Please note that MIP participants will be responsible for all charges exceeding the reasonable and customary limits applicable in Thailand.
Lesotho	South Africa

Please note that the insurance contract is the only authentic text.

Liberia	Ghana
Libya	Tunisia (for staff with duty station Libya but physically located in Tunisia, it is also Tunisia)
Mali	Senegal
Myanmar	Thailand Expenses incurred at the Bumrungrad Hospital will be strictly reimbursed on the basis of reasonable and customary limits applicable in Thailand. Please note that MIP participants will be responsible for all charges exceeding the reasonable and customary limits applicable in Thailand.
Sierra Leone	Ghana
Serbia	Macedonia, Montenegro, Bosnia, Serbia, Slovenia, Albania, Croatia (for staff with duty station Serbia but physically located in Kosovo)
Somalia	Kenya
South Sudan	Uganda, Kenya and Sudan Sentence removed
Sudan	Egypt
Swaziland	South Africa
Syria	Lebanon and Jordan (only when services not available in Lebanon); Turkey (since 2 August 2021)
Tanzania (Arusha only)	Kenya (Nairobi)
Turkmenistan	India
Yemen	Jordan (since 7 December 2022)
Ukraine	Poland, Slovakia, Hungary, Romania, Moldova (Since 4 March 2022)
Zimbabwe	South Africa

This list will be reviewed on a yearly basis.

3.2. Official Duty Travel (DT)

Expenses for emergency treatment will be reimbursed according to the pattern of charges for professional and other health services prevailing in the country where the expenses are incurred.

Expenses for non-emergency treatments will be reimbursed according to the pattern prevailing in the country of the staff member's duty station. DT is not available for retirees/ASHI participants.

3.3. Medical Evacuation Travel (MET)

Please note that the insurance contract is the only authentic text.

Expenses will be reimbursed according to the pattern of charges for professional and other health services prevailing in the country where MET is authorised. The medical expenses incurred during MET will be reimbursed according to the conditions set out by the plan for the type of care that has been approved. MET is not available for retirees/ASHI participants.

In case you chose to be evacuated to another country than the country that is authorised, the expenses will be reimbursed according to the pattern of charges prevailing in the country where MET is authorised.

3.4. Stop Loss Clause and Out-of-pocket maximum

'Out-of-pocket maximum' refers to the total sum of co-payments paid by all family members in a calendar year.

Once the out-of-pocket maximum for covered treatments and services has reached the stop loss limit defined below, the MIP will start reimbursing an additional 80% of the out-of-pocket expenses. This is what is called the 'stop loss clause'.

The stop loss limits are:

- Active staff: 50% of the staff member's monthly net base salary (i.e. gross salary minus staff assessment)
- Retired staff: 50% of the remuneration used for the calculation of the retired staff member's contribution (i.e. 25% of the monthly net base salary at the date of separation adjusted by the global cost-of-living increases declared by the UNJSPF)

The stop loss clause will not apply until the total amount of non-reimbursed medical and hospital expenses incurred by the MIP participant and enrolled family members (for reasonable and customary care) have exceeded the stop loss limits mentioned above in a single calendar year.

The following items do not count towards the out-of-pocket maximum:

- non-reimbursed portion of dental care, outpatient mental and nervous care, eyeglasses and hearing aids;
- non-recognised medical and hospital expenses (for example, the difference between semi-private and private accommodation in the hospital does not count towards the out-of-pocket maximum).

3.5. Hardship provision

The maximum amount of reimbursement of medical expenses per individual person (not per family) in a single calendar year is established at 6 times the MIP Reference Salary.

The MIP Reference Salary is updated on a yearly basis.

MIP participants are expected to meet these expenses after this limit has been reached.

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In the event of major medical expenses, MIP participants may be faced with expenses that considerably exceed the normal limits payable under the MIP, so much so that they may experience undue financial hardship. Under such very exceptional circumstances, amounts in excess of the regular limit of 6 times the MIP Reference Salary may be reimbursed.

Such cases will be examined together by Cigna and UN Insurance and Disbursement Service. Please note that such cases will not be considered as hardship until the total amount of non-reimbursed medical and hospital expenses incurred by the MIP participant and enrolled family members (for reasonable and customary care) have exceeded the stop loss limits mentioned under 3.4.

4. Exclusions

The coverage shall, amongst other items, not extend to:

- Insured participants who are mobilised or who volunteer for military service in time of war;
- Injuries resulting from motor-vehicle racing or dangerous competitions in respect of which betting is allowed (normal sports competitions are covered);
- The consequences of insurrections or riots if, by taking part, the plan member has broken the applicable laws; and the consequences of brawls, except in cases of self-defence;
- Spa cures, rejuvenation cures or cosmetic treatment (reconstructive surgery is covered where it is necessary as a result of an accident for which coverage is provided);
- 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;
- 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;
- Expenses that are not deemed to be reasonable and customary. The determination of the reasonable and customary charge for each service is made by Cigna, 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 Cigna 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;
- Medical care that is not medically necessary or medical care that is not medically recognized as a treatment for the diagnosis provided;

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- 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;
- Elective surgery that is not resulting from an accident, illness or maternity;
- Alternative medicine; see [2.5](#) for detailed information.
- Food and dietary products;
- Fertility/infertility treatment.

This is a non-limitative list. In case the treatment you are considering is not listed here nor in the [List of reimbursable and non-reimbursable items](#), we advise you to contact us to request prior approval.

5. Access to forms

On your personal webpages you can download the claim form and the cost estimate form. You can access your personal webpages as follows:

- Go to www.cigna.healthbenefits.com and click 'Plan members'
- Fill in your personal reference number and password. You can find your personal reference number on your membership card (414/xxxxx).