UNITED NATIONS **ST**

Secretariat

ST/IC/1997/91
31 December 1997

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 1998

1. The purpose of the present information 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 1998.

2. Heretofore, the annual information circular setting out the premium levels, contribution rates and description of benefits pertaining to the Van Breda plan also included a section dealing with eligibility criteria and enrolment rules. By Secretary-General's bulletins ST/SGB/1997/1 and ST/SGB/1997/2 dated 28 May 1997, the Secretary-General introduced a new system for the promulgation of administrative issuances and information circulars. Therefore, in line with the new system, the present circular is confined to the announcement of premium, contribution and benefit information relating to the Van Breda plan. A separate administrative instruction will be issued in due course which will set out eligibility criteria and enrolment rules and procedures governing all United Nations contributory health insurance plans. Until the new administrative instruction is issued, the eligibility criteria and enrolment rules pertaining to the Van Breda plan as set out in information circular ST/IC/1996/78 dated 23 December 1996 (paras. 8-24) will remain in effect.

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* Expiration date of the present information circular: 31 December 1998.

** Personnel Manual index No. 6191.

3. The key features of the renewal for 1998 are as follows:

(a) Premium levels

Owing to the favourable financial experience of the plan in 1997, premium levels for 1998 are reduced by 15 per cent for the 12-month policy period commencing on 1 January 1998;

(b) Benefits

(i) With effect from 1 January 1998, reimbursement rates for radiological treatment will be improved to include major medical coverage, not just basic (80 per cent) coverage as heretofore;

(ii) The rate of reimbursement of out-patient mental health expenses is raised from 50 per cent to 80 per cent of the reasonable and customary fee level. The annual maximum reimbursement of US$ 1,000 per insured person in any 12-month period remains unchanged;

(iii) With the exception of the above, the benefit structure of the Van Breda plan will be the same as in 1997.

4. 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, that is, the ratio of claim reimbursement to premium paid, would be more or less equal among all locations at which there were significant numbers of participants.

5. In information circular ST/IC/1996/78 relating to the renewal of the Van Breda plan for 1997, it was announced that premium rates for subscribers based in Chile had to be raised further over the 1996 premium rates applicable to that country owing to the continued high loss ratio that had been incurred. The special measures adopted in 1996 and 1997 combined with cost containment initiatives adopted with respect to medical costs in Chile have led to an amelioration of the loss ratio position. In consequence, the premium reduction of 15 per cent achieved for the Van Breda plan as a whole in 1998 is also applicable to the premium structure for Chile.

6. 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 7 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.

7. The schedule of premiums that will become effective on 1 January 1998, as well as the related staff contribution rates, are set out in the table below:

	Monthly premiums (United States dollars)		Percentages of medical net salary	
Type of coverage	1997	Effective 1 January 1998	1997	Effective 1 January 1998
A. All duty stations (other than Chile)				
Staff member only	102.00	87.00	1.44	1.30
Staff member and one family member	216.00	184.00	2.26	2.03
Staff member and two or more eligible family members	356.00	303.00	3.60	3.24
B. Chile				
Staff member only	156.00	133.00	2.19	1.97
Staff member and one family member	330.00	281.00	3.57	3.21
Staff member and two or more eligible family members	545.00	463.00	5.66	5.09

Hospital room rate maxima

8. 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, that is, 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.

II. CONVERSION PRIVILEGES

9. 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

10. 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

11. Although the staff of the Insurance 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 9 above.

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

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

14. 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 that 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
(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

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(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, that is, 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, that is, 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. These caps will be maintained in 1998, 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. With effect from 1 January 1998, the cost in respect of insured participants is reimbursable at the rate of 80 per cent of the reasonable and customary fee level and to a maximum reimbursement of $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) With effect from 1 January 1998, the cost of radiological treatment is reimbursable at the rate of 80 per cent of the reasonable and customary fee level under the basic component and a further 80 per cent under the major medical component, provided that 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
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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