UNITED NATIONS **ST**

Secretariat

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ADMINISTRATIVE INSTRUCTION

To: Members of the staff at designated duty stations away from Headquarters

From: The Controller

Subject: MEDICAL INSURANCE PLAN FOR LOCALLY RECRUITED STAFF AT DESIGNATED DUTY STATIONS AWAY FROM HEADQUARTERS

1. The purpose of the present administrative instruction is: (a) to introduce with effect from 1 September 1987 the Medical Insurance Plan (MIP), a new contributory health insurance scheme for locally recruited General Service, and National Officer staff members and former staff members and their eligible family members at designated duty stations away from headquarters; and (b) to present the rules governing the Plan.

2. As previously announced in information circular ST/IC/87/33 of 19 June 1987, the new scheme, hereafter referred to as "MIP" or "the Plan", is established, as approved by the General Assembly at its forty-first session in accordance with staff regulation 6.2, and replaces the existing Medical Expense Assistance Plan (MEAP), set out in appendix E to the Staff Rules, which will be cancelled as of 1 September 1987.

3. At duty stations away from headquarters other than those designated in annex II to the rules, MIP provides for automatic health insurance for United Nations locally recruited staff members and, on an optional basis, for their eligible family members. MIP introduces after-service health insurance protection to these categories of staff members and is designed to provide coverage to eligible former staff members and their family members. No provision for after-service health insurance was available under MEAP.

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RULES GOVERNING THE MEDICAL INSURANCE PLAN

CONTENTS

CONTENTS (continued)

MEDICAL INSURANCE PLAN (MIP)

1.0 GENERAL

The Medical Insurance Plan (also referred to as MIP or the Plan) is a health insurance scheme operated by the United Nations and related organizations e.g., the United Nations Development Programme (UNDP), the United Nations Children's Fund (UNICEF) and the Office of the United Nations High Commissioner for Refugees (UNHCR), for the benefit of their locally recruited General Service and National Officer active staff members and former staff members (and their eligible family members) serving at designated duty stations away from the relevant headquarters locations. The purpose of MIP is to assist subscribers and their eligible family members in meeting the cost of certain health services, facilities and supplies. A complete description of the Plan is set forth within these rules.

1.1 Definitions

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

(a) Administering office. The administering office is the office that has the responsibility on behalf of its organization for the day-to-day operation of the Plan (e.g., enrolment, claims processing, reimbursements accounting) at a given duty station;

(b) After-service participant. This term is used for convenience to refer equally to retirees, participating survivors, disability pensioners and appendix D beneficiaries;

(c) 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 Staff Rules of the United Nations;

(d) 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 or her eligible family members. With respect to MIP, the benefits of each medical scheme under which a given subscriber and his or her eligible family members are insured must be utilized before the benefits available under MIP will apply (see rule 4.9);

(e) 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 or she practises the profession of dentistry;

(f) 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;

(g) Eligible family members. Eligible family members constitute the subscriber's spouse and children or, in the case of retired staff member, 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;

(h) Mental and nervous care. Mental and nervous care constitutes medical treatment for emotional disturbance provided by a physician licensed in the speciality of psychiatry;

(i) 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 scale. For this purpose any Extended General Service or National Professional 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;

(j) Participating survivor. A participating survivor is an eligible family member who survives a subscriber;

(k) 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 or she is licensed to practise medicine;

(1) Reasonable and customary. Reasonable and customary refers to the prevailing pattern of charges for professional and other health services at the duty station where the service is provided;

(m) Recognized expenses. This term refers to 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 amount as determined by the administering office;

(n) 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

1. Participation in MIP is automatic for all staff members holding a contract of three months or more in the General Service and National Officer categories who serve at a designated duty station away from one, of the relevant headquarters locations.

2. All staff members, regardless of their length of contract, will have a deduction taken from their salary in respect of their participation in MIP. If a staff member who is not initially eligible remains in the employment of the organization beyond three months, he or she may claim retroactively for assistance in reimbursement for HIP-covered services. If he or she leaves the organization during the initial period of three months, he or she will not have been entitled to benefits and will be refunded the premiums deducted during that period.

3. Notwithstanding that participation in MIP is automatic, an MIP enrolment form, obtainable from the administering office, must be completed by the staff member in respect of his or her own participation, and, additionally, to provide an opportunity to enrol his or her eligible family members.

2.2 Voluntary participation

1. Health coverage for family members is highly recommended as a protection against the high cost of health care. A staff member is therefore encouraged to enrol his or her spouse and children in MIP. However, enrolment of these family members is voluntary. Coverage is not available for secondary dependants (such as a parent, brother or sister). ELIGIBLE FAMILY MEMBERS OF ACTIVE STAFF MUST BE ENROLLED WITHIN 30 DAYS AFTER THE PLAN IS FIRST INTRODUCED AT THE DUTY STATION, 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. If eligible family members are at any time withdrawn from the Plan, they may not subsequently re-enter, nor will they be eligible at a later date for after-service health insurance.

2. An eligible child is insurable under MIP until the end of the year in which he or she reaches the age of 25, provided all of the following conditions are met: he or she is (a) a dependant of the subscriber, (b) not married, and (c) not engaged in full-time employment. There is no limit to the number of children eligible for after-service coverage, provided the subscriber concerned provides satisfactory evidence of parenthood or adoption.

3. Subject to consultation with the United Nations Medical Director, this 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 or she is unable to earn a living, coverage under MIP 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 organization. If the United Nations Joint Staff Pension Fund continues to pay a child's benefit because of the child's incapacity, such payment may constitute satisfactory evidence of disability.

4. If an insured 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 (see rule 7.0).

5. After-service coverage for former staff members and their eligible family members is available on a voluntary basis (see rule 7.0).

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

2.3 Waivers for certain duty stations

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

(a) 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 United Nations 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.

(b) Where staff at the duty station have traditionally had health insurance coverage through a United Nations-recognized plan other than MIP or its predecessor, MEAP. A list of the duty stations affected is set out in annex II to the present rules. 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 headquarters, subsequent withdrawal from MIP will not be permitted. In some instances, the United Nations and related organizations, e.g., UNDP, UNICEF and UNHCR, may be operating different medical schemes.

2.4 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 or her eligible family members to qualify for coverage.

2.5 Special leave without pay

Coverage under MIP may be continued during a period of special leave without pay provided the staff member pays both his or her own contribution and that of the organization.

2.6 Cessation of coverage

1. A staff member participating in MIP remains covered through the-last day of the month in which the employment ceases. 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 below under rule 7.0.

2. 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 rule 2.2) ceases. Surviving family members who continue contributing to MIP maintain their coverage until their eligibility ceases or until they elect to discontinue, whichever occurs first.

3. Withdrawal of eligible family members from MIP must be effected in writing; once electing to withdraw, RE-ENTRY INTO THE PLAN WILL NOT BE PERMITTED.

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3.0 ENROLMENT PROCEDURES

1. Every staff member who participates in MIP is required to complete an MIP enrolment form. Current staff members must complete the form within 30 days after the introduction of MIP, while new staff members must complete the form within 30 days after joining the organization. The MIP enrolment form is also used to designate the eligible family members to be covered under the Plan.

2. To enrol additional eligible family members (upon marriage, birth, adoption) or to delete family members, the staff member must, within 30 days of the event, complete an enrolment form.

3. Retirees and other eligible former staff members must also complete an MIP enrolment form. This must be done by the separating staff member as part of the separation procedure (see also rule 7.3).

4. It is the responsibility of the staff member or retiree to inform the administering office within 30 days of changes in family coverage by completing a new enrolment form in order to ensure that new family members will be covered, as well as to avoid paying contributions for family members who are no longer eligible.

4.0 BENEFITS

4.1 Reasonable and customary

MIP covers the benefits described below, subject to the stated limitations. The administering office is authorized to reimburse claims in line with these benefits on the basis of the reasonable and customary charges applicable at the duty station. Reasonable and customary refers to the prevailing pattern of charges for professional and other health services at the duty station where the service is provided.

4.2 Hospital expenses

Reimbursement at 100 per cent is provided for hospital services and supplies, including bed and board (semi-private accommodations), operating room, recovery room, intensive care, general hospital nursing care, as well as drugs and medicines administered in the hospital. Where hospital accommodation is provided at rates for a private room with only one bed, then 70 per cent 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.

4.3 Professional services and medications

The following services are reimbursed at 80 per cent:

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

(b) Obstetrical services, including midwifery;

(c) Laboratory tests and X-rays;

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

(e) Immunizations.

4.4 Mental and nervous care

Outpatient psychiatric care for mental and nervous disorders is reimbursed at the 50 per cent rate, subject to a limit (per eligible patient) in any calendar year of one month at the MIP reference salary.

4.5 Optical lenses and hearing aids

1. 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.

2. Optical lenses. Subject to the one-year waiting period, reimbursement is made at the 80 per cent rate with a maximum of $25 per lens and a maximum of two lenses in a period of two years (per eligible patient) (see example 1 in annex III to the present rules).

3. Hearing aids. Subject to the one-year waiting period, reimbursement is made at the 80 per cent rate with a maximum of $150 per apparatus, including the related examination, and a maximum of one apparatus per ear in a period of three calendar years (per eligible patient).

4.6 Dental care

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

(a) False teeth, crowns, bridges, other similar appliances;

(b) Dento-facial orthodontics (e.g. braces), if treatment is started before the patient is 15 years of age (except in the case of an accident); treatment period up to 4 years.

2. The general provision regarding reasonable and customary charges (see rule 4.1) 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.

3. 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 (see example 2 in annex III to the present rules).

4.7 Exclusions

1. The following will not be reimbursed under the Plan:

(a) Eye examinations, except in the case of illness or injury;

(b) Eyeglass frames (as distinct from lenses, which are covered under rule 4.5);

(c) Preventive health examinations;

(d) Spa cures, rejuvenation cures, cosmetic treatment;

(e) Consequences of a voluntary or intentional act committed by the beneficiary: e.g. a brawl, except in the case of self-defence;

(f) Motor-vehicle racing or dangerous competitions in respect of which betting is allowed (normal sports competitions are covered);

(g) Any portion of the expenses for medical services and supplies that exceeds the regular and customary charge for the services or supplies;

(h) Home help, family help or similar household assistance, and fees of persons who are not qualified nurses;

(i) Any charges for services or supplies that have not been prescribed or approved by a physician;

(j) Hospital charges for telephone, television, or for persons other than the patient, etc.;

(k) Elective plastic surgery;

(l) Food and dietary products (other than those normally provided during hospitalization), cosmetics and toilet articles;

(m) Expenses for travel and accommodations.

2. In case of doubt with respect to the meaning of any of the above exclusions, the relevant headquarters should be consulted.

4.8 Maximum reimbursement of expenses

1. Under the Plan, reimbursement of expenses at the rates described above will be allowed in respect of any eligible patient up to a limit in any calendar year equivalent to three times the MIP reference salary in effect on 1 January and converted to United States dollars (at the United Nations operational rate of exchange or the ad hoc rate of exchange established by the relevant headquarters, as applicable) or $US 1,000, whichever is greater (see also rule 5.4).

2. 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 rules 4.2 to 4.6.

3. Under very exceptional circumstances, where demonstrated hardship is involved, the Plan may reimburse amounts in excess of those described in paragraph 1. Such cases must be submitted to the relevant headquarters for its decision.

4. Information is to be reported to the relevant headquarters on patients who have reached the calendar year limit on reimbursements under the provisions for major expenses.

4.9 Co—ordination of benefits

The Plan does not reimburse costs for services that have been or are expected to be reimbursed under another insurance, social security or similar arrangement (Government or private). THE PARTICIPANT IS THEREFORE REQUIRED

TO CLAIM UNDER ANY APPLICABLE ARRANGEMENT and, thereafter, to submit a claim under MIP for any unreimbursed amount. The financial benefit for the participant is illustrated in example 3 of annex III to the present rules.

5.0 CLAIMS PROCEDURE AND REIMBURSEMENT

5.1 When and where to submit

When a subscriber or eligible family member has incurred expenses for services reimbursable under MIP, the subscriber is to file a claim under the Plan with the administering office as soon as possible after treatment or care has been provided, normally within 60 days. Claims not presented within 12 months will normally be denied. Several small claims for the same patient may be grouped and submitted at one time.

5.2 Forms and supporting documentation

1. The subscriber fills out, signs and submits the MIP claim form, copies of which are available from the administering office. Signing the 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.

2. In addition to the MIP claim form, the subscriber must submit proper supporting documentation consisting of:

(a) Original receipted bills showing the name of the patient and the nature, dates and detailed costs of the services rendered. If the Government/local authorities in the country have requirements regarding receipts for services, these must be fulfilled in respect of the claims submitted under MIP;

(b) Original prescriptions and original detailed receipts for drugs, medicines, optical lenses and hearing aids.

5.3 Screening of claims

The administering office is responsible for screening and monitoring the completeness and correctness of each claim and for ensuring that it conforms to the requirements of the present rules and is consistent with reasonable and customary costs for similar services in the locality. The administering office 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.

5.4 Referral to the relevant headquarters

1. The administering office has the authority to settle medical claims under MIP. At the office's discretion, claims may be referred to the relevant headquarters for advice. Guidance may also be sought in case of doubt as to the interpretation of the rules (see also rule 4.8).

2. Individual claims exceeding an amount equivalent to twice the MIP reference salary are considered to have reached a threshold that merits special attention; accordingly, the administering offices should give particular emphasis to the monitoring of such claims. While the administering offices are authorized to settle these claims locally, such claims will be reported to the relevant headquarters on a periodic basis.

5.5 Reimbursement of claims

1. If the claim is in line with the requirement of the present rules, it is settled and the appropriate amount is reimbursed to the subscriber, who is provided with a copy of the processed claim form.

2. If the claim includes charges for any service found to be in excess of reasonable and customary costs, the administering office calculates the reimbursement on the basis of the reasonable and customary charges in the locality for similar services and the subscriber is so informed.

3. Services and medication provided outside the country of the subscriber's duty station will be covered on the basis of the reasonable and customary costs prevailing at that duty station. Expenses that are above these limits will not be reimbursed (see example 4 in annex III to the present rules).

5.6 Currency of reimbursement

The currency of reimbursement will be the same as that in which the subscriber contributes to MIP (see rules 6.2 and 7.5). If the medical services are paid in another currency, reimbursement is to be made in the currency of contribution to MIP. The rate of exchange used will be that of the United Nations, as applicable, on the date the expenses were reimbursed.

6.0 FINANCING

6.1 Contributory nature of the scheme

MIP operates as a health insurance plan for which premiums are paid to finance the cost. To enable the Plan to provide for adequate medical care and in view of the costs involved, all subscribers (active and former staff members and surviving spouses and children) in the Plan are required to contribute towards the payment of premiums, as is typical in all insurance plans of the United Nations system. Also, as under other United Nations health insurance plans, the organization will share in the cost of the premiums.

6.2 Remuneration basis for assessing contributions

Contributions of the subscribers are determtned on the basis of their remuneration, which for the purposes of MIP consists of net base salary plus any language and non-resident's allowance. The remuneration is that which appears on the salary scale for the month in question, at the grade and step of the staff member. For active staff members, 100 per cent of the remuneration is used to compute the contribution. For after-service participants, an amount equivalent to 50 per cent of the remuneration (as indicated in rule 7.4) is used to compute the contribution. A further adjustment is made in respect of surviving family members. Additional explanations are given in rule 7.

6.3 Contribution by the subscriber

1. The actual contribution to be paid by the subscriber is based on a percentage multiplied by the remuneration of the active or former staff member. The percentage varies according to the number of insured family members based on the following categories:

(a) For one insured person (subscriber alone);

(b) For two insured persons (subscriber plus one eligible family member);

(c) For three, four or five insured persons (subscriber plus two, three or four eligible family members);

(d) For six or more insured persons (subscriber plus five or more eligible family members).

2. The percentage of contribution for each category of coverage is set forth in annex I to the present rules and is subject to change from time to time. In addition, the percentage rates of contribution are the same for all duty stations and all organizations participating in the Plan (see example 5 in annex III).

6.4 Collection of contributions

The contributions of staff members towards MIP premiums are collected by monthly payroll deductions. All other subscribers are billed quarterly in advance by the administering office.

6.5 Review of contribution levels

The premiums in MIP are based on the overall claims experience of the Plan. The initial level of contributions of subscribers is based on a projection of overall medical costs reimbursed globally under MIP. Periodically the claims experience is monitored by comparing actual and projected costs and, in the light of the financial experience of the Plan, the contribution levels may be changed.

7.0 AFTER-SERVICE HEALTH INSURANCE

7.1 General

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

2. 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

1. The following categories of former staff members and their family members are eligible for after-service coverage:

(a) Former staff members who left the service at or after the age of 55 and, who at the time of separation, had at least five years' in-service participation in MIP, its predecessor, MEAP, or, prior to that in a health insurance plan recognized by the United Nations;

Such former staff members are entitled to a subsidy from the organization provided they had at least 10 years of in-service participation in MIP, MEAP, another United Nations 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 or she has fulfilled the 10-year requirement.

(b) Former staff members who retired prior to 1 September 1987 will be eligible to participate under the conditions specified below:

(i) Former staff members (and their eligible family members) who separated on or after 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 five years in MEAP, or another United Nations recognized plan or a combination thereof;

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 United Nations 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;

(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 United Nations recognized plan or a combination thereof;

Such former staff members will be entitled to a subsidy from the organization.

(c) Former staff members who are eligible for periodic disability benefits from the United Nations Joint Staff Pension Fund and/or a periodic benefit under appendix D of the United Nations Staff Rules (which govern compensation for service-incurred illness, injury or death) and who were covered under MIP at the time of separation. No minimum qualifying period of in-service coverage is necessary in such cases;

(d) The spouse and children of a former staff member who is eligible for and who has opted to be covered under the Plan, provided that they were insured at the time of the staff member's separation;

(e) The surviving spouse and children of a former staff member who dies after leaving the service of the United Nations or who dies at any age while still in the service, provided that they were insured in MIP at the time, of the former staff member's death.

2. A child is insurable under the after-service coverage until the end of the year in which he or she reaches the age of 25, provided he or 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.

3. 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.

4. 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 organization. If the United Nations Joint Staff Pension Fund continues to pay a child's benefit because of the child's incapacity, such payment may constitute satisfactory evidence of disability.

5. Spouses and dependent children or, as the case may be, surviving spouses and children, are only eligible for coverage if they have been insured continuously through the staff member concerned and remained insured at the time of the latter's separation.

6. If, before joining the United Nations, the insured former staff member had been covered under any of the other contributory health insurance plans of the United Nations 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 periods 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.

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

1. Applications for after-service coverage should be made by filling out the MIP enrolment form and returning it to the relevant administering office. After the application has been approved, the applicant will be informed of the amount of the contribution and method of payment.

2. Separating staff members who are eligible for after-service coverage should normally arrange for their enrolment within 30 days of their separation. Separating staff and eligible family members who do not enrol in the after-service coverage within 30 days of being eligible are not permitted to enter the Plan at a later date.

3. 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.

7.4 Contributions

1. The cost of after-service participation is met through joint contributions by the organization and the subscribers, except in the case of persons referred to in the following paragraph who must pay the entire cost of the premium.

2. There will be no subsidy for those staff members who are 55 years or older on leaving the service on or after 1 January 1984 and who had five years or more but less than 10 years' coverage under MIP or, prior to the establishment of MIP, in a health insurance plan recognized by the United Nations for after-service coverage. They are, however, eligible for after-service coverage under MIP but must pay the entire cost of insurance until they have accumulated 10 years of coverage, after which the United Nations begins paying the applicable subsidy (see example 6 in annex III to the present rules).

3. The contributions of those insured for after-service coverage are based on a percentage of remuneration identical to those established for in-service coverage (see rule 6.2), and are set forth in annex I to the present rules. The percentages will be reviewed periodically and may be adjusted as necessary. The categories of coverage provided are stated below:

(a) For one insured person (former staff member without spouse or children);

(b) For two insured persons (former staff member plus one eligible family member);

(c) For three, four or five insured persons (former staff member plus two, three or four eligible family members);

(d) For six or more insured persons (former stiff member plus five or more eligible family members).

4. For former staff members, the calculation of the contribution is based on the application of the relevant percentage mentioned in annex I to the present rules to 50 per cent of the current net salary (see rule 6.2) corresponding to the grade and step of the staff member at the date of his or her separation. This percentage and the amount of net salary used may be adjusted periodically by the organization for each duty station.

5. The contributions of the eligible surviving spouse and children shall be one half of those of the former staff members through whom they were originally insured. That is, the contribution is based on the application of the relevant percentage mentioned in paragraph 3 above and set forth in annex I to the present rules to 25 per cent of the current net salary corresponding to the grade and step of the deceased staff member at the date of his or her separation (see example 7 in annex III to the present rules).

7.5 Method of payment of contributions

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 United Nations, 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 the enrolment.

7.6 Change in country of residence

1. Any subscriber who is eligible for after-service health insurance and who changes his or her country of residence after separation is responsible for informing the appropriate United Nations office in the new country of residence. Participation in the after-service coverage will continue, provided the subscriber pays contribution appropriate for the new country of residence.

2. The administering office in the new country of residence refers to its relevant headquarters for advice about the appropriate grade and step on which to base the contribution. This contribution will be in the currency of the new country of residence. The administering office in the new country of residence 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.

3. If the new country of residence does not have a United Nations office where MIP is in effect, the relevant headquarters will designate the comparable after-service scheme and determine the appropriate contribution.

7.7 Type of benefits and currency of reimbursement

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

2. The currency of reimbursement will be governed by the provisions of rule 5.6.

7.8 Cessation of coverage

1. After—service coverage for eligible former staff members ceases: (a) upon their death; (b) upon their failure to make timely contributions; (c) upon their giving written notice of withdrawal to the United Nations office concerned or (d) when their periodic disability or periodic compensation benefits stop (unless he or she returns to service or he or she qualifies for after-service coverage).

2. After-service coverage for insured surviving spouses and insured children ceases upon death, 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

1. Each participating organization determines which office or offices are responsible for administering MIP. Participating organizations consult at the headquarters and field levels to ensure that similar approaches are followed in administering the Plan under the present rules.

2. The administering office is responsible for enrolling subscribers and their eligible family members, screening and processing their claims and collecting the subscriber's contributions. Additionally, it will keep appropriate records on these matters.

3. The administering office is responsible also for ensuring compliance by subscribers with these rules and avoiding unreasonable or abusive use of the plan (see also rule 5.2). It may seek advice at the local and headquarters levels or refer difficult or doubtful cases to headquarters for guidance.

8.2 Forfeiture and suspensfon of benefits

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

(a) If he or she does not comply with the present rules;

(b) If it is determined that he or she fraudulently attempted to obtain benefits to which he or she was not entitled;

(c) If he or she is delinquent in the payment of contributions to the Plan.

8.3 Employment injury

In the event of illness or accident which may be attributable to the performance of the official duties, the resulting medical and related expenses are payable under appendix D to the Staff Rules (rules governing compensation in the event of death, injury or illness attributable to the performance of official duties on behalf of the United Nations). 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.

8.4 Further information

Further information about the specific types of benefits available under MIP, the schedule of contributions and claims and enrolment procedures may be obtained at any of the United Nations offices administering the Plan, or, if necessary, from the relevant headquarters of the participating organizations concerned.

Annex I

CONTRIBUTIONS AND TOTAL PREMIUM EFFECTIVE 1 SEPTEMBER 1987

(Expressed as a percentage of applicable net salary) a/

Category of coverage	Subscriber's contributions	Organization's contributions	Total premium
For one insured person (subscriber alone)	1.00	3.00	4.00
For two insured persons (subscriber plus one eligible family member)	1.25	3.75	5.00
For three, four or five insured persons (subscriber plus two, three or four eligible family members)	1.75	7.00	8.75
For six or more insured persons (subscriber plus five or more family members)	2.25	9.00	11.25

_____

a/ As explained in rule 7.4, paragraphs 3 and 4, the level of remuneration used is adjusted in order to calculate the contributions of former staff members and their eligible survivors.

Annex II

DUTY STATIONS AT WHICH THE PLAN SHALL NOT APPLY

The Medical Insurance Plan (MIP) shall be applied at all duty stations except those listed below:

Bangkok a/

Beirut b/

Geneva

London

Mexico City c/

New York

Paris

Rome

Santiago

The Hague

Vienna

Washington, D.C.

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a/ For staff of the Economic and Social Commission for Asia and the Pacific (ESCAP) only.

b/ For staff of the United Nations Development Programme (UNDP) and the United Nations Children's Fund (UNICEF) only.

c/ For staff of the United Nations and UNICEF only.

Annex III

EXAMPLES ILLUSTRATING SPECIFIC MIP RULES

The examples contained within this annex are intended to clarify specific rules of the Medical Insurance Plan (MIP) and ARE FOR ILLUSTRATION ONLY.

Example No.

1. MIP rule 4.5, paragraphs 2 and 3 (optical lenses)

Mr. Uhuru, a staff member of the United Nations High Commissioner for Refugees (UNHCR), having been in MIP for more than one year, purchased eyeglasses in 1987. The glasses cost the equivalent of $US 80, broken down as follows: $20 for the frames and $30 for each of the two lenses. MIP reimbursed $24 for each lens (80 per cent x 30) for a total of $48. The frames are not a reimbursable expense. Mr. Uhuru would only be entitled to an additional reimbursement of $2 ($1 for each lens) for the remainder of 1987 and all of 1988 should he submit a claim for additional expenses.

2. MIP rule 4.6, paragraphs 1 and 2 (dental care)

In a certain duty station, G-7/step X is the highest step on the General Service scale and the corresponding annual net salary is 18,000 pesos. Thus the monthly net salary at the highest step is 1,500 pesos and the maximum benefit payable in a calendar year to any participant in the plan for dental services in respect of one insured person is 750 pesos.

3. MIP rule 4.9 (co-ordination of benefits)

Ms. Lee was treated by a doctor for a mild ulcer, which did not call for surgery. Her total bill came to 450 rupees, for which her national health scheme reimbursed her 150 rupees. The organization, under the terms of reference of MIP, considered the bill for 450 rupees to be reasonable and customary and would have ordinarily reimbursed Ms. Lee 360 rupees (80 per cent x 450). Since Ms. Lee had received reimbursement of 150 rupees from the national health plan, she then submitted a request for reimbursement under MIP for the balance of 300 rupees. Given that the balance of 300 rupees was within her maximum entitlement, she received that entire amount. As a result, her combined reimbursement amounted to 450 rupees, 100 per cent of her bill. Ms. Lee's total bill was therefore reimbursed at the 100 per cent rate since she claimed under the two medical insurance coverages available to her (the national health scheme and MIP).

Example
No.

4. MIP rule 5.5, paragraph 3 (reimbursement of claims)

Mr. Mbongo, while at a training course in New York, decided to have a crown made for his tooth by a dentist in the United States. The work cost $US 600, or the equivalent of 12,000 shillings in the currency of his duty station. When he returned and submitted his claim, the local office determined that the same work would have cost 3,000 shillings if done at the duty station. Mr. Mbongo was thus reimbursed 2,400 shillings (80 per cent x 3,000).

5. MIP rule 6.3 (contribution by the subscriber)

Mrs. Buendia retired from a United Nations information centre at age 60 in 1972 at the G-5/step IX level. At that time her annual net salary was 4,000 francs. She now participates with her husband in the after-service coverage of MIP. At the duty station, the current salary scale shows an annual net salary of 6,600 francs at the G-5/step IX level. Therefore, her current contribution to MIP would be determined by taking 50 per cent of the 6,600 francs salary, dividing by 12 to obtain a monthly basis for the contribution, and multiplying by 1.25 per cent.

$$\text{Therefore: } \frac{0.50 \times 6{,}600 \times 0.0125}{12} = 3.44 \text{ francs.}$$

Her monthly assessment would be 3.44 francs, payable every three months for a total quarterly contribution of 10.32 francs.

6. MIP rule 7.4, paragraph 2 (contributions)

Mr. Mohamed retired on 31 December 1985 at age 60, having completed 8 years and 3 months of participation in the Medical Expense Assistance Plan (MEAP) of the United Nations Children's Fund (UNICEF) and, prior to that, one year of participation in a qualifying medical scheme during service with the International Labour Organisation (ILO). He, therefore, had a total of 9 years and 3 months of qualifying participation, 9 months short of the 10-year participation required for a subsidy. He will have to pay the full premium for the first three quarters of his after-service coverage until he completes the 10 years of qualifying coverage. Thereafter, he will receive the applicable subsidy from UNICEF.

Example
No.

7. MIP rule 7.4, paragraph 5 (contributions)

Mrs. Peres retired from the United Nations Development Programme (UNDP) at age 55 with more than 10 years of MEAP participation. She joined the MIP after-service plan with her husband and son. At the time of her retirement she had been at the G-6/step X level, receiving a net monthly salary of 2,000 pesos. Therefore, her contribution was calculated as follows:

.50 x 2,000 x .0175 = 17.50, or 52.50 pesos per quarter.

Two years later, Mrs. Peres died. At the time of her death, she had been paying 17.50 pesos as her monthly contribution. Two months after the death of his wife, Mr. Peres visited the UNDP office to confirm his and his son's participation in MIP. The administrative officer informed Mr. Peres that one revision to the salary scale since his wife's death allowed for a 50 per cent increase in salary to 3,000 pesos; therefore, his monthly contribution would now be 9.38 pesos, that is 1.25 per cent times 25 per cent of 3,000. (The 1.25 per cent rate applies because there are now two insured persons instead of three, and, as indicated in MIP rule 7.4, paragraph 5, the contribution of the eligible surviving spouse and children will be one half that of the former staff member through whom they were insured. The contribution would be calculated as follows: .25 x 3,000 x .0125 = 9.38. Mr. Peres will now pay 28.14 pesos per quarter).

Annex IV

MIP ENROLMENT AND CLAIMS FORMS

The two forms that follow are the only forms with which the participant need be concerned: these are the MIP enrolment form (MIP.1) and the MIP claims envelope (MIP.2). Copies of these forms can be obtained from the participant's administering office.

UNITED NATIONS **NATIONS UNIES**

MIP Enrolment Form

ORGANIZATION: ☐ UN ☐ UNDP ☐ UNICEF ☐ UNHCR ☐ OTHER _____

DUTY STATION (COUNTRY/CITY): _____ DATE OF ENROLMENT: _____

SUBSCRIBER INFORMATION

1. ☐ Active staff member ☐ Pensioner (after service)
☐ Participating survivor (after service) ☐ Appendix D beneficiary (after service)

2. Number of persons covered (including subscriber) _____

3. Category of coverage requested:
☐ (a) Subscriber only
☐ (b) Subscriber and one family member
☐ (c) Subscriber and two, three or four family members
☐ (d) Subscriber and five or more family members

PERSONAL DATA

4. Name of subscriber (last name, first, middle)	Sex	Marital status	Date of birth (D/M/Y)
Payroll No. (if active) or pension No. (if retired)			
5. Name of spouse (last name, first, middle)	Sex	Date of marriage (D/M/Y)	Date of birth (D/M/Y)

6. Insurable children (list in descending order of age)*

	NAME	Sex		Date of birth			Is child married?		Is child employed on full-time basis?	
		F	M	D	M	Y	Y	N	Y	N
01		☐	☐				☐	☐	☐	☐
02		☐	☐				☐	☐	☐	☐
03		☐	☐				☐	☐	☐	☐
04		☐	☐				☐	☐	☐	☐
05		☐	☐				☐	☐	☐	☐
06		☐	☐				☐	☐	☐	☐
07		☐	☐				☐	☐	☐	☐
08		☐	☐				☐	☐	☐	☐
09		☐	☐				☐	☐	☐	☐

7. **AUTHORIZATION TO OBTAIN INFORMATION AND CERTIFICATIONS:** I certify that the facts presented above are correct and that I will notify the administering office immediately of any changes in respect of the above situation. I authorize the organization to verify any facts connected with my and my family's participation in MIP. Additionally, I authorize physicians, hospitals, clinics, dispensaries, sanitoriums, druggists and all other agencies (including other insurance companies) to permit the United Nations or its representative to obtain or view a copy of their records pertaining to the examination, treatment, history, prescription and medical expenses of the above-named subscriber and eligible family members. Such information may be used to the extent deemed necessary by the United Nations to determine the validity of amounts payable on accounts of claims.

Signature: Date:
Name:

8. Date verified	Name of administrative officer	Signature

* An eligible child is insurable until the end of the calendar year in which he or she attains the age of 25, provided that he or she is not married and not in full-time employment: disabled children may be eligible for continued coverage after age 25.

UNITED NATIONS NATIONS UNIES

MIP Claims Envelope CONFIDENTIAL

INSTRUCTIONS:

1. Separate claims envelopes must be submitted for each person receiving services.
2. If medical expenses have been incurred in more than one country, a separate claims envelope must be completed for treatment in each country.
3. In order for a claim to be processed, the claim must include original receipts/bills, stating the nature, dates and detailed costs of services rendered, as well as copies of prescriptions and original detailed receipts for drugs, medicines, optical lenses and hearing aids.
4. The enclosed documents should be numbered consecutively by the subscriber.
5. Reimbursement will be based upon the reasonable and customary charges prevailing at the duty station as determined by the organization (rule

TO BE FILLED IN BY SUBSCRIBER	CODE	FOR USE BY ADMINISTERING OFFICE
1. Name of subscriber: last name, first, middle		**Upon receipt of claim** **15.** Country code | **16.** Claim No. | **17.** Claim
2. Name of eligible patient: last, first, middle		
3. Duty station		**Upon payment of claim** **18.** Payment voucher | **19.** Payment date
4. Organization		
☐ UN	1	
☐ UNDP	2	**20.** Remarks (to be provided by persons screening claim):
☐ UNICEF	3	
☐ UNHCR	4	
☐ OTHER	5	
5. Status: ☐ Active staff member	6	
☐ After-service participant	7	
6. Were expenses incurred outside duty station (rule 5.5)?		
☐ Yes	8	
☐ No	9	
Country: Currency:		

EXPENSES SUBMITTED BY SUBSCRIBER	CODE	AMOUNTS TO BE REIMBURSED		
		Recognized Expenses	Reimbursed amount Local curr.	Reimbursed amount $US
7. Hospital services (rule 4.2) Bed, board, general nursing care: 100% unless private room provided. Check if stay was in private room ☐	10			-
8. Professional services/medication – 80%				
Professional services (rule 4.3)	11			-
Medication (rule 4.3)	12			-
Sub-total				-
9. Miscellaneous services				
Dental care (rule 4.6 – 80%)	13			-
Medical care (rule 4.4 – 50%)	14			-
Optical lenses (rule 4.5 – 80%)	15			-
Hearing aid (rule 4.5 – 80%)	16			-
10. Total amout				-

11. Is the illness or injury considered to be service incurred (rule 8.3)?
☐ Yes ☐ No

12. Have any of the services been or do you expect them to be reimbursed by any other insurance?
☐ Yes ☐ No
If yes, please enclose details.

13. Number of documents, receipts, etc., enclosed herein.

14. I certify that these bills are for services rendered to the above-mentioned person, and I hereby authorize the organization to investigate or seek further information regarding the claim in accordance with the authorization on the enrollment form.

Date _____ Signature of subscriber _____

21. The participant has reached the reimbursement limit in

	Please
(a) The annual reimbursement limit	☐
(b) Dental care	☐
(c) Mental care	☐
(d) Optical lenses	☐
(e) Hearing aids	☐

22. I certify that this claim has been screened in accordance with the rules of MIP:

Name & signature of certifying officer _____

Date _____

ATTENTION: TO ENSURE THAT LIMITS ARE NOT EXCEEDED, COMPLETE MIP 3 BEFORE PAYMENT OF CLAIM!