UNITED NATIONS **ST**

Secretariat

ST/IC/1996/78
23 December 1996

INFORMATION CIRCULAR

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

From: The Controller

Subject: VAN BREDA MEDICAL, HOSPITAL AND DENTAL INSURANCE*

I. RENEWAL PROVISIONS FOR 1997

1. The purpose of the present circular is to set out the provisions concerning renewal of the Van Breda medical, hospital and dental insurance plan for staff members at offices away from Headquarters, which will take effect on 1 January 1997. The key features of the renewal for 1997 are:

(a) An average premium increase of 9.92 per cent for 1997. This average reflects a premium increase of 41.56 per cent applicable to participants located in Chile and a 5.64 per cent increase applicable to all other participants;

(b) Limitation of the reimbursement for surgical or laser procedures to correct refraction in respect of myopia to the optical lens benefit as set out in paragraph 2 (j) (ii) of annex I to the present circular;

(c) With the exception of the above, the benefit structure of the plan will be the same as in 1996.

2. The Van Breda plan is a global scheme covering staff members who reside in all parts of the world, except the United States of America. The annual cost of the plan reflects claims incurred for hospitalization and medical treatment in all parts of the world and reflects widely varying price levels. If levels of plan utilization and the charges levied by hospitals and other medical providers were comparable throughout the world, then loss ratios, i.e., the ratio of claim reimbursement to premium paid, would be more or less equal among all locations

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* Personnel Manual index No. 6190.

at which there were significant numbers of participants. This, however, is not the case, notably so in respect of loss ratios generated in Chile.

3. While the plan as a whole performed better in 1996 than in the prior year, so that the overall premium increase required for 1997 is lower than that implemented in 1996, the continuing high cost of medical services in Chile resulted in an aggregate loss ratio for Chile-based subscribers which substantially exceeded the loss ratio for the plan as a whole. As a first step in addressing this imbalance, a premium differential of approximately 15 per cent was implemented in respect of Chile-based participants in the 1996 policy period. This adjustment, however, inadequately reflected the actual experience incurred in Chile in 1996. As a result, it has been decided that a further substantial premium adjustment is warranted in respect of the 1997 policy period in order to produce a more equitable alignment between medical cost levels and the related premium structure pertaining to Chile. Thus, the average 9.92 per cent premium increase required to meet projected plan costs in the renewal period will be met by implementing a 41.56 per cent premium increase for participants in Chile, and a 5.64 per cent increase for participants at other locations worldwide. Specific premium surcharges are also applicable in respect of small groups of participants located in Bonn and Vienna.

4. In line with the methodology used in the calculation of staff contributions towards premiums for other United Nations insurance schemes, the premium contributions of participants in the Van Breda scheme are determined as a percentage of their respective medical net salaries by application of the rates set out in paragraph 5 below. The percentage contribution rates have been computed to take account of the requirement for an overall 50:50 cost-sharing relationship between the Organization and participants in the plan. Medical net salary consists of gross salary, less staff assessment, plus language allowance, non-resident's allowance and post adjustment, as applicable. In no case will staff contributions be greater than 85 per cent of the premiums shown below.

5. The schedule of premiums which will become effective on 1 January 1997, as well as the related staff contribution rates, are set out in the tables below:

Type of coverage	Monthly premiums (United States dollars) 1996	Monthly premiums (United States dollars) Effective 1 January 1997	Percentages of medical net salary 1996	Percentages of medical net salary Effective 1 January 1997
A. All duty stations (other than Chile)				
Staff member only	97.00	102.00	1.36	1.44
Staff member and one family member	204.00	216.00	2.20	2.26
Staff member and two or more eligible family members	337.00	356.00	3.49	3.60
B. Chile				
Staff member only	110.00	156.00	1.55	2.19
Staff member and one family member	233.00	330.00	2.52	3.57
Staff member and two or more eligible family members	385.00	545.00	4.00	5.66

Hospital room rate maxima

6. The daily room rate maxima for hospital accommodation reimbursable under the plan and introduced on 1 January 1996 will continue, as follows:

(a) Europe and North America. The maximum reimbursement per day for hospital accommodation (room and board) in Europe and North America is $600. Details concerning the application of the $600 per day limit for hospitalization in the United States are set out in annex II to the present circular. Semi-private room accommodation is the normal standard in Europe and North America. Only under the following conditions, subject to the provision of documentation satisfactory to the insurer, will private-room care be reimbursed in full, up to the $600 daily limit:

(i) When the nature and gravity of the illness requires private room care and the need for such care is substantiated by the attending physician;

(ii) When the patient is admitted on an emergency basis to a hospital that has semi-private accommodation but none is available at the time;

(iii) When the patient is admitted to a hospital that does not have any semi-private accommodation, i.e., it has no standard of accommodation other than private rooms and general wards;

(b) Israel. The daily room rate cap applicable in Israel is $700. This reimbursement ceiling conforms to the nationally uniform semi-private hospital accommodation rate in that country;

(c) Rest of the world. A $330 per day reimbursement ceiling is applicable to all locations other than Europe, North America and Israel.

Out-patient mental health treatment

7. Commencing in 1996, the out-patient mental health benefit provided for 50 per cent reimbursement of the reasonable and customary fee of psychiatrists, licensed psychoanalysts, licensed psychologists and licensed psychiatric social workers up to a maximum of $1,000 per year. This benefit will continue during the 1997 renewal period.

II. ELIGIBILITY CRITERIA AND ENROLMENT RULES

Eligibility for enrolment in the Van Breda plan

8. Except for staff members whose duty station is New York, Geneva or Vienna and locally recruited staff members at duty stations where the Medical Insurance Plan (MIP) is established, all staff members holding appointments of three months or longer under the 100 series of the Staff Rules or one month or longer under the 200 series of the Staff Rules may enrol themselves and eligible family members in the United Nations Van Breda plan. Staff members holding appointments of limited duration under the 300 series of the Staff Rules, except those who receive a fixed monthly cash amount towards the cost of health insurance, are also eligible to enrol in the Van Breda plan in line with the relevant provisions of administrative instruction ST/AI/395, dated 2 June 1994.

9. Staff members are ineligible for coverage under the Van Breda plan if they reside in the United States or if their covered dependants reside in the United States. In addition, the coverage of staff members under the Van Breda plan while on assignment from Headquarters with field offices or missions will be terminated upon the staff member's return to Headquarters. In such cases, if the staff member had been enrolled in a Headquarters plan prior to assignment on mission, insurance coverage will revert to the insurance plan to which the staff member subscribed prior to the mission assignment, at least until the next annual enrolment campaign. Staff members who, prior to assignment on mission, were not enrolled in any Headquarters insurance plan but who were covered under the Van Breda plan while on mission assignment must enrol in a Headquarters plan within 31 days of return to duty from mission assignment in order to ensure continuity of health insurance coverage. Coverage in a Headquarters health insurance plan following return from mission assignment will become effective from the first day of the month after return to duty at Headquarters.

10. Enrolment in the Van Breda plan at the time of initial appointment must be accomplished within 31 days of the date of entry on duty. For enrolment purposes, applicants will be required to present proof of eligibility from their respective personnel or administrative officers attesting to their current contractual status. The enrolment of eligible family members requires the provision of evidence of the status of such family members. In most instances, the necessary proof of eligibility will be contained in the personnel action form.

Eligible family members for insurance purposes

11. "Eligible family members" refers to a spouse and one or more eligible children. A spouse is always eligible. A child is eligible to be covered under this scheme until the end of the calendar year in which he or she attains the age of 25, provided that he or she is not married and not in full-time employment; disabled children may be eligible for continued coverage after age 25. Complete information regarding these provisions can be found in information circular ST/IC/86/72, entitled "Age limitation on the participation of dependent children in United Nations health insurance schemes".

Enrolment at times other than upon entry on duty

12. Staff members appointed under the 100 series of the Staff Rules who have not enrolled themselves and eligible family members within 31 days of the date of their entry on duty have an opportunity one time each year to do so. The annual enrolment period generally is set for the first week of June, the specific dates being announced each year sufficiently in advance of the occasion. The effective date of insurance coverage which is applied for during the annual enrolment week is the first day of the following month.

13. Staff members appointed under the 200 series of the Staff Rules (project personnel) are, under staff rule 206.4 (a), required to participate in a medical insurance scheme provided by the United Nations unless exemption from such participation is expressly stated in the letter of appointment. Staff rule 206.4 (b) provides that such personnel, if appointed for a period of one month or more and participating in a medical insurance scheme provided by the United Nations, may enrol their spouses and dependent children in the scheme. Project personnel who have not enrolled their spouses and eligible dependent children in the Van Breda plan at the time of initial appointment have an annual opportunity to do so. In the case of project personnel, the annual enrolment opportunity occurs on the anniversary of their entry on duty and insurance coverage for added dependants will be effective as of that date.

14. Eligible staff members holding appointments of limited duration under the 300 series of the Staff Rules who have not enrolled themselves in the Van Breda plan at the time of initial appointment because they maintain their own coverage have an annual opportunity to do so. The annual enrolment opportunity occurs on the anniversary of their entry on duty.

15. At times other than the annual enrolment periods referred to in paragraphs 8 to 10 above, staff members (100 and 200 series) and their eligible family members may be enrolled in the Van Breda plan ONLY if at least one of the following events occurs and application for enrolment is made within 31 days thereafter:

(a) Upon transfer from one duty station to another;

(b) Upon return from special leave without pay (see para. 19 below);

(c) Upon assignment to a mission under certain conditions (see para. 20 below);

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

16. Staff members who can demonstrate that they were on mission or annual or sick leave during the annual enrolment opportunity period may enrol within 31 days of their return to their duty station.

17. Applications between enrolment opportunity periods based on circumstances other than those listed in paragraph 15 above or not received within 31 days of the event giving rise to eligibility will not be receivable. In this regard, it should be noted that termination of health insurance coverage under a scheme not offered by the United Nations or another organization within the common system will in no case give rise to any right on the part of a staff member or family member to immediate enrolment in a United Nations plan. If such termination occurs between annual enrolment opportunity periods, the staff member must wait until the next annual enrolment opportunity to enrol in a United Nations plan. Staff members who for any reason may be uncertain about the continuity of their outside coverage are urged to consider enroling in the United Nations scheme during the established annual enrolment period.

Staff transferred to another duty station

18. Staff members who transfer to another duty station but who did not have medical insurance prior to the transfer may enrol themselves and eligible family members in the United Nations health insurance plan upon transfer. The enrolment application must be submitted within 31 days of the date of transfer, and the effective date of coverage will be the transfer date at the new duty station. This provision applies also in the case of transfer to Headquarters, in which case the new enrolment will be in one of the health insurance plans offered at Headquarters. Staff members are reminded that if they transfer from one duty station to another and in the process are transferred from one payroll system to another, they should, upon arrival at the new duty station, ensure that their insurance coverage is recorded in the new payroll system so that the deduction of monthly premium contributions may be continued without a break.

Staff on special leave without pay

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

(a) Insurance coverage maintained during special leave without pay. If the staff member decides to retain coverage during the period of special leave without pay, the Insurance, Claims and Compensation Section (if payrolled at Headquarters) or the relevant administrative office (if payrolled elsewhere) MUST be informed directly in writing by the staff member of his or her intention at least one month in advance of the commencement of the special leave. At that time, the administrative office concerned will require evidence of the approval of the special leave, together with payment covering the full amount of the cost of the coverage retained (both the staff member's contribution as well as the Organization's share, since no subsidy is payable during such leave);

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

(c) Re-enrolment upon return to duty following special leave without pay. Regardless of whether a staff member has decided to retain or drop insurance coverage during a period of special leave without pay, it is essential that he or she re-enrol in the plan within 31 days of return to duty. Failure to do so will mean that the staff member will be unable to resume participation in the insurance plan until the following annual enrolment opportunity period.

Staff members assigned on mission

20. With regard to staff members going on mission assignment, it has been decided to continue to extend a special health insurance enrolment opportunity to such staff members. The provisions in this respect, which will apply to all staff members going on mission for six months or more, are as follows:

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

(b) Staff members who elect to enrol in the Van Breda plan in the circumstances set out in subparagraph (a) above forgo the right to make any further change during the annual enrolment period taking place in the same calendar year as the commencement of the mission assignment. The next opportunity for these staff members to make any change in their insurance coverage will be at the time of the annual enrolment period of the following year;

(c) Staff members going on mission assignment who wish to enrol in the Van Breda plan or change their present coverage, as provided above, must present evidence to the Insurance, Claims and Compensation Section or to their administrative office, as the case may be, of the mission assignment and its duration.

Staff member married to another staff member

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

Staff members with dependants residing in the United States

22. Staff members are reminded that the Van Breda plan is designed to provide medical, hospital and dental coverage for participants stationed outside the United States. Therefore, staff members stationed outside the United States but with covered eligible dependants residing in the United States should enrol instead in a Headquarters health insurance plan. It should be noted that, at Headquarters, dental coverage is a separate plan component for which specific application must be made.

Cessation of coverage of family members

23. The Insurance, Claims and Compensation Section at Headquarters or the relevant administrative office should be notified immediately in writing of changes in the staff member's family that result in a family member ceasing to be eligible, e.g., a spouse upon divorce or a child reaching the age of 25 years, marrying or taking up full-time employment. Staff members who wish to discontinue coverage of a family member under a United Nations plan for any other reason may do so at any time, although this is strongly discouraged. The responsibility for initiating the resulting change in coverage (e.g. from "staff member and spouse" to "staff member only" or from "family" to "staff member and spouse") rests with the staff member. It is in the interest of staff members to provide this notification promptly whenever changes in coverage occur in order to benefit from any reduction in premium contribution which may result. Any such change will be implemented on the first of the month following receipt of notification. No retroactive adjustments can be made as a result of failure to provide timely notification of any change to the Insurance, Claims and Compensation Section or administrative office.

After-service health insurance

24. Established policy in regard to eligibility to participate in the United Nations after-service health insurance programme, as well as the related administrative procedures, is set out in administrative instruction ST/AI/394, dated 19 May 1994. Staff members are reminded that, among the eligibility requirements for after-service health insurance coverage, they must be enrolled in a United Nations scheme at the time of separation from service. A minimum of 5 years of prior coverage in a United Nations or specialized agency health insurance scheme is necessary to qualify for unsubsidized after-service health insurance participation and 10 years of prior coverage for subsidized participation. In both cases, the staff member must be 55 years of age or over as of the date of separation. It should also be noted that only family members enrolled with the staff member at the time of separation are eligible for continued coverage under the after-service health insurance programme. Former staff members who reside in the United States are reminded that they are ineligible for participation in the Van Breda plan and that they must switch to a Headquarters plan within 31 days of taking up residence in the United States.

Conversion privilege

25. Participants who cease employment with the United Nations and who do not qualify for after-service health insurance benefits may arrange for medical coverage with Van Breda under an INDIVIDUAL CONTRACT, provided that application is made within 31 days of termination of coverage under the United Nations group policy. The conversion privilege, which is part of the United Nations group contract with Van Breda, means that the insurer cannot refuse to insure an applicant and that no certification of medical eligibility is required. The conversion privilege, however, does not mean that the same insurance premium rates or schedule of benefits in effect for the United Nations group policy will be offered in respect of individual insurance contracts. Participants should bear in mind, however, that under the conversion privilege, dependants may only apply for individual coverage at the same time as the staff member, upon cessation of employment with the United Nations. The spouse of a staff member whose eligibility for coverage under the United Nations group plan ceases as a result of divorce is eligible to apply for medical coverage with Van Breda under the above arrangements, so long as application is made within 31 days of termination of coverage under the United Nations group policy. Details concerning conversion to an individual insurance policy may be obtained by communicating directly with Van Breda at the following address:

J. Van Breda and Co. International
Plantin en Moretuslei 295
B-2140 Borgerhout
Antwerp, Belgium

Telex No.: BREDCO B 31788
Fax No.: 00 323 271 02 47 (facsimile transmission)
Telephone No.: 00 323 217 5111

III. CLAIMS AND INQUIRIES

Basis for claim reimbursement in United States dollars

26. Claim reimbursement is made in United States dollars, converted from the currency in which the hospital, medical or dental expenses have been incurred. Reimbursement in United States dollars is based on the United Nations operational rate of exchange in effect on the date the medical and dental expenses are incurred and, in the case of hospital expenses, on the date the hospital bill is rendered.

Where to address claims and benefit inquiries

27. Although the staff of the Insurance, Claims and Compensation Section is available to assist staff members in administrative matters concerning participation in the Van Breda plan, claims questions should always be taken up on the first instance directly with the insurance company concerned. The address and telephone, telex and fax numbers of Van Breda are provided in paragraph 25 above.

28. Annex I to the present circular contains a summary of the benefits payable under the Van Breda plan.

29. Annex II contains a recapitulation of the provisions pertaining to hospitalization in the United States.

30. Annex III sets out relevant details concerning 16 surgical procedures for which a second opinion will be reimbursed in full.

ANNEX I

Van Breda insurance scheme

1. The Van Breda insurance scheme provides for reimbursement of medical, hospital and dental treatment costs up to a maximum of $250,000 per insured participant per calendar year. In addition to the maximum reimbursement per calendar year, certain maxima per treatment, procedure or service may also be applied on the basis of a determination of "reasonable and customary" charges for the benefit at the place of treatment. Fees for treatments, procedures or services which may be considered by Van Breda 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.

2. The scheme is subject to the following reimbursement provisions and limitations:

(a) Under the basic coverage component, reimbursement in respect of medical treatment prescribed by qualified doctors is limited to 80 per cent of the costs incurred, including doctors' fees;

(b) Under the major medical coverage component, 80 per cent of the remaining unpaid costs is paid, subject to an annual deductible (co-payment) of $200 per participant and $600 per family;

(c) The following example illustrates how reimbursement in respect of basic coverage and major medical coverage operates:

	United States dollars
(i) Basic coverage	
Cost of medical treatment (if reasonable and customary)	3 200
Reimbursement under basic coverage (80 per cent)	- 2 560
Residual (20 per cent)	640
(ii) Major Medical coverage	
Basis for Major Medical coverage (20 per cent residual remaining under basic coverage)	640
Annual (calendar year) deductible	- 200
Basis for Major Medical coverage after application of deductible	440
Reimbursement under Major Medical coverage: 80 per cent of expenses in excess of deductible ($440 x 80 per cent)	352

	United States dollars
(iii) Total reimbursement (recapitulation of (i) and (ii))	
Basic coverage	2 560
Major Medical coverage	+ 352
Total reimbursement	2 912
Participant's total out-of-pocket expense	288

(d) The cost of hospital services (excluding doctors' fees) is reimbursed at the rate of 100 per cent of the costs involved, including such items as bed and board, general nursing service, use of the operating room and equipment, use of the recovery room and equipment, laboratory examinations, X-ray examinations and drugs and medicines for use in the hospital. For hospitalization in Europe and in North America, the standard of accommodation is limited to semi-private room care, i.e., two or more patients in the same room, except that, under the following circumstances, subject to the provision of documentation satisfactory to the insurer, private-room care will be reimbursed in full up to the daily limit specified in paragraph 2 (e) (i) below:

(i) When the nature and gravity of the illness requires private-room care and the need for such care is substantiated by the attending physician;

(ii) When the patient is admitted on an emergency basis to a hospital that has semi-private accommodation but none is available at the time;

(iii) When the patient is admitted to a hospital that does not have any semi-private accommodation, i.e., it has no standard of accommodation other than private rooms and general wards.

Europe and North America are defined for this purpose as Europe, including Malta, Cyprus and Turkey (European portion), and Canada and the United States of America;

(e) With effect from 1 January 1996, reimbursement for hospital accommodation expenses has been subject to daily room rate caps, as follows:

(i) Europe and North America. The maximum reimbursement per day for hospital accommodation (room and board) in Europe and North America is $600;

(ii) Israel. The daily room rate cap applicable in Israel is $700;

(iii) Rest of the world. A $330 per day reimbursement ceiling is applicable to all locations other than Europe, North America and Israel;

(f) The cost of dental treatment is reimbursable at the rate of 80 per cent up to a maximum sum of $750 per insured participant per calendar

year. The cost of dento-facial orthopaedics is covered only if the treatment is started before the patient has reached his or her fifteenth birthday, and reimbursement is provided only during a treatment period of four years;

(g) The cost of out-patient mental health treatment by a psychiatrist is covered, as well as the services of a licensed psychoanalyst, a licensed psychologist or a licensed psychiatric social worker. The cost in respect of insured participants is reimbursable at the rate of 50 per cent and to a maximum reimbursement of $1,000 per insured person in any 12-month period;

(h) The cost of treatment for substance (alcohol and/or drug) abuse is covered, under certain conditions. The coverage includes in-patient treatment for detoxification and rehabilitation at a facility certified for such treatment, subject to the prior approval of Van Breda. Such treatment will normally be limited to 30 days in a calendar year. In addition, the plan covers out-patient counselling for the purpose of diagnosis and treatment. The costs of out-patient counselling are reimbursable at the rate of 50 per cent and to a maximum reimbursement of $1,000 for not more than 50 visits per insured person in any consecutive 12-month period. Of these 50 visits, up to 20 may be allocated to counsel covered family members of the participant undergoing treatment for the substance abuse problem;

(i) The cost of radiological treatment is reimbursable at the rate of 80 per cent only if the patient has been referred to the specialist by the doctor in attendance;

(j) The cost of hearing aids and optical lenses is covered, with the following limitations:

(i) Hearing aids. Reimbursement at 80 per cent (only basic coverage, no major medical coverage), with a maximum of $300 per apparatus, including the related examination, and a maximum of one apparatus per ear in any period of three years;

(ii) Optical lenses. Reimbursement at 80 per cent (only basic coverage, no major medical coverage), with a maximum of $30 per lens and a maximum of two lenses in any period of two years. These maxima will also apply to surgical or laser treatment for the correction of refraction in respect of myopia.

In order to be entitled to these benefits, a staff member or the participating family member will have to have been a participant in the Van Breda scheme for one year or more;

(k) The cost of two blood tests per year for the human immunodeficiency virus (HIV).

3. The insurance scheme does not cover:

(a) Periodic preventive health examinations;

(b) Examination of the eyes for optical lenses (eyeglasses or contact lenses);

(c) Injuries as a consequence of voluntary or intentional action on the part of the insured participant;

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

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

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

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

(h) 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;

(i) 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;

(j) In-vitro fertilization.

4. In respect of 16 surgical procedures listed in annex III to the present circular, the cost of a second opinion will be reimbursed at 100 per cent and, should a participant desire a third opinion, the cost of that opinion will also be reimbursed at the rate of 100 per cent. No penalty will be assessed in cases in which surgery is performed without the benefit of a second opinion.

5. Subscribers should note that claims for reimbursement must be submitted to Van Breda no later than two years from the date on which the medical expenses were incurred. CLAIMS RECEIVED BY VAN BREDA LATER THAN TWO YEARS AFTER THE DATE ON WHICH THE EXPENSE WAS INCURRED WILL NOT BE ELIGIBLE FOR REIMBURSEMENT.

ANNEX II

Provisions pertaining to hospitalization in the United States

1. While a participant is free to seek admission to a United States hospital without providing any notification to Van Breda, reimbursement for such hospitalization will be subject to a limit of $600 in respect of the daily semi-private room rate. Thus, if a participant chooses a hospital at which the daily semi-private room rate exceeds $600, the cost of the daily room rate above $600 will be borne entirely by the participant. There will be no change in the reimbursement for other services. In this connection, it should be noted that hospital costs vary considerably throughout the United States, and costs may exceed the $600 reimbursement ceiling, particularly in parts of California, Florida, Massachusetts, New York, Texas and Washington, D.C., where the costs may be much higher in certain hospitals.

2. The $600 LIMIT WILL NOT APPLY to semi-private hospital accommodation in three specific circumstances:

(a) In connection with medical evacuation to any hospital in the United States authorized by the United Nations Medical Director;

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

(c) In situations where the necessary medical treatment can only be provided at a hospital where the daily semi-private room rate exceeds $600. To avoid the obligation to meet daily room-rate expenses in excess of $600 in such cases, confirmation must be obtained from Van Breda prior to the hospital admission.

ANNEX III

Second surgical opinion requirement

1. With effect from 1 January 1992, participants were no longer required to obtain a second opinion prior to undergoing surgery. As of that date, no reimbursement penalty has been assessed by Van Breda for failure to provide evidence of a second opinion in connection with any surgery. However, whenever feasible, participants are encouraged to seek a second surgical opinion, particularly for the 16 surgical procedures listed below. For this reason, Van Breda will continue to reimburse at 100 per cent the cost of a second opinion rendered by a qualified physician in connection with these 16 surgical procedures. If the second opinion does not agree with the first, a third opinion may be sought, and will also be fully reimbursed. Please note that the second opinion must be provided by a physician not associated or in practice with the physician who originally recommended or proposed to perform the surgery.

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

	Procedure	Explanation
1.	Bunionectomy	Removal of bunions
2.	Cholecystectomy	Removal of gall bladder
3.	Dilation and curettage	Dilation of cervix and scraping of uterus
4.	Excision of cataracts	Removal of cataracts
5.	Haemorrhoidectomy	Removal of haemorrhoids
6.	Hernia (inguinal) repair	Repair of hernia in the groin
7.	Hysterectomy	Removal of uterus
8.	Knee surgery	Knee operation
9.	Laminectomy	Removal of part of spine
10.	Mastectomy: partial or complete	Partial or complete removal of breast tissue
11.	Prostatectomy	Removal of prostate
12.	Septo-rhinoplasty	Nose surgery for functional improvement

	Procedure	Explanation
13.	Spinal fusion	Surgical welding of spine segments
14.	Tonsillectomy and/or adenoidectomy	Removal of tonsils and/or adenoids
15.	Varicose veins	Removal and tying of varicose veins
16.	Coronary artery bypass	Heart surgery to bypass one or more blocked arteries feeding the heart

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