United Nations ST/IC/2000/38

Secretariat

29 May 2000

Information circular*

To: Members of the staff at Headquarters

From: The Controller

Subject: **Renewal of the Headquarters medical and dental insurance plans effective 1 July 2000, and annual enrolment campaign, 5-9 June 2000****

General

1. The purpose of the present circular is to announce:

(a) Changes in the premium and contribution rates for the medical and dental plans offered at Headquarters (Aetna preferred provider organization (PPO), Blue Cross preferred provider organization (PPO), Health Insurance Plan of Greater New York/Health Maintenance Organization (HIP/HMO) and CIGNA dental preferred provider organization (PPO)), which will come into effect on 1 July 2000 (see chart on p. 2);

(b) Significant changes in the benefits under the Blue Cross PPO plan. Empire Blue Cross/Blue Shield has taken a corporate decision to cease offering the BlueChoice PPO plan effective 1 July 2000 and to offer instead a plan called Empire Deluxe PPO. While in many respects the new Blue Cross plan is identical to the expiring BlueChoice plan, in several key areas the new plan will be more restrictive than the outgoing plan and will limit provider options available to subscribers. Principally, the new plan will include inflexible pre-certification requirements (including an up to $2,500 penalty for failure to pre-certify hospitalizations), deductibles and co-insurance for a range of in-hospital benefits where previously no deductible or co-insurance applied, and in-network coverage only for certain other benefits where formerly coverage existed whether the services were provided in-network or out-of-network. The annual out-of-pocket limit (after deductible) remains at $1,000 per individual, but will drop from $3,000 to $2,500 per family. However, deductibles are increased from $125 per individual to $200 and from $375 per family to $500. In addition, a few benefits, such as hearing aids, available under the BlueChoice plan will not be available under the new Empire Deluxe plan. Staff

* Expiration date of the present information circular: 30 June 2001.

** *Personnel Manual* index No. 6170.

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Headquarters medical and dental insurance schedule of monthly premiums[a] and contribution rates[b] (Effective 1 July 2000)

	Aetna Open Choice		*Blue Cross Empire Deluxe PPO*		*HIP/HMO*		*CIGNA Dental with Medical Plan*		*CIGNA Dental alone*
Type of coverage	*1999 rates*	*2000 rates*	*1999 rates*	*2000 rates*	*1999 rates*	*2000 rates*	*1999 rates*	*2000 rates*	*2000 rates*
Staff member only									
Premium rate ($)	336.25	369.85	229.84	229.84	197.88	234.08	33.00	44.83	44.83
Contribution rate (per cent)	2.82	2.95	1.94	1.84	1.68	1.88	0.26	0.33	0.44
Staff member and one child									
Premium rate ($)	670.90	737.97	458.60	458.60	391.74	440.08	66.00	89.66	89.66
Contribution rate (per cent)	4.94	5.16	3.42	3.25	2.78	2.95	0.46	0.59	0.78
Staff member and spouse									
Premium rate ($)	670.90	737.97	458.60	458.60	391.74	440.08	66.00	89.66	89.66
Contribution rate (per cent)	4.94	5.16	3.42	3.25	2.78	2.95	0.46	0.59	0.78
Staff member and two or more eligible family members									
Premium rate ($)	839.50	923.43	665.84	665.84	577.82	649.12	122.00	144.77	144.77
Contribution rate (per cent)	5.51	5.76	4.39	4.17	3.72	3.95	0.79	0.89	1.34

[a] The cost of the medical/dental insurance plans at Headquarters is shared between the participants and the Organization. Staff members may determine their exact contribution by multiplying their "medical net" salary (see below) by the related percentage of salary.

[b] "Medical net" salary for insurance contribution purposes is calculated as gross salary, less staff assessment, plus language allowance, non-resident's allowance, post adjustment or the variable element of monthly subsistence allowance, as applicable. Actual contributions are capped at 85 per cent of the corresponding premium.

members, whether currently enrolled in BlueChoice PPO or who are considering switching to the Blue Cross PPO during the enrolment campaign, are strongly urged to study the benefit design of the new plan, details of which are set out in annex I to this circular;

(c) A two-month premium rebate for participants in both the Aetna and Blue Cross plans (for details regarding administration of the rebate, see paras. 7-8);

(d) All staff members who are currently enrolled in BlueChoice PPO and who elect to maintain Blue Cross coverage will automatically be enrolled in the Empire Deluxe PPO plan effective 1 July. As may be seen from the chart on page 2, the premium scale for the new Blue Cross plan is unchanged from the current BlueChoice premium scale. New Empire Deluxe ID cards (which will also serve as ID cards for the discount pharmacy programme) will be distributed to all subscribers in time for the 1 July 2000 commencement date;

(e) For subscribers to the CIGNA "Option B" plan, the annual deductible is increased from $25 per individual to $50 and from $75 per family to $150. No deductible applies to CIGNA "Option A".

2. Annexes I to VIII to the present circular set out plan outlines and benefit summaries. They are listed in paragraph 16.

Annual enrolment campaign

3. The annual enrolment campaign at Headquarters will be held from 5 to 9 June 2000 in the Insurance, Claims and Compensation Section of the Office of Programme Planning, Budget and Accounts, room S-2765, between the hours of 10 a.m. and 5 p.m. **Staff members at Headquarters must come in person to the Insurance, Claims and Compensation Section to complete the application form and other forms as necessary.** The staff of the Insurance, Claims and Compensation Section will be available during the designated dates and hours to provide information and answer specific questions regarding the health plans being offered to staff. In addition, representatives of the insurance companies will be on hand on 5 and 6 June to provide information about the various insurance plans offered. The insurance company desks will be located in the staff activities area near the Secretariat cafeteria entrance.

4. Staff members are reminded that this will be the **only** opportunity until the month of June 2001 to enrol in the United Nations medical and dental insurance plans. This is also an opportunity to review current health insurance coverages within or outside the Organization and either enrol in one of the United Nations plans or apply for changes within these plans. Staff members who are satisfied with their coverage do not need to take any action at this time.

5. The medical and dental plans being offered during the June campaign and the pages on which plan outlines may be found are as follows:

(a) Blue Cross Empire Deluxe PPO (p. 9);

(b) Aetna "Open Choice" Plan (p. 24);

(c) Health Insurance Plan of Greater New York/Health Maintenance Organization (HIP/HMO) (p. 38);

(d) CIGNA Dental PPO Plan (CIGNA) (p. 41).

6. The effective date of insurance coverage for all campaign applications, whether for enrolment, change of plan or change of family coverage, will be 1 July 2000. A change in enrolment between the Aetna and Blue Cross plans will oblige the participant to meet the annual out-of-network deductible in the new plan.

Premium rebate for Aetna and Blue Cross subscribers

7. Owing to the favourable claims experience of the Aetna and Blue Cross plans in recent years, which has resulted in the accumulation of surplus funds, it has been decided to effect a two-month premium rebate to participants. The rebate will be implemented in two instalments, in July and August 2000. The amount of the rebate for each participant will equal the premium contributions which normally would be due for July and August, and will be reflected in the end-of-month payroll statements.

8. The criterion for eligibility to receive a premium rebate is that the participant must be enrolled in the health insurance plan concerned in the month in which the rebate is given and must also have been in the plan one year previously. In view of the fact that the rebate covers both Aetna and Blue Cross participants, the distribution criterion will take account of those staff members who switch from Aetna to Blue Cross, or vice versa, during the 2000 enrolment campaign. Accordingly, staff members who were enrolled in Aetna or Blue Cross in July 1999, and who continue to be in either plan in July 2000, will receive a rebate. Similarly, staff members enrolled in either plan in August 1999 and who are in one of the two plans in August 2000 will receive a rebate.

Eligibility and enrolment rules and procedures

9. 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. A separate administrative instruction will be issued in due course which will set out the eligibility criteria and enrolment rules and procedures governing all United Nations contributory health insurance plans. However, until the new administrative instruction is issued, the eligibility criteria and enrolment rules pertaining to the Headquarters medical and dental health insurance plans as set out in information circular ST/IC/1997/32 dated 28 May 1997 (paras. 7-16) will remain in effect. For the convenience of staff members and for ease of reference, these administrative provisions are recapitulated in annex VII to the present circular.

Cessation of coverage of staff member and/or family members

10. The Insurance, Claims and Compensation Section should be notified immediately of changes in the staff member's family that result in a family member ceasing to be eligible, for example, a spouse upon divorce or a child marrying or taking up full-time employment. The Insurance, Claims and Compensation Section has initiated a procedure by which covered children who reach the age of 25 will be automatically dropped from the staff member's coverage at the end of the year in

which they reach the age of 25. Other than with respect to the children reaching 25, **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.** Staff members who wish to discontinue their coverage, or that of an eligible family member under a United Nations plan for any other reason, may do so at any time, although this is strongly discouraged. Such terminations of coverage should be communicated to the Insurance, Claims and Compensation Section directly, in writing. It is in the interest of staff members to notify the Insurance, Claims and Compensation Section 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.

After-service health insurance

11. Staff members are reminded that, among the eligibility requirements for after-service health insurance coverage, the applicant must be enrolled in a United Nations scheme at the time of separation from service. A minimum of five 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 after-service health insurance staff member at the time of separation are eligible for continued coverage under the programme. After-service participants are reminded that the restriction set out in paragraph 4 above, to the effect that staff members may switch from one insurance plan to another only during the period of the annual enrolment campaign, does not apply fully to them. Full details on the eligibility requirements and administrative procedures relating to after-service health insurance coverage are set out in administrative instruction ST/AI/394, dated 19 May 1994.

Conversion privilege

12. Participants who cease employment with the United Nations and are not eligible for after-service benefits may arrange for medical coverage under an individual contract. This provision applies to all medical plans currently offered. The conversion privilege means that the insurer cannot refuse to insure an applicant and that no certification of medical eligibility is required. In general, unless the separating staff member has had a history of poor health, exercising the conversion privilege will be more costly than acquiring new insurance coverage. **In addition, the conversion privilege 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.** It should be noted, moreover, that the conversion privilege may be exercised only for separating staff who continue to reside in the United States, as the insurers cannot write individual policies for persons residing abroad. In all cases, the conversion privilege must be exercised **within 31 days of the date of separation.** Details concerning conversion to individual policies under Aetna and Blue Cross BlueChoice may be obtained from the Insurance, Claims and Compensation Section, room S-2765. Details concerning

conversion to individual policies under the Health Insurance Plan of Greater New York (HIP) plan should be obtained from HIP directly. **The CIGNA dental plan does not have a conversion option.**

Claims and benefit inquiries and disputes

13. Although the staff of the Insurance, Claims and Compensation Section is available to assist staff members in administrative matters concerning participation in the various Headquarters insurance plans and problematic claims issues, claims questions should always be taken up in the first instance directly with the insurance company concerned. The addresses and relevant telephone numbers of the insurance companies are listed in annex VIII to the present circular.

14. Staff members are reminded that the plan descriptions set out in annexes I to IV constitute summaries of the benefits available under the respective plans. Every care has been taken to ensure that the plan summaries are as comprehensive as possible. However, each of the plans is subject to certain exclusions and limitations which are set out in the respective plan description booklets and in the policy contract. In the event of a claim dispute with any of the insurance carriers or plan administrators concerned, the resolution of such dispute will be guided by the terms and conditions of the policy contract in question and the final decision will rest with the insurance carrier or plan administrator and not with the United Nations. The policy contracts with the insurance carriers or plan administrators are available for review by subscribers, as may be necessary, by appointment at the Insurance, Claims and Compensation Section, room S-2765.

Headquarters health insurance plans: outlines and summaries of benefits

How plans are costed

15. The United Nations policies with Aetna, Blue Cross and CIGNA are "experience-rated". This means that the premium cost each year of the Aetna, Blue Cross and CIGNA dental plans is based on the level of claims incurred in the prior year and expected rates of utilization and medical cost inflation for the renewal period. In effect, the costs of these plans (claims incurred plus administrative expenses) are borne collectively by participants in these schemes. In a year following a period of heavy utilization, premium increases are likely to be relatively high. Conversely, if utilization in the prior year has been moderate, the premium increase in the subsequent year will be correspondingly moderate. The Health Maintenance Organization (HMO) plan, HIP, is "community-rated". This means the premium scale is based on the combined experience of all employers participating in the plan and not just the United Nations, and is approved by the relevant state insurance authorities. It should be emphasized, particularly with respect to the three experience-rated plans, that prudent utilization by all participants concerned will have the effect of moderating premium costs for the benefit of all.

Plan outlines and benefit summaries

16. Outlines of the health insurance plans offered as well as summaries of benefits of each plan are set out in the following annexes:

17. In addition, information regarding the World Access emergency facility for Aetna and BlueChoice subscribers, a listing of participating Aetna and BlueChoice pharmacies as well as a listing of insurance carrier addresses and telephone numbers are set out in the following annexes:

Finding providers through the Internet

18. On-line provider directories may be used to search for health-care providers, physicians, participating hospitals, pharmacies, medical equipment suppliers and dentists. Subscribers may search by location and/or by name. Enter the search criteria that will be used for the type of search being conducted. Subscribers also have the option of entering additional search criteria, such as a provider's medical specialty, hospital affiliation or languages spoken. If there are matches for the criteria selected, a list of providers will be presented for viewing or printing. In addition, in the Blue Cross web site, a map showing the provider's location can also be generated for viewing or printing. It is suggested that the following web addresses be "bookmarked" for ease of future reference.

Finding PPO providers through the "Insurance" Intranet web site

19. As an alternative to searching for providers directly on the Internet, participants may initiate a search from the Intranet web site of the Insurance, Claims and Compensation Section. On the United Nations Intranet home page, click on "Insurance" under the "Quicklinks" drop-down menu and then click on the insurance company desired from the Insurance Section home page. Then follow the instructions set out in the paragraph above.

Claim forms

20. Arrangements have been made with Blue Cross, Aetna and CIGNA to provide claim forms on-line through the United Nations Intranet (claim forms cannot be accessed through the Internet). Claim forms for these three companies will be found through the Insurance Section home page.

On-line Provider Directories	Instructions
AETNA www.aetnaushc.com/docfind/index.html	1. Select DocFind® Provider Directory. 2. Select a search category such as Doctors or Vision One. 3. Select OpenChoice PPO from the HealthPlan Menu. 4. Provide the search criteria to be used. 5. Click on the Continue button to see the listing of providers. If there are matches for the criteria you selected, you will be presented with a summary list of results.
BLUE CROSS www.bluecares.com/bluecard/index.html	1. Enter zip code, or city and state or an area code of the provider's telephone number. 2. Select the type of search you want to conduct. 3. Select PPO® Network for the type of network search. Click on the Next button. 4. Select the type of Health Care Provider. Click on the Next button. 5. Select the type of Health Care Provider by specialty. 6. Click on the Next button to see the listing of providers.
CIGNA www.cigna.com/healthcare/docdira.html	1. Click on Dentists. 2. Select managed Care Plan with Open Access to dentists: CIGNA Dental PPO. 3. Click on the Continue Search button at the bottom of the page. 4. Enter the provider's zip code or city and state if preferred. 5. Select dentist type (i.e. Endodontics, General Dentistry, Orthodontics).

Annex I

Blue Cross Empire Deluxe

Switch to Empire Deluxe PPO

Empire Blue Cross Blue Shield has announced that, with effect from 1 July 2000, the Blue Cross BlueChoice PPO plan will be discontinued. In its place, Blue Cross is offering the Empire Deluxe PPO plan which, while similar in design and structure to the BlueChoice plan in some respects, differs from the BlueChoice plan in several key areas. These differences will be highlighted in the paragraphs below, under the heading "Benefits".

Plan outline

The Blue Cross Empire Deluxe PPO plan provides in-network benefits, including an extensive network of participating providers covering most medical specialties, as well as out-of-network (non-network) benefits. A network of physicians covering New York City, the New York metropolitan area and nationally, participate in the Empire Deluxe plan and accept as payment a fee schedule arranged with Blue Cross. When treatment is rendered by an in-network provider, the only charge to the participant is a small co-payment, mostly $10 (for certain services co-payments vary between $0 and $35). On the other hand, the participant may also be treated by a physician who is not a participating practitioner in the plan. Medical services rendered by non-participating (out-of-network) providers, when covered, will be reimbursed at 80 per cent, subject to the deductible and 20 per cent co-insurance. If a participating physician refers a patient to another provider who is non-participating, the deductible and 20 per cent co-insurance will apply in connection with reimbursement of the cost of the services rendered by the non-participating provider, including mental health providers. A number of diagnostic laboratories are participating providers under the Empire Deluxe plan. When laboratory tests are required, it is important that the physician be told to send the tests to a participating laboratory, if possible. If this is done, the cost of the test will be paid in full and will not be subject to the normal deductible and co-insurance.

Premiums

It should be noted that, had Blue Cross continued to offer its BlueChoice PPO plan, premiums would have risen by approximately 6 per cent. As a result of the design of the Empire Deluxe PPO plan, it is possible to maintain the existing Blue Cross premium schedule for the forthcoming policy period.

The premiums and related percentages of salary contribution are shown on page 2 of the present circular. The staff member's contribution, based on the relevant percentage of salary, is not shown directly on the end-of-month payroll statement. The payroll statement shows the total monthly premium for the particular level of coverage involved as a deduction from salary as well as the Organization's subsidy towards the cost of that coverage (shown as a credit). The actual out-of-pocket cost of the insurance to the staff member is the difference between the total premium and the organizational subsidy.

Benefits

The package of benefits under the Blue Cross Empire Deluxe plan is itemized in the plan summary (pp. 15-19). A more complete description of Blue Cross benefits is set out in the summary plan description (SPD). Copies of that booklet, which every participant should possess, will be available after July.

As indicated above, certain benefits or provider options available under BlueChoice PPO will be modified or become unavailable under the Empire Deluxe plan. These areas of change in benefit structure have been referred to briefly on page 1 of the present circular. A more detailed comparison of the BlueChoice and Empire Deluxe PPO plans is set out below. Benefits not cited below are identical in both plans.

Deductible. Under BlueChoice, the annual deductible per individual is $125 and $450 per family. Under Empire Deluxe, these deductible levels will rise to $200 and $500, respectively. Subscribers who have already met the deductible limit under BlueChoice will have $75 of additional deductible to meet at the individual level and $50 more to meet at the family level during the balance of 2000.

Co-Insurance — annual out-of-pocket maximum. Under BlueChoice, the individual annual maximum is $1,000, with a $3,000 maximum for family. Under Empire Deluxe, the individual maximum remains the same, while the family annual maximum drops to $2,500. Subscribers who have fully or partially met their out-of-pocket requirement by 30 June 2000 will be credited towards the maxima under the Empire Deluxe programme. Subscribers who by 30 June 2000 have already met $3,000 in family-level co-insurance under BlueChoice may apply for a $500 refund. Those who by 30 June have not yet reached the $3,000 family co-insurance level but who have passed the $2,500 mark should apply for a refund of the amount between $2,500 and $3,000 at the end of 2000. Applying for the refund at the end of the year ensures that all claims incurred prior to 1 July 2000, when the lower family co-insurance limit comes into effect, will have been processed. In both cases, refund applications should be addressed to the Insurance, Claims and Compensation Section, room S-2765, together with photocopies of the relevant explanation of benefit documents from Blue Cross.

Lifetime maximum. Under BlueChoice, there is no lifetime benefit maximum. Under Empire Deluxe, there will be no lifetime maximum with respect to network-incurred expenses, but there will be a $1,000,000 lifetime maximum with respect to non-network reimbursements.

In-patient hospital benefits. Under BlueChoice, as long as accommodation is at the semi-private room level, hospital costs are paid 100 per cent, whether the hospital is in-network or out-of-network. Under Empire Deluxe, in-network hospitalizations are paid 100 per cent, but non-network hospitalization claims are subject to satisfaction of the annual deductible and 20 per cent co-insurance. However, this restriction will have negligible impact for staff members at Headquarters, as there is only one known hospital which at this time is non-network in the tri-state Empire Blue Cross area, namely, Englewood Hospital in Bergen County, New Jersey.

Out-patient ambulatory surgery, pre-surgical testing, chemotherapy, radiation therapy, mammography and cervical cancer screening. Under BlueChoice, coverage is available both in- and out-of-network at 100 per cent. Under Empire Deluxe,

coverage will be available on an in-network basis at 100 per cent, while on an out-of-network basis coverage for the above benefits will be subject to the annual deductible and 20 per cent co-insurance.

Home health care. There are two components with respect to home health care: visits to the home (up to 200 visits per calendar year) and home infusion therapy. Under BlueChoice, coverage is 100 per cent whether in or out-of-network. Under Empire Deluxe, in-network care is still reimbursed at 100 per cent, while out-of-network care, up to 200 visits, requires the payment of 20 per cent co-insurance only (deductible does not apply). Home infusion therapy is covered in-network only.

Out-patient kidney dialysis. Under BlueChoice, coverage is 100 per cent, whether in-network or out-of-network. Under Empire Deluxe out-of-network benefits will be subject to deductible and 20 per cent co-insurance.

Skilled nursing facility. Under BlueChoice, the benefit includes 100 per cent coverage whether in-network or out-of-network and up to 365 days per calendar year. Under Empire Deluxe, skilled nursing facility care will be covered on an in-network basis only and up to 120 days per calendar year.

Hospice. Under BlueChoice, the hospice benefit is covered 100 per cent whether in-network or out-of-network. Under Empire Deluxe, this benefit will be available on an in-network basis only.

Physical therapy. Under BlueChoice, physical therapy is covered on an in-patient basis at 100 per cent both in- and out-of-network for 45 visits when performed by hospital personnel. Physical therapy performed by an in-network therapist not connected with the hospital where one may be hospitalized is reimbursed for up to 45 visits in-network at 100 per cent, while out-of-network providers are reimbursed 80 per cent after satisfaction of the deductible. Out-patient physical therapy is covered for 30 visits in-network at 100 per cent subject to a $10 co-payment, while on an out-of-network basis, coverage is subject to the deductible and co-insurance. Under Empire Deluxe, physical therapy is covered on an in-patient basis at 100 per cent for 60 visits with no co-payment when performed by in-network hospital personnel, while out-of-network reimbursement is subject to deductible and co-insurance. Physical therapy performed by a therapist not connected with the hospital where one may be hospitalized is reimbursed 60 visits in-network at 100 per cent with no co-payment, while out-of-network 60 visits are covered at 80 per cent after satisfaction of the deductible. Out-patient physical therapy is covered for 60 visits on an in-network basis only at 100 per cent subject to a $10 co-payment.

Annual physical exam. Under BlueChoice, this benefit is available on an in-network and out-of-network basis. Under Empire Deluxe, the benefit will be available only on an in-network basis.

Well child care. Under BlueChoice, coverage is 100 per cent whether in-network or out-of-network. Under Empire Deluxe out-of-network benefits will be subject to deductible and 20 per cent co-insurance.

Cardiac rehabilitation. Under BlueChoice, cardiac rehabilitation is covered in-network with no co-pay, while out-of-network reimbursement is subject to deductible and 20 per cent co-insurance. Under Empire Deluxe, a $10 co-payment

will apply in-network, while out-of-network treatment will be subject to the deductible and co-insurance.

Second surgical opinion. Under BlueChoice, reimbursement for a second surgical opinion is covered in-network at 100 per cent with no co-payment, while out-of-network it is covered subject to deductible and co-insurance if not arranged through Empire Blue Cross Blue Shield. Under Empire Deluxe, a $10 co-payment will apply in-network, while on an out-of-network basis; the deductible and co-insurance will apply if the second opinion is not arranged through Empire Blue Cross Blue Shield Medical Management.

Prosthetics, orthotics, and durable medical equipment. Under BlueChoice, coverage is available both in and out-of-network at 100 per cent. Under Empire Deluxe, coverage will be available at 100 per cent on an in-network basis only.

Occupational, speech, vision therapies. Under BlueChoice, coverage is available in-network at 100 per cent after a co-payment has been made for home or office care, and without a co-payment if care is sought at an out-patient facility. On an out-of-network basis, reimbursement is made after satisfaction of deductible and 20 per cent co-insurance. Under Empire Deluxe coverage will be available on an in-network basis only at 100 per cent after a co-payment has been made.

Mental health care. Under BlueChoice, 90 in-patient days are covered at 100 per cent in-network and at 100 per cent out-of-network after satisfaction of the deductible. Additionally, in-patient care provides for 90 visits per calendar year by a professional not employed by the hospital at 100 per cent with no co-payment. Out-patient care provides for 50 visits in-network at 100 per cent with no co-payment, while out-of-network care also provides for 50 visits after the deductible and 20 per cent co-insurance have been met. Under Empire Deluxe, 90 in-patient days are covered at 100 per cent in-network, while out-of-network satisfaction of the deductible and 20 per cent co-insurance are required. Additionally, in-patient care provides for 90 visits per calendar year by an in-network professional not employed by the hospital at 100 per cent with no co-payment. On an out-of-network basis, this benefit requires satisfaction of the deductible and co-insurance. Out-patient care provides for 60 visits in-network at 100 per cent with a $25 co-payment, while out-of-network care also provides for 60 visits after the deductible and 20 per cent co-insurance have been met.

In-patient alcohol and substance abuse. Under BlueChoice, the benefit consists of up to 60 days of rehabilitation (two confinements per lifetime) and is covered at 100 per cent in-network and 100 per cent out-of-network after application of the deductible. Under Empire Deluxe, up to 7 days of detoxification and 30 days of rehabilitation are provided in-network at 100 per cent with no co-payment, while out-of-network the benefit is subject to the deductible and 20 per cent co-insurance.

Hearing appliance. Under BlueChoice, one hearing aid per ear every three years is covered and one hearing exam (limit $100) is also covered every three years on an out-of-network basis only. Under Empire Deluxe, there will be no coverage for hearing aids. A hearing exam every three years will be covered in-network with a $10 co-payment and out-of-network subject to a deductible and 20 per cent co-insurance.

Private duty nursing. Under BlueChoice, private duty nursing is covered on an out-of-network basis only, in the home only, for up to $5,000 per year and with a

$10,000 lifetime maximum. Under Empire Deluxe, there is no coverage for private duty nursing services.

Acupuncture benefits. Blue Cross covers acupuncture treatment provided by a licensed acupuncturist. Covered diagnoses for treatment by acupuncture include the following types of chronic pain syndrome:

– Tension, migraine headache

– Muscle spasm, psychalgia, neuralgia

– Backache, lumbago, bursitis

Services for which pre-certification is required

Pre-certification of hospital and other institutional services with the Medical Management Program (telephone: 1 (800) 982-8089) is required. The reason for this is constructive, as pre-certification ensures that (a) all expenses related to the hospitalization or treatment will be covered and (b) that a hospitalization case is medically monitored from the first day of admission so that if complications should arise, or if after-hospital care should be required, the case may be managed promptly and effectively.

When to call the Medical Management Program

– At least two weeks prior to any planned surgery or hospital admission. This applies to ambulatory surgery as well as in-patient surgery;

– Within 24 hours of an emergency hospital admission;

– Within the first three months of pregnancy and no more than one business day after the actual delivery;

– Prior to receiving home health care or home infusion therapy services (the network vendor must call medical management to pre-certify benefits);

– Prior to admission to a skilled nursing facility;

– Prior to receiving hospice care;

– Prior to receiving physical, occupational, speech or vision therapy;

– Prior to cardiac rehabilitation;

– Prior to renting or purchasing durable medical equipment, prosthetics or orthotics (the network vendor must call medical management to pre-certify);

– Prior to undergoing magnetic resonance imaging scans (MRIs).

With respect to mental health care and alcohol and substance abuse treatments, pre-approval must be sought from Magellan Behavioral Health (telephone: 1 (800) 626-3643).

Medical Management penalties

If you do not comply with the Medical Management requirement, your hospital/facility benefits may be reduced as follows (does not apply for providers outside the United States):

- In-patient hospital admissions, ambulatory surgery, cardiac rehabilitation and home health care, hospice care, occupational speech and vision therapy, physical therapy, MRIs, and skilled nursing facilities — 50 per cent up to $2,500 maximum per admission;
- Home infusion therapy and prosthetics, orthotics and durable medical equipment (vendor is penalized, member is held harmless).

Home health care

Home health care is covered at 100 per cent and is limited annually to 200 visits of up to 4 hours per visit. To be eligible for reimbursement, home health care must be prescribed by a physician and determined to be medically necessary. A written prescription or home health care treatment plan is required as well as any supporting documentation from the physician to facilitate Blue Cross' review of a claim for the payment of benefits. It is also a requirement (subject to a monetary penalty) that proposed home health care services be submitted to the Blue Cross Medical Management Program for a predetermination of benefits payable prior to contracting with a nursing or home health care agency. Services provided at home need not follow a hospital confinement.

It is important to note that covered home health care services **exclude** all types of custodial care services. Custodial care services are categorized as personal care and comprise services designed to help a person perform activities of daily living, which include assistance with bathing, eating, dressing, toileting, continence and transferring. Such services are performed at home or in other facilities such as nursing homes, adult day care centres and assisted living facilities. Custodial care services may be of a short-term nature or provided on a long-term basis. Health insurance plans, including the Empire Deluxe PPO plan, provide no coverage for custodial care.

Worldwide participating Blue Cross hospitals

Subscribers to Blue Cross health insurance plans have the benefit of a network of hospitals in more than 40 countries worldwide which accept the Blue Cross ID card and which bill Blue Cross directly for any medical services rendered. A list of these hospitals may be obtained from the Insurance, Claims and Compensation Section, room S-2765.

EMPIRE DELUXE™ PPO BENEFITS SUMMARY

This summary of your Empire Deluxe PPO program is not a full contractual description of your benefits. Please see your group's contract for more information about covered services, limitations and exclusions.

COST SHARING	IN-NETWORK[a] MEMBER PAYS	OUT-OF-NETWORK MEMBER PAYS
ANNUAL DEDUCTIBLE	$0	$200 Individual $500 Maximum for a Family
CO-INSURANCE	$0	20%
ANNUAL OUT-OF-POCKET MAXIMUM	$0	$1,000 Individual $2,500 Family in addition to annual deductible
LIFETIME MAXIMUM	Unlimited In-Network benefits. Up to $1Million lifetime Out-of-Network benefits.	
DEPENDENT CHILDREN	Covered to end of calendar year in which child reaches age 25.	

HOSPITAL BENEFITS	IN-NETWORK MEMBER PAYS	OUT-OF-NETWORK MEMBER PAYS
INPATIENT[b] *(except behavioral health)* • Unlimited days -- semiprivate room and board • Hospital-provided services • Routine nursery care	$0	Deductible and 20% Co-insurance
OUTPATIENT • Surgery and ambulatory surgery[b] • Pre-surgical testing (performed within 7 days of scheduled surgery) • Blood • Chemotherapy and radiation therapy • Mammography screening and cervical cancer screening	$0	Deductible and 20% Co-insurance
EMERGENCY ROOM/FACILITY[c] *(initial visit)* • Accidental injury • Sudden and serious medical condition	$35 Co-payment (waived if admitted within 24 hours)	$35 Co-payment (waived if admitted within 24 hours)

EMPIRE DELUXE™ PPO BENEFITS SUMMARY		
OTHER FACILITY BENEFITS	***IN-NETWORK*** MEMBER PAYS	***OUT-OF-NETWORK*** MEMBER PAYS
HOME HEALTH CARE[b,d] • Up to 200 visits per calendar year • Home Infusion Therapy	 $0 $0	20% Co-insurance Only (deductible does not apply) Covered In-Network Only
OUTPATIENT KIDNEY DIALYSIS • Home, Hospital based or free-standing facility treatment	$0	Deductible and 20% Co-insurance
SKILLED NURSING FACILITY[b] • Up to 120 days per calendar year	$0	In-Network Only
HOSPICE[b] • Up to 210 days per lifetime	$0	In-Network Only
PHYSICAL THERAPY[b] • Up to 60 inpatient days per calendar year	$0	Deductible and 20% Co-insurance
PREVENTIVE CARE BENEFITS	***IN-NETWORK*** MEMBER PAYS	***OUT-OF-NETWORK*** MEMBER PAYS
ANNUAL PHYSICAL EXAM	$10 Co-payment	In-Network Only
DIAGNOSTIC SCREENING TESTS	$0	Deductible and 20% Co-insurance
PROSTATE SPECIFIC ANTIGEN (PSA) TEST	$0	Deductible and 20% Co-insurance
WELL WOMAN CARE	$10 Co-payment	Deductible and 20% Co-insurance
MAMMOGRAPHY SCREENING	$0	Deductible and 20% Co-insurance
WELL CHILD CARE (including recommended immunizations)[d] • Newborn Baby 1 in-hospital exam at birth • Birth to 1 year of age 6 visits • 1 through 2 years of age 3 visits • 3 through 6 years of age 4 visits • 7 up to 19th birthday 6 visits	$0	Deductible and 20% Co-insurance

EMPIRE DELUXE™ PPO BENEFITS SUMMARY		
MEDICAL BENEFITS	***IN-NETWORK*** MEMBER PAYS	***OUT-OF-NETWORK*** MEMBER PAYS
OFFICE/HOME VISITS/OFFICE CONSULTATIONS	$10 Co-payment	Deductible and 20% Co-insurance
SURGERY	$0	Deductible and 20% Co-insurance
SURGICAL ASSISTANT[e]	$0	Deductible and 20% Co-insurance
ANESTHESIA[f]	$0	Deductible and 20% Co-insurance
INPATIENT VISITS/CONSULTATIONS	$0	Deductible and 20% Co-insurance
MATERNITY CARE	$0	Deductible and 20% Co-insurance
DIAGNOSTIC X-RAYS	$0	Deductible and 20% Co-insurance
LAB TESTS	$0	Deductible and 20% Co-insurance
CHEMOTHERAPY & RADIATION THERAPY Hospital outpatient or physician's office	$0	Deductible and 20% Co-insurance
MRIs[b]	$0	Deductible and 20% Co-insurance
CARDIAC REHABILITATION[b]	$10 Co-payment	Deductible and 20% Co-insurance
SECOND SURGICAL OPINION[g]	$10 Co-payment	Deductible and 20% Co-insurance
SECOND MEDICAL OPINION FOR CANCER DIAGNOSIS	$10 Co-payment	Deductible and 20% Co-insurance[h]

EMPIRE DELUXE™ PPO BENEFITS SUMMARY		
MEDICAL BENEFITS	***IN-NETWORK*** MEMBER PAYS	***OUT-OF-NETWORK*** MEMBER PAYS
ALLERGY TESTING AND ALLERGY TREATMENT	$10 Co-payment per office visit for testing. $0 for testing fees and treatment visits	Deductible and 20% Co-insurance
PROSTHETIC, ORTHOTICS and DURABLE MEDICAL EQUIPMENT[i]	$0	In-Network Only
MEDICAL SUPPLIES	$0	$0
PHYSICAL THERAPY and OTHER SKILLED THERAPIES	***IN-NETWORK*** MEMBER PAYS	***OUT-OF-NETWORK*** MEMBER PAYS
PHYSICAL THERAPY[b] • 60 inpatient visits and, • 60 visits combined in home, office or outpatient facility.	$0 $10 Co-payment	Deductible and 20% Co-insurance In-Network Only
OCCUPATIONAL, SPEECH, VISION[b] • 30 Visits combined in home, office or outpatient facility.	$10 Co-payment	In-Network Only
BEHAVIORAL HEALTH CARE BENEFITS	***IN-NETWORK[8]*** MEMBER PAYS	***OUT-OF-NETWORK*** MEMBER PAYS
MENTAL HEALTH CARE[d,j] • Up to 90 inpatient days per calendar year • Up to 60 outpatient visits in office or facility. • Up to 90 professional visits per calendar year while in an inpatient facility.	$0 $25 Co-payment per visit $0	Deductible and 20% Co-insurance
OUTPATIENT ALCOHOL AND SUBSTANCE ABUSE[d, j] • Up to 60 outpatient visits which include 20 family counselling visits per calendar year.	$0	Deductible and 20% Co-insurance
INPATIENT ALCOHOL AND SUBSTANCE ABUSE[d, j] • Up to 7 days detoxification and 30 days rehabilitation per calendar year.	$0	Deductible and 20% Co-insurance

EMPIRE DELUXE™ PPO BENEFITS SUMMARY		
OTHER BENEFITS	***IN-NETWORK*** MEMBER PAYS	***OUT-OF-NETWORK*** MEMBER PAYS
ACUPUNCTURE	$10 Co-payment	Deductible and 20% Co-insurance
CHIROPRACTIC CARE	$10 Co-payment	Deductible and 20% Co-insurance
HEARING EXAM (Every 3 years)	$10 Co-payment	Deductible and 20% Co-insurance
HEARING APPLIANCE	Not Covered	Not Covered
AMBULANCE[k]	$0 up to the allowed amount	
PRESCRIPTION DRUGS (Card and Mail Order Program)	15% co-payment up to a maximum of $15 per prescription; $10 co-payment for mail order	40% co-insurance (claim form must be filed for reimbursement)
VISION CARE PROGRAMME (in-network only through a designated group of providers)	$5 co-payment for 1 exam every 24 months; $10 co-payment for basic frames; $35 for co-payment for non-plan eyewear allowance.	In-Network Only

[a] In-Network services (except Mental Health or Alcohol/Substance Abuse) are those from a provider that participates with Empire or another BlueCross and BlueShield Plan through the BlueCard Program, or a participating provider with another BlueCross and BlueShield Plan that does not have a PPO network and does accept a negotiated rate arrangement as payment-in-full.

[b] Medical Management Program must pre-approve or benefits will be reduced 50% up to $2,500.

[c] If admitted, Medical Management must be called within 24 hours or as soon as reasonably possible.

[d] Combined maximum visits for In-Network and Out-of-Network Services.

[e] If the surgical assistant is an out-of-network provider and is assisting a participating surgeon, payment will be made in full.

[f] If the anesthesiologist is an out-of-network provider but is affiliated with a participating hospital, payment will be made in full.

[g] Charges to member do not apply if the second surgical opinion is arranged through our Medical Management Program.

[h] If arranged through our Medical Management Program, services provided by an out-of-network specialist will be covered as if the services had been in-network (i.e. subject to the in-network co-payment).

[i] In-Network Vendor must call Medical Management to pre-certify.

[j] Magellan Behavioral Health must pre-approve or benefits will be reduced 50% up to $2,500. Out-of-network mental health care does not require pre-certification, however, out-patient alcohol, substance abuse visits, must be pre-certified. In-Network Mental Health Services are those from providers that participate with Magellan Behavioral Health.

[k] Air Ambulance and Ambulette services are not covered.

Discount prescription drug programme (Empire Pharmacy Management)

The Blue Cross Empire Pharmacy Management (EPM) discount prescription drug programme is administered by MedImpact. The Empire Pharmacy Management (EPM) programme reimburses at significant savings prescription drugs obtained from participating pharmacies. Under this programme, a retail pharmacy network is provided by Empire Pharmacy Management through MedImpact as well as a mail order facility through Express Pharmacy Services.

Significant cost savings are being passed on to participants by utilizing either a participating pharmacy or the Express Pharmacy Services mail order facility. In respect of drugs obtained at participating pharmacies, the discount will be at least 15 per cent off the average wholesale price (AWP) of the drug. If the physician does not request on the written prescription that a brand-name drug be dispensed by indicating "Dispense as written" or "DAW", a generic equivalent drug will be provided by the pharmacist, and the discount off the AWP will average 43 per cent depending on the generic equivalent supplied. The discount for maintenance drugs obtained through Express Pharmacy Services will range from 18 per cent to as high as 50 per cent off AWP, depending on whether or not a generic equivalent to the brand-name drug is provided. (Maintenance drugs are drugs used on a continual basis for the treatment of chronic health conditions.) Whenever a prescription carries the words "Dispense as written" or "DAW", the pharmacist or mail order firm will fill the prescription accordingly and no substitution will be made.

The procedure under which prescription drugs are reimbursed through the Empire Pharmacy Management programme is as follows. Written prescriptions for drugs are presented at a participating pharmacy of one's choice **along with the Empire Pharmacy Management card** (a listing of participating pharmacies in the New York metropolitan area may be found in annex VI). The pharmacist will fill the prescription for up to a 34-day supply and charge a co-insurance of 15 per cent (rather than the normal 20 per cent co-insurance) on the discounted price of the drug, but never more than $15 per prescription. No claim form is required for prescriptions filled at participating pharmacies.

Prescriptions for maintenance drugs may provide for up to a 90-day supply and are most economically filled through the Express Pharmacy Services mail order facility, which will charge a fixed $10 co-payment per prescription. The Express Pharmacy Services claim form supplied with the Empire Pharmacy Management card should be utilized for ordering maintenance drugs by mail. A new order form will be sent along with the filled prescription. The address and telephone number of the mail order prescription drug facility is as follows:

Express Pharmacy Services
P.O. Box 270
Pittsburgh, PA 15230-9949

Tel. No. (888) 624-5376

It should be noted that if a generic equivalent is available and a participant receives a brand-name drug at his or her request, even though the physician has not specified a brand name by indicating "Dispense as written" (DAW) on the prescription, the participating pharmacy and/or the Express Pharmacy Services mail order facility will charge the participant the normal co-payment ($10) in addition to

the difference between the cost of the brand-name drug and the allowance for the generic equivalent.

As the Blue Cross BlueChoice prescription drug programme is administered separately by Empire Pharmacy Management, the annual deductible under the BlueChoice plan will **not** be applied to prescription drugs. At the same time, the prescription drug co-payment will also **not** count towards meeting the annual co-insurance limit of $1,000. Prescription drugs obtained outside the United States or within the United States but not through the Empire Pharmacy Management MedImpact's participating network will be reimbursed through the submission of a claim form to the claims office at the following address:

Empire BCBS (EPM)
Pharmacy Unit
P.O. Box 5099
Middletown, NY 10940-9099

Tel. No. (800) 839-8442

The special claim form to be utilized for this purpose is available in the offices of the Insurance, Claims and Compensation Section, room S-2765. Claims submitted to the claims office will be subject to the annual deductible. Claims for prescription drugs dispensed outside the United States will be reimbursed at 80 per cent after deductible, while claims for prescription drugs dispensed within the United States but **not** through the Empire Pharmacy Management programme will be reimbursed at the rate of 60 per cent. In addition, the 20 or 40 per cent co-insurance will **not** count towards meeting the annual co-insurance limit of $1,000.

Behavioural health and substance abuse benefits

Under the Blue Cross plan, in-patient care for both the treatment of mental and nervous conditions and substance abuse as well as in-network out-patient treatment by a psychiatrist, clinical psychologist or psychiatric social worker requires prior approval by Behavioral Health Care Management (1-800-626-3643).

Vision care

To qualify for vision care benefits, you must receive care from a provider participating in the Blue Cross Davis Vision Network. There are no out-of-network benefits for vision care. To find a participating Davis Vision Network provider in your area, simply call 1-888-EYEBLUE (1-888-393-2583) between 9 a.m. and 5 p.m. weekdays.

The vision care benefits include an eye exam and eyewear, consisting of a select group of frames, and soft contact lenses once every 24 months. During this benefit period, you are **not** required to purchase the eyewear at the time of the examination, nor are you required to purchase the covered eyewear from the same provider who rendered the eye examination.

Service	*Amount you pay*
Eye exam	$5.00
Frames (limited selection)	$10.00
Premier frames	$40.00
Soft contact lenses — per pair (standard daily wear)	$25.00
Single vision lenses	0
Bifocal lenses	0
Trifocal lenses	0
Progressive addition lenses	$80.00
Blended segment lenses	$20.00
Photochromic single vision lenses	$15.00
Photochromic multifocal vision lenses	$25.00
Supershield single vision lenses	$15.00
Supershield multifocal lenses	$25.00
Ultraviolet coating	$10.00
Reflection-free coating	$33.00
Polaroid lenses	$60.00
Polycarbonate lenses	$30.00
High index lenses	$55.00
Transition lenses	$70.00

In addition, vision care benefits include a $35.00 allowance for non-plan frames.

Exclusions and other provisions

Certain expenses are not covered under the Empire Deluxe plan. These comprise expenses for services or supplies not deemed by Blue Cross as being necessary, reasonable and customary or not recommended by the attending physician. There are also certain exclusions and limitations under the plan. For example, cosmetic surgery and certain experimental or investigational procedures are not covered. In addition, inoculations for travel purposes are not covered. If a participant has any question as to whether a medical procedure or service will be recognized by Blue Cross as reimbursable under the plan, Blue Cross should be contacted at (800) 342-9816 prior to commencement of treatment. In addition, the Blue Cross policy contract document is on file in the offices of the Insurance, Claims and Compensation Section and may be consulted and photocopied, as necessary. An appointment should be made for this purpose.

Recourse if a claim is denied

If Blue Cross denies a claim in whole or in part, the subscriber has the right to appeal the decision. Blue Cross will send written notice of the reason for the denial. The subscriber then has 60 days to submit a written request for review. Blue Cross will send a written decision with an explanation within 60 days of receiving the appeal. If special circumstances require more time, Blue Cross can extend the review period up to 120 days from the date the appeal was received. For a review of a hospital or medical claim, write to:

Empire Blue Cross and Blue Shield
P.O. Box 1407
New York, NY 10008-1407
Attention: Member Services

Time limit for filing a claim

Subscribers should note that claims for reimbursement must be submitted to Blue Cross no later than two years from the date on which the medical expense was incurred. **Claims received by Blue Cross later than two years after the date on which the expense was incurred will not be eligible for reimbursement.**

Annex II

Aetna "Open Choice" Plan

Plan outline

The Aetna "Open Choice" health benefits plan (Aetna) offers worldwide coverage for hospitalization and surgical, medical and prescription drug expenses. Under this plan, medically necessary treatment for a covered illness or injury may be obtained at a hospital or from a physician of one's own choosing, whether an in-network or non-network provider.

Aetna "Open Choice" is a dual-track plan that offers all the benefits of the traditional Aetna indemnity plan, plus the option of a preferred provider organization (PPO) network of physicians and other medical providers nationwide. This means that participants can choose, if they wish, to go to a doctor who is in-network and pay only $10 per visit or treatment without any further need to file a claim with Aetna. Alternatively, participants may opt to receive treatment from any physician not in the network and be reimbursed by Aetna in the usual way, subject to the annual deductible and the normal co-insurance. A summary of the plan, both the in-network and the non-network (traditional indemnity) benefits, is set out in outline form commencing on page 27.

Under the non-network (traditional) track of the Aetna plan, when a participant has met the annual deductible of $125 per individual and $375 per family and a further $1,000 per covered individual in co-insurance (20 per cent of $5,000 of recognized expenses), Aetna will reimburse all further claims incurred in the year, subject to the provision that they be "reasonable and customary", at 100 per cent. The deductible and co-insurance requirement must be met each calendar year. There is no lifetime reimbursement limit under the Aetna plan. When a participant is treated by a network physician, paying the fixed $10 co-payment for each visit, it is important to note that those $10 amounts do not count towards meeting the $1,000 out-of-pocket expense limit referred to above. This is so because, under the in-network track of the plan, medical expenses are already considered to have been paid at 100 per cent to the network provider after the participant has met the fixed $10 co-pay.

Premium

The premiums and related percentages of salary contribution are shown on page 2 of the present circular. The staff member's contribution, based on the relevant percentage of salary, is not shown directly on the end-of-month payroll statement. The payroll statement shows the total monthly premium for the particular level of coverage involved as a deduction from salary as well as the Organization's subsidy towards the cost of that coverage (shown as a credit). The actual out-of-pocket cost of the insurance to the staff member is the difference between the total premium and the organizational subsidy.

Benefits

The package of benefits under the Aetna "Open Choice" plan is itemized in the plan summary (pp. 27-31). A more complete description of Aetna benefits is set out

in the summary plan description (SPD). Copies of that booklet, which every participant should possess, will be available after July.

Participants are reminded of certain other provisions which came into effect last year, as follows:

Emergency room co-payment. There is a $35 co-payment for the emergency use of hospital emergency room facilities. If the visit to the emergency room results in a hospital admission within 24 hours, the $35 co-payment will be waived. Non-emergency use of the emergency room will be reimbursed at 80 per cent if a network hospital is used, and at 80 per cent after deductible if a non-network hospital is used, as heretofore.

Private duty nursing and home health care. Private duty nursing is covered on an in-home basis only (no in-hospital benefit). In addition, the benefit is limited to $5,000 per year, with a $10,000 lifetime maximum. Home health care is covered at 100 per cent and is limited annually to 200 visits of up to 4 hours per visit. To be eligible for reimbursement, both private duty nursing and home health care services must be prescribed by a physician and determined to be medically necessary. A written prescription or home health care treatment plan is required as well as any supporting documentation from the physician to facilitate Aetna's review of a claim for the payment of benefits. It is strongly recommended that both in-home private duty nursing and home health care requirements be submitted to Aetna for a predetermination of benefits payable prior to contracting with a nursing or home health care agency. Services provided at home need not follow a hospital confinement.

It is important to note that covered home health care services exclude all types of custodial care services. Custodial care services are categorized as personal care and comprise services designed to help a person perform activities of daily living, which include assistance with bathing, eating, dressing, toileting, continence and transferring. Such services are performed at home or in other facilities such as nursing homes, adult daycare centres and assisted living facilities. Custodial care services may be of a short-term nature or provided on a long-term basis. Health insurance plans, including the Aetna plan, provide no coverage for custodial care.

Pre-registration of hospital and other institutional services. Mandatory pre-registration applies to in-hospital admissions, skilled nursing facility admissions, home health care, private duty nursing and hospice care. The reason for such pre-registration (to which no financial penalty attaches) is a constructive one, namely that pre-registration assures the patient (a) that all related hospital expenses will be covered under the plan, and most importantly that (b) a hospitalization case is medically monitored from the first day of admission, so that if complications should arise, or if after-hospital care should be required, the case may be managed promptly and effectively. The telephone number to call for pre-registration of hospital admissions and the other services is: 1-800-333-4432. For an emergency admission, call within 48 hours, or the next business day if admitted on a weekend.

Artificial insemination. This benefit is subject to a maximum of six courses of treatment in a covered person's lifetime. With effect from 1 July 2000, artificial insemination will be covered under the infertility treatment benefit.

Non-network prescription drug reimbursement. Participants are reminded that non-network prescription drugs will be reimbursed at the rate of 60 per cent (40 per

cent co-insurance), after deductible. In addition, the 40 per cent co-insurance which is the responsibility of the participant will **not** count towards meeting the annual out-of-pocket limit of $1,000. All prescriptions filled at pharmacies outside the United States will be reimbursed at 80 per cent after deductible. However, the co-insurance will not count towards fulfilment of the annual $1,000 out-of-pocket limit.

Aetna claims

The address to which Aetna claim forms should be sent is as follows:

Aetna Life Insurance Company
Unit 73
3541 Winchester Road
Allentown, PA 18195-0501

AETNA OPEN CHOICE SUMMARY OF BENEFITS

BENEFITS	NETWORK BENEFITS	NON-NETWORK BENEFITS
ANNUAL DEDUCTIBLE Individual Family	 $0 $0	 $125 $375
CO-INSURANCE (% at which the plan pays benefits)	100% except where noted	100% Hospital; 80% all other, except where noted
OUT-OF-POCKET LIMIT Individual Family	N/A	$1,000 $3,000 (network and prescription drug co-pays do not count toward the out-of-pocket limit)
LIFETIME MAXIMUM	Unlimited	Unlimited
CLAIM SUBMISSION	**PROVIDER** files claims	**YOU** file claims
HOSPITAL SERVICES AND RELATED CARE		
COVERAGE In-patient Coverage Out-patient Coverage	100% 100%	
MANDATORY PRE-REGISTRATION (1-800-333-4432) Applies to in-patient hospital, skilled nursing facility, home health care, hospice care, and private duty nursing care	**Provider responsible**	**Subscriber or provider responsible**
(FOR EMERGENCY ADMISSION, CALL WITHIN 48 HOURS OR NEXT BUSINESS DAY IF ADMITTED ON WEEKEND)		
Hospital Emergency Room Based on symptoms, i.e. constituting a perceived life threatening situation	100% including physician's charges after $35 co-pay (waived if admitted within 24 hours)	100% including physician's charges after $35 co-pay (waived if admitted within 24 hours)
Hospital Emergency Room for non-emergency care (examples of conditions: skin rash, ear ache, bronchitis, etc.)	80%	80% after deductible
Ambulance ***[There are no network providers for these services at the present time.]***	100%	
Skilled Nursing Facility 365 days per year	100%	

BENEFITS	NETWORK BENEFITS	NON-NETWORK BENEFITS
Private Duty Nursing (in-home only)	100% subject to a $5,000 maximum per year and $10,000 lifetime	
Home Health Care up to 200 visits per year	100% Must be medically necessary and supported by a doctor's prescription/ medical report. Precertification, is strongly recommended.	
Hospice (210 days) plus 5 days bereavement counselling	100% per lifetime	
PHYSICIAN SERVICES **(excluding mental health and substance abuse treatment)**		
Office Visits for treatment of illness or injury (non-surgical)	100% after $10 co-pay	80% after deductible
Maternity (includes voluntary sterilization and voluntary abortion, see Family Planning)	100% after $10 co-pay;	80% after deductible
Physician In-Hospital Services	100%	80% after deductible
Other In-Hospital Physician Services (e.g. attending/independent physician who does not bill through hospital)	100%	80% after deductible
Surgery (in hospital or office)	100%	80% after deductible
Second Surgical Opinion	100% after $10 co-pay	100% after deductible
Anesthesia	100% (if participating hospital)	80% after deductible
Allergy Testing and Treatment (given by a physician)	100% after $10 co-pay	80% after deductible
Allergy Injections (not given by a physician)	100%	80% after deductible
PREVENTIVE CARE		
Routine Physicals and Immunizations Children age 19+ and adults: one routine exam every 24 months. Age 65+: one routine exam every 12 months	100% after $10 co-pay	80% after deductible
Well-Child Care and Immunizations Well-child care to age 7. 6 visits per year age 0 to 1 year 2 visits per year age 1 to 2 years 1 visit per year age 2 to 7 years One visit every 24 months from age 7 to 19.	100%	
Routine Ob/Gyn Exam One routine exam per calendar year including one Pap smear	100% after $10 co-pay	80% after deductible

BENEFITS	NETWORK BENEFITS	NON-NETWORK BENEFITS
Family Planning - Office visits including tests and counseling - Surgical Sterilization procedures For vasectomy/tubal ligation (excludes reversals)	100% after $10 co-pay 100%	80% after deductible 80% after deductible
Infertility Treatment - Office visits including testing and counseling - Limited to procedures for correction of infertility including artificial insemination (but excluding in-vitro fertilization, G.I.F.T., Z.I.F.T., etc.)	100% after $10 co-pay 100%	80% after deductible 80% after deductible
Routine Mammogram (no age limit)	100%	80% after deductible 100% if performed on an in-patient basis or in the out-patient department of a hospital
Annual Urological exam by Urologist	100%	80% after deductible
MENTAL HEALTH AND ALCOHOL/DRUG ABUSE SERVICES		
MENTAL HEALTH IN-PATIENT SERVICES (1-800-424-1601) **In-patient Coverage** *[The benefit maximum is for network and non-network services combined.]*	100% Maximum benefit of 90 days per calendar year	100% after deductible Maximum benefit of 90 days per calendar year
These services are provided under the Focused Psychiatric Review (FPR) programme. Pre-registration of in-patient confinements is required. For in-network services, the network provider is responsible for pre-registration. For non-network in-patient services, either the physician or the participant must pre-register the confinement.		
Out-patient Coverage *[The benefit maximum is for network and non-network services combined.]*	100% up to 50 visits per calendar year	80% after deductible up to 50 visits per calendar year
Crisis Intervention	100% up to 3 visits per calendar year	80% after deductible up to 3 visits per calendar year
ALCOHOL/DRUG ABUSE - **In-patient Coverage** *[The benefit maximum is for network and non-network services combined.]*	100% up to 60 days per calendar year *2 confinements per lifetime*	100% after deductible up to 60 days per calendar year
Out-patient Coverage *[The benefit maximum is for network and non-network services combined.]*	100% up to 60 visits per calendar year	80% after deductible up to 60 visits per calendar year

PLAN BENEFITS	NETWORK BENEFITS	NON-NETWORK BENEFITS
PRESCRIPTION DRUG BENEFITS		
Retail Programme (1-888-792-8742) **(30-day supply)**	100% at participating pharmacies after $15 co-pay; co-pay maximum is $15	60% after deductible 40% co-payment which will not count towards $1,000/$3,000 out-of-pocket limit
Mail Order Programme **(1-877-849-5521)** **(90-day supply)**	100% after $10 co-pay for up to a 90-day supply from participating mail order vendor	
Prescriptions for both Retail Programme and Mail Order Programme - when brand name is requested, you pay the co-pay plus the difference between the brand and generic price, unless the physician specifically prescribes the brand-name drug.		
VISION AND HEARING CARE		
Eye Exam (once every 24 months)	100% after $10 co-pay	80% after deductible
Optical Lenses (including contact lenses)	80%, deductible does not apply; $100 maximum for any two lenses and frames purchased in a 24 month period	
Vision One Programme **(1-800-793-8616)**	Save up to 65% on frames; up to 50% on lenses; about 20% on contact lenses at participating Cole Vision Centers	
Hearing Exam Evaluation and Audiometric exam	100% after $10 co-pay	80% after deductible (one exam every three years; exam must be performed by otolaryngologist or state certified audiologist)
Hearing Device ***[There are no network providers for these services at the present time.]***	80% co-pay, deductible do not apply; $750 maximum benefit, one hearing aid per ear every three years	
OTHER HEALTH CARE		
Short-Term Rehabilitation **Physical and Occupational Therapy**	100%	80% after deductible
Laboratory Tests, Diagnostics X-rays	100%	80% after deductible
Speech Therapy	80%, deductible does not apply (where services are rendered by a participating provider, 100% reimbursement applies after $10 co-pay)	
Out-patient Diabetic **Self-Management Education** **Programme**	80%, deductible does not apply *[If services are rendered in a hospital, 100% reimbursement applies with no co-pay. If rendered in a network doctor's office, 100% reimbursement with $10 co-pay applies.]*	

PLAN BENEFITS	NETWORK BENEFITS	NON-NETWORK BENEFITS
Durable Medical Equipment	80%, deductible does not apply *[If services are rendered by a network provider or within a hospital setting, 100% reimbursement applies with no co-pay.]*	
Acupuncture (for chronic pain treatment only; services must be rendered by a medical doctor or licensed acupuncturist)	100% after $10 co-pay up to a maximum benefit of $1,000/year *[Network and non-network benefits are combined for a maximum of $1,000 per calendar year]*	80% after deductible up to a maximum benefit of $1,000/year *[Network and non-network benefits are combined for a maximum of $1,000 per calendar year]*
Chiropractic Care	100% after $10 co-pay up to a maximum benefit of $1,000/year *[Network and non-network benefits are combined for a maximum of $1,000 per calendar year]*	80% after deductible up to a maximum benefit of $1,000/year *[Network and non-network benefits are combined for a maximum of $1,000 per calendar year]*

Eye examination

An eye examination once every 24 months is covered at 100 per cent after a $10 co-payment if carried out by a network provider, and at 80 per cent after deductible if carried out by an out-of-network provider.

"Vision One" eyecare discount programme

The Vision One programme offers subscribers and covered family members immediate discounts on eyecare needs, including frames, lenses and contact lenses. This programme is an addition to, not a substitute for, the existing optical lens benefit which will be continued as before. The programme is available at over 2,500 locations nationwide, including the optical centres in national retail outlets, such as Sears, JC Penney and Montgomery Ward and many of the Pearle Vision Centers, as well as selected independent providers/offices. To obtain the discounts available under this programme, it is only necessary to show the provider the Aetna identification card at the time of the visit. The provider will apply the discounts to any purchases made and will accept valid prescriptions from any licensed optometrist or ophthalmologist. The Vision One programme may be used as often as desired. As it is simply a discount programme, claim forms are not required. For more details and outlet locations, call Vision One at (800) 793-8616, weekdays from 9 a.m. to 9 p.m. and Saturdays from 9 a.m. to 5 p.m. Vision One providers can also be found on the Internet at "http://www.aetnaushc.com/docfind/eyeware/eyeware.js". A schedule of costs and typical savings is set out below.

Benefits	*Vision One cost*
Frames	
Priced up to $60.00 retail	$16.00
Priced from $61.00 to $80.00 retail	$26.00
Priced from $81.00 to $100.00 retail	$36.00
Priced from $101.00 to $200.00 retail	50 per cent
Lenses — per pair (uncoated plastic)	
Single vision	$28.00
Bifocal	$48.00
Trifocal	$58.00
Lenticular	$98.00
Lens options — per pair (add to lens prices above)	
Standard-Progressive (no-line bifocals)	$50.00
Polycarbonate	$30.00
Scratch-resistant coating	$12.00
Ultraviolet coating	$12.00
Solid or gradient tint	$8.00
Glass	$18.00
Photochromic	$34.00
Anti-reflective coating	$35.00

Eye examinations (by licensed independent doctors of optometry)

Eyeglasses — $34.00

Contact lenses — $10.00 off normal fee

Contact lenses (two ways to save on contact lenses)

1. Visit the more than 2,500 locations nationwide and save 20 per cent discount from regular retail prices.

2. Use the Vision One Contact Lens Replacement Program for additional savings and convenience.

Call (800) 391-5367 for this service.

Dispensing fee

The fee for fitting and dispensing (including unlimited eyeglass adjustments) is only $10.00.

Acupuncture benefits

The Aetna "Open Choice" plan provides benefits for acupuncture treatment rendered by a medical doctor or licensed acupuncturist, up to a maximum benefit of $1,000 per calendar year. While this benefit will be described in the plan description book to be made available to all participants, the scope of the benefit may be summarized as follows:

Covered diagnoses for treatment by acupuncture include the following types of chronic pain syndrome:

- Tension headache
- Migraine headache
- Psychalgia
- Neuralgia
- Backache
- Lumbago
- Muscle spasm
- Bursitis

Acupuncture treatment in lieu of anaesthesia has been recognized as a reimbursable procedure by Aetna under the traditional plan. This benefit, as well as all other benefits under the traditional plan, will be maintained under Aetna "Open Choice".

Mental and nervous and substance abuse benefits

A. In-patient benefits

All hospitalization for mental and nervous and substance abuse conditions is subject to the Focused Psychiatric Review (FPR) procedure. **Staff members are**

assured that the FPR programme is conducted in the strictest confidence. The procedure is as follows:

Prior to a non-emergency hospital admission, Aetna must be informed of the intended admission. This is accomplished by placing a telephone call to a toll-free Aetna number (800-424-1601). The call will be taken by a member of the Aetna FPR team. The telephone call may be placed by the subscriber himself or herself, the attending physician, a family member, or any other person acting for the patient to be hospitalized.

The initial information required by Aetna in order to pre-certify the admission includes the subscriber's identification number (payroll index number), the reason for the admission, the physician's name, address and telephone number, the hospital name, address and telephone number, and the scheduled admission date.

The FPR specialist then contacts the attending physician to review the information prior to certification of the admission. If the attending physician makes the original call to the 800 number, this step will be accomplished at that time. The FPR specialist certifies a certain number of in-patient days, if appropriate, and develops a plan of regular follow-up visits with the attending physician.

An emergency admission, which cannot be pre-certified before the confinement begins, must be called in to the Aetna FPR number within 48 hours of the emergency admission.

B. In-patient mental and nervous and substance abuse care

The full cost (semi-private accommodation) of 30 days of hospitalization for the treatment of mental and nervous disorders. Hospital confinements beyond 30 days are reimbursed subject to the normal deductible and co-insurance provisions.

The full cost (semi-private accommodation) of 30 days of hospitalization for substance (alcohol and/or drug) abuse detoxification and rehabilitation, limited to two 30-day benefit periods in a lifetime. Continuous confinement of up to 30 days beyond this 30-day limit is subject to the provision under the paragraph below.

Coverage for up to 30 days of hospitalization for substance abuse (alcohol and/or drug) rehabilitation after the 30-day hospitalization benefit described in the paragraph above has been exhausted. This benefit is available twice in a lifetime and is applicable only as a continuation of each of the two 30-day hospitalization periods provided under the preceding paragraph.

C. Out-patient mental and nervous and substance abuse care

A maximum of 50 out-patient visits per year to a medical doctor engaged in the practice of psychiatry (and, depending on the state in which the provider is licensed, for the services of a psychologist and psychiatric social worker). If treatment is obtained from a network provider, the plan pays 100 per cent of the cost. If the provider does not participate in the PPO network, reimbursement will be at 80 per cent of the reasonable and customary fee level for the area in which the services are rendered, and will be subject to the annual deductible. The 50-visit annual maximum is for network and non-network treatment combined. Co-insurance

payments made in respect of out-of-network treatment will not be applied to the $1,000 annual co-insurance maximum.

Sixty out-patient visits per calendar year for the treatment of alcoholism or drug abuse diagnosed by a physician. Of these 60 annual visits, 20 may be utilized for the counselling of the patient's family if directly related to the patient's alcoholism or drug abuse.

Discount prescription drug programme (Aetna Pharmacy Management)

With effect from 1 July 2000, Express Scripts Inc. (ESI) mail service programme will replace Walgreens Healthcare Plus as Aetna's contracted mail order pharmacy administrator. Prescriptions for maintenance drugs may provide for up to a 90-day supply and are most economically filled through ESI which will charge a fixed $10 co-payment. New ESI order forms are available at the Insurance, Claims and Compensation Section office, room S-2765.

The Aetna Pharmacy Management (APM) prescription drug programme, along with its mail order affiliate, Express Scripts Inc. (ESI), reimburses, at significant savings, the cost of prescription drugs obtained from participating pharmacies and from the Express Scripts Inc. (ESI) mail order facility.

In respect of drugs obtained at participating pharmacies, the discount will be at least 15 per cent off the average wholesale price (AWP) of the drug. If the physician does not request on the written prescription that a specific brand be dispensed by indicating "Dispense as written" or "DAW", the generic equivalent drug will be provided by the pharmacist, and the discount off the AWP can be as high as 50 per cent, depending on the generic equivalent supplied. The discount for maintenance drugs obtained by mail through the Express Scripts Inc. (ESI) mail order facility will range from 18 per cent to as high as 50 per cent off AWP depending on whether or not a generic equivalent to the brand-name drug is provided. (Maintenance drugs are drugs used on a continual basis for the treatment of chronic health conditions.) Whenever a prescription carries the words "Dispense as written" or "DAW", the pharmacist or mail order firm will fill the prescription accordingly and no substitution will be made.

The procedure under which prescription drugs are reimbursed through the Aetna Pharmacy Management Programme is as follows. Written prescriptions for drugs are presented at a participating pharmacy of one's choice **along with the Aetna card** (a listing of participating pharmacies in the New York metropolitan area may be found in annex VI). The pharmacist will fill the prescription for up to a 30-day supply and charge a co-insurance of 15 per cent (rather than the normal 20 per cent co-insurance) based upon the discounted price of the drug, but never more than $15 per prescription. No claim form is required for prescriptions filled at participating pharmacies.

It should be noted that if a participant wishes to receive the brand-name drug even though the physician has not specifically prescribed the brand name, the participating pharmacy will charge a participant 15 per cent of the cost of the brand-name drug, but not more than $15 per prescription. In cases in which a brand-name maintenance drug is ordered through the ESI mail order facility even though it has not been specifically prescribed, ESI will charge the participant the normal co-

payment ($10) in addition to the difference between the cost of the brand-name drug and the allowance for the generic equivalent.

As the Aetna prescription drug programme benefit is administered separately by Aetna Pharmacy Management, the annual deductible under the Aetna plan will **not** be applied to prescription drugs obtained at network pharmacies. At the same time, however, prescription drug co-payment expenses will **not** count towards meeting the annual co-insurance limit of $1,000. **Prescription drugs obtained at pharmacies in the United States, but not through network pharmacies, will be reimbursed at 60 per cent and be subject to deductible. In addition, the 40 per cent co-insurance amount will not count towards the annual $1,000 out-of-pocket limit.** Prescription drugs obtained outside the United States will be reimbursed through submission of the standard claim form to the Aetna claims office in Allentown, Pennsylvania. In such cases, the annual deductible will have to be met before reimbursement is made, as well as the 20 per cent co-insurance, which will **not** count towards meeting the annual limit of $1,000.

Exclusions and other provisions

Special conditions apply to certain medical procedures for injury-related dental and cosmetic injury, for convalescent facility expenses and for treatment of temporo-mandibular joint syndrome (TMJ). Participants are advised to consult the Aetna claims office in advance of commencing treatment for these conditions.

Certain expenses are not covered under the Aetna plan. These comprise expenses for services or supplies not deemed by Aetna as being necessary, reasonable and customary or not recommended by the attending physician. There are also certain exclusions and limitations under the plan. For example, cosmetic surgery and certain experimental or investigational procedures are not covered. In addition, inoculations for travel purposes are not covered. If a participant has any question as to whether a medical procedure or service will be recognized by Aetna as reimbursable under the plan, Aetna Member Services should be contacted at (800) 784-3991 prior to commencement of treatment. In addition, the Aetna policy contract document is on file in the offices of the Insurance, Claims and Compensation Section and may be consulted and photocopied, as necessary. An appointment should be made for this purpose.

Recourse if a claim is denied

If Aetna denies a claim in whole or in part, the subscriber will receive a written notice from Aetna. This notice will explain the reason for the denial and the appeal procedure. The request for review must be submitted in writing within 60 days of receipt of the notice. The subscriber should include the reasons for requesting the review and submit the request to the Aetna Allentown Claim Office. Aetna will review the claim and ordinarily notify the subscriber of its final decision within 60 days of receipt of the request. If special circumstances require an extension of time, notification will be given to that effect.

Time limit for filing claims

Subscribers should note that claims for reimbursement must be submitted to Aetna no later than two years from the date on which the medical expense was incurred. **Claims received by Aetna later than two years after the date on which the expense was incurred will not be eligible for reimbursement.**

Annex III

Health Insurance Plan of Greater New York/Health Maintenance Organization (HIP/HMO)

Health Insurance Plan of Greater New York (HIP)/New Jersey

The Health Insurance Plan of Greater New York (HIP) has ceased to be available in New Jersey, owing to termination of its operations in that state in late 1998.

Plan outline

The HIP/HMO plan follows the concept of total prepaid group practice hospital and medical care, that is, there is no out-of-pocket cost to the staff member for covered services at numerous participating medical groups in the Greater New York area, including New Jersey and certain areas in Florida. The costs of necessary emergency treatment obtained outside the covered area are included in the plan coverage. Additionally, prescription drugs (a $5 co-payment applies) and medical appliances (in full) are covered when obtained through HIP/HMO participating pharmacies and are prescribed by HIP/HMO physicians or any physician in a covered emergency. HIP/HMO participants may select a physician at a HIP medical centre or from a new listing of neighbourhood affiliated physicians for primary care services. The affiliated physician is visited in his or her private office. Specialty care, however, will continue to be given in a HIP medical centre based upon the referral of the selected affiliated physician. To select a neighbourhood affiliated physician, the HIP participant should call HIP at (800) HIP-TALK. Additional information regarding this expansion of HIP providers will be provided to participants during the annual enrolment campaign and also mailed by HIP to all participants.

Premium

The premiums and related percentages of salary contribution are shown on page 2 of the present circular. The staff member's contribution, based on the relevant percentage of salary, is not shown directly on the end-of-month payroll statement. The payroll statement shows the total monthly premium for the particular level of coverage involved as a deduction from salary as well as the Organization's subsidy towards the cost of that coverage (shown as a credit). The actual out-of-pocket cost of the insurance to the staff member is the difference between the total premium and the organizational subsidy.

Benefits

Benefits under the HIP/HMO plan will remain unchanged in the renewal period.

HIP/HMO benefits summary

Type of benefit	HIP/HMO coverage
Hospital services	Covered in full when authorized by HIP/HMO physician
In-hospital physician's services	Covered in full if rendered by HIP/HMO physician
Private duty nursing	Covered in full when authorized by HIP/HMO physician or by any physician in a covered emergency
Skilled nursing facility	No limit on number of days when care is in lieu of hospitalization. Care must be arranged by HIP/HMO physician
Visits to physician's office/health centre	Covered in full at any HIP/HMO medical centre or if care is rendered by HIP/HMO physician
House calls	Covered in full when authorized by HIP/HMO physician or emergency service programme
Maternity care	No waiting periods. Covered in full when care is rendered by HIP/HMO physician. Prenatal, post-natal and well-baby check-ups are covered in full
Preventive care:	
Annual physicals, well-baby care, eye examinations, hearing tests, diagnostic X-rays, laboratory tests, immunizations and allergens	Covered in full when care is rendered by a HIP/HMO physician. Eye examinations are covered in full when rendered by a HIP/HMO physician (eyeglasses and hearing aids are excluded)
Mental health services:	
In-patient	Covered in full for 30 days per calendar year for mental or nervous disorders
Out-patient	HIP/HMO has its own mental health centres that provide psychotherapy and counselling for adults and children with mental or emotional problems
	Individual, family or group therapy sessions are provided as long as treatment is effective. Intensive psychotherapy is excluded
Alcoholism and substance abuse:	
In-patient	Covered in full for up to 30 days in any calendar year in a state-certified alcoholism or substance-abuse treatment facility
Out-patient	Medical services for diagnosis and treatment of alcoholism or substance abuse for a period not to exceed 60 visits in any calendar year. HIP/HMO mental health centres will be used for the out-patient services

Type of benefit	HIP/HMO coverage
Emergency services:	
In-area	HIP/HMO has an emergency service programme that is in operation when your medical group is closed. This provides the HIP/HMO subscriber with a 24-hour, 7-day service
Out-of-area	Hospital service:
	In-patient — covered in full
	Out-patient — covered in full, when care is received within 12 hours of onset of illness or within 72 hours (three days) following injury
	Doctor services — HIP/HMO pays customary and reasonable non-HIP/HMO physician fees for covered emergency illness or accidental injury
Prescription drugs and medical appliances	$5 co-payment for prescription drugs, but not appliances, when obtained through HIP/HMO participating pharmacies. The drugs and appliances must be prescribed by HIP/HMO physicians, or any physician in a covered emergency
Preventive dental care	Annual cleaning and other preventive dental services performed by a HIP dentist. $5 co-payment per service
Grievance procedure	Refer to member handbook sent to subscribers

Annex IV

CIGNA Dental PPO Plan

Plan outline

The design of the CIGNA Dental PPO plan offers staff not only a large network of participating providers in the Greater New York metropolitan area and nationally, but also two distinct plan options, Option A and Option B, while retaining a single premium structure. The dual option structure is designed to ensure (a) that staff members have the dental treatment for themselves and their family members provided by a PPO network of dentists, and (b) that those staff members whose dental treatment is not rendered by network (or participating) dentists, will have the option of selecting a track which reimburses on the basis of a percentage of "reasonable and customary" dental fees, in much the same way as do the Aetna and Blue Cross PPO health plans. Please note that the CIGNA ID card does not indicate the option selected. The selection of either Option A or Option B is recorded in CIGNA's database and will be known to a provider at the time that coverage eligibility is checked by the provider's office.

Premium

The premiums and related percentages of salary contribution for the CIGNA plan are shown on page 2 of the present circular. The staff member's contribution, based on the relevant percentage of salary, is not shown directly on the end-of-month payroll statement. The payroll statement shows the total monthly premium for the particular level of coverage involved as a deduction from salary as well as the Organization's subsidy towards the cost of that coverage, which is shown as a credit. The actual out-of-pocket cost of the insurance to the staff member is the difference between the total premium and the organizational subsidy.

Benefits

With effect from 1 July 2000, the annual deductible under the CIGNA "Option B" plan is increased from $25 per individual to $50 and from $75 per family to $150. No deductible applies to CIGNA "Option A".

Option A:

Option A provides for 100 per cent coverage for most dental procedures without any deductible if the dental treatment is rendered by a dentist participating in the CIGNA provider network (a few dental procedures involving costly materials may require additional payment to the dentist by the participant). The CIGNA participating provider network is nationwide, and includes a total of over 38,000 dentists, with approximately 4,800 in New York State (3,000 in New York City), 2,100 in New Jersey and 700 in Connecticut.

Participants who choose Option A may also visit non-participating (or non-network) dentists and will be reimbursed the CIGNA in-network fee contracted with participating dentists who practice in the same area as the non-participating dentists. If the non-network dentist's fee is higher than the contracted in-network fee, the difference will be payable by the participant. It is important to note that, under the CIGNA plan, there is no single PPO contracted fee schedule. The contracted fee

levels vary in accordance with prevailing costs in the different areas in which the dental practices are located. A chart summarizing the Option A benefits and reimbursement levels is set out on page 45.

Option B:

The key feature of Option B is the reimbursement allowance formula for participants who wish to utilize non-network dentists. Under this option, out-of-network dental treatment will be reimbursed at certain percentage levels after an annual deductible of $50 per person or $150 per family has been met. The percentage reimbursement levels apply to the "reasonable and customary" dental fee levels prevailing in the dentist's zip-code area. Reasonable and customary fee levels are determined by reference to a national database maintained by the Health Insurance Association of America (HIAA). The percentage reimbursement rate depends on the level of dental treatment as follows: 90 per cent for preventive/diagnostic treatment; 80 per cent for major and minor restorative treatment; 70 per cent for orthodontics.

Under Option B, participants may also be treated by in-network dentists. In this case there is no deductible. The reimbursement percentages for preventive/diagnostic care, major and minor restorative treatment and orthodontics are 100 per cent, 90 per cent and 80 per cent, respectively, based on the network provider's contracted fee level with CIGNA. Thus the amount payable by the participant will be the difference between the 90 or 80 per cent reimbursement and the CIGNA contracted PPO fee for the service provided. A chart summarizing the Option B benefits and reimbursement levels is set out on page 46.

Pre-treatment review (pre-determination of benefits)

If a course of treatment can reasonably be expected to involve covered dental expenses of $300 or more, a description of the procedures to be performed and an estimate of the dentist's charges should be filed with CIGNA before the course of treatment begins. The dentist should be sure to include the American Dental Association (ADA) procedure code for each procedure claimed. This process will inform the participant as to whether the proposed dental fee is within reasonable and customary norms (the Insurance Claims and Compensation Section has no information in this regard) and exactly how much will be reimbursed.

Dental treatment outside the United States

Participants who obtain dental treatment outside the United States may file their claims with CIGNA and are eligible for reimbursement on the same basis as a participant who visits a non-participating dentist in New York.

Maximum annual benefits

The annual benefit ceiling is $2,000 per covered person, and is the same for Option A and Option B. There is an additional lifetime allowance of $2,000 for orthodontic treatment, limited to dependent children up to 19 years of age.

CIGNA web site

Access to CIGNA's nationwide network of participating dentists is also available through the Insurance home page of the Insurance, Claims and Compensation Section on the United Nations Intranet. In addition, the CIGNA dental provider directory can be accessed directly from the CIGNA Internet web site, www.cigna.com/healthcare/docdira.html.

Benefit summaries

The benefit summaries on pages 45 and 46 highlight the many benefits which are available under the CIGNA Dental PPO plan. A complete description regarding the terms of coverage, exclusions and limitations will become available following implementation of the plan.

How to appeal a claim

If you do not agree with the reason given for denial of your claim in whole or in part, you should write within 60 days to the CIGNA claims office. Be sure you state why you believe the claim should not have been denied and submit any data, questions or comments you think are appropriate. Your appeal will be reviewed by the office that processed your claim. Any appeal that cannot be resolved by that office will be forwarded to the company's Home Office for review and final decision. You will be notified of the final decision within 60 days of the date your appeal is received, unless there are special circumstances, in which case you will be notified within 120 days. If you are not satisfied with the final decision, and you wish to review the documents pertinent to any appealed claim, you should write to the office that processed your claim.

Benefit exclusions

The following list, while not necessarily complete, gives examples of benefit exclusions:

- Services performed solely for cosmetic reasons
- Replacement of a lost or stolen appliance
- Replacement of a bridge or denture within five years following the date of its original installation
- Replacement of a bridge or denture which can be made usable according to dental standards
- Procedures, appliances or restorations, other than full dentures, whose main purpose is to change vertical dimension, diagnose or treat conditions of TMJ, stabilize periodontally involved teeth, or restore occlusion
- Veneers of porcelain or acrylic materials on crowns or pontics on or replacing the upper and lower first, second and third molars
- Bite registrations; precision or semi-precision attachments; splinting
- Surgical implant of any type including any prosthetic device attached to it
- Instruction for plaque control, oral hygiene and diet

- Dental services that do not meet common dental standards
- Services that are deemed to be medical services
- Services and supplies received from a hospital
- Charges which the person is not legally required to pay
- Experimental or investigational procedures and treatments
- Any injury resulting from, or in the course of, any employment for wage or profit
- Any sickness covered under any workers' compensation or similar law
- Charges in excess of the reasonable and customary allowances

OPTION A

CIGNA DENTAL PPO SUMMARY OF BENEFITS

Benefits[a]	In-Network[b]		Out-of-Network[b]	
Plan Year Maximum - 1 July 2000-30 June 2001 (Class I, II and III expenses)	$2,000		$2,000	
Plan Year Deductible	None		None	
Reimbursement Levels	Based on reduced contracted fees		Based on In-Network reduced contracted fees	
	Plan Pays	***You Pay***	***Plan Pays***	***You Pay***
Class I - Preventive & Diagnostic Care Oral Exams (Two per year) Cleanings (Two per year) Full Mouth X-rays (One complete set every three years Bitewing X-rays (Two per year) Panoramic X-ray (One every three years) Fluoride Application (One per year for persons under 19) Scalants (Limited to posterior tooth for a person less than 14/One treatment per tooth every three years) Space Maintainers (Limited to non-orthodontic treatment) Emergency Care to relieve pain	100%	No Charge	100% of In-Network contracted fee	Remainder of dentist's fee
Class II - Basic Restorative Care[c] Fillings Root Canal Therapy Osseous Surgery Periodontal Scaling and Root Planing Denture Adjustments and Repairs Extractions Oral Surgery	100%	No Charge	100% of In-Network contracted fee	Remainder of dentist's fee
Class III - Major Restorative Care[c] Crowns Dentures Bridges	100%	No Charge	100% of In-Network contracted fee	Remainder of dentist's fee
Class IV - Orthodontia	100%	No Charge	100% of In-Network contracted fee	Remainder of dentist's fee
Lifetime Maximum (In addition to the Class I, II and III maximum)	$2,000 Dependent children to age 19		$2,000 Dependent children to age 19	

[a] Pre-treatment review (pre-determination of benefits) is strongly recommended when dental work in excess of $300 is proposed. The dentist deals directly with CIGNA in this regard.

[b] The $2,000 maximum is for the plan year, whether the provider is in-network or out-of-network, or a combination of the two.

[c] Some dental procedures involving costly materials may require additional payment by the participant to the provider.

OPTION B

CIGNA DENTAL PPO SUMMARY OF BENEFITS

Benefits[a]	In-Network[b]		Out-of-Network[b]	
Plan Year Maximum - 1 July 2000-30 June 2001 (Class I, II and III expenses)	$2,000		$2,000	
Plan Year Deductible - 1 July 2000-30 June 2001				
Individual	None		$50 per person	
Family	None		$150 per family	
Reimbursement Levels	Based on reduced contracted fees		Based on Reasonable & Customary Allowances	
	Plan Pays	***You Pay***	***Plan Pays***	***You Pay***
Class I - Preventive & Diagnostic Care Oral Exams (Two per year) Cleanings (Two per year) Full Mouth X-rays (One complete set every three years Bitewing X-rays (Two per year) Panoramic X-ray (One every three years) Fluoride Application (One per year for persons under 19) Scalants (Limited to posterior tooth for a person less than 14/One treatment per tooth every three years) Space Maintainers (Limited to non-orthodontic treatment) Emergency Care to relieve pain	100%	No Charge	90%	10%
Class II - Basic Restorative Care[c] Fillings Root Canal Therapy Osseous Surgery Periodontal Scaling and Root Planing Denture Adjustments and Repairs Extractions Oral Surgery	90%	10%	80%[d]	20%[d]
Class III - Major Restorative Care[c] Crowns Dentures Bridges	90%	10%	80%[d]	20%[d]
Class IV - Orthodontia Lifetime Maximum (In addition to the Class I, II and III maximum)	80% $2,000 Dependent children to age 19	20%	70%[d] $2,000 Dependent children to age 19	30%[d]

[a] Pre-treatment review (pre-determination of benefits) is strongly recommended when dental work in excess of $300 is proposed. The dentist deals directly with CIGNA in this regard.

[b] The $2,000 maximum is for the plan year, whether the provider is in-network or out-of-network, or a combination of the two.

[c] Some dental procedures involving costly materials may require additional payment by the participant to the provider.

[d] Subject to plan year deductible.

Annex V

World Access

World Access (formerly known as Access America) is a facility available to Aetna and BlueChoice subscribers. The $0.25 per month per subscriber cost of the World Access facility is built into the premium schedule for Aetna and BlueChoice set out on page 2 of the present circular.

World Access provides an international travellers' 24-hour hotline assistance programme for obtaining medical care abroad, or within the United States, when at least 100 miles from one's normal place of residence. Participants who call the hotline numbers below will, where possible, be provided with referrals from a worldwide network of physicians, dentists, hospitals, pharmacies and other medical facilities. In addition, in most cases, World Access will settle the costs of emergency foreign hospital admission and treatment. If the emergency hospitalization occurs in the United States and the hospital does not accept the Aetna or the Blue Cross BlueChoice identification cards, World Access will also settle the related costs directly with the hospital and then claim reimbursement directly from Aetna or Blue Cross as the case may be. In the case of hospitalization, World Access medical staff will contact the insured patient's local physician in order to monitor the case and services being received. In the event of an emergency hospitalization in the circumstances described above, it is important that World Access be contacted upon admission to the hospital or, at the latest, before discharge. It should also be emphasized that any hospital bill paid by the participant must be sent to Aetna for reimbursement or Blue Cross, as World Access does not reimburse participants directly.

The hotline numbers are:

(800) 654-1901 (in the United States, Canada, Puerto Rico and the Virgin Islands)

(804) 673-1159 — collect (from Alaska, Washington, D.C. and all other locations), or

Fax No. (804) 673-1179

When contacting World Access, be sure to identify yourself as a United Nations participant. Please state the World Access identification number for the United Nations, which is 2065, in addition to your United Nations index number.

Annex VI

Aetna and Blue Cross Plans: list of participating pharmacies

Set out below are lists of the major participating chain pharmacies under the Aetna and Blue Cross discount prescription drug programmes. The Aetna and Blue Cross directories of participating pharmacies are available at the offices of the United Nations Insurance, Claims and Compensation Section; the Division of Personnel, United Nations Development Programme; and the Office of Personnel, United Nations Children's Fund. In addition, if a participating pharmacy is needed while travelling, referral information is available from Aetna ((888) 792-8742) and Blue Cross ((800) 839-8442).

Aetna participating chain pharmacies			*Blue Cross participating chain pharmacies*
New York	*New Jersey*	*Connecticut*	
AARP Phcy Service	ACME Phcy	AARP Phcy Service	A & P Phcy
A & P Phcy	A & P Phcy	A & P Phcy	Brooks Phcy
Brooks Drug	Brooks Drug	Arrow Prescription Ctr	Costco
Costco Phcy	Clover Phcy	Arthur Drug Stores	CVS
CVS	Costco Phcy	Brooks Drug	Drug Mart
Drug Mart	CRX Phcy	Costco Phcy	Duane Reade
Drug World	CVS	CVS	Eckerd
Duane Reade	Drug Fair	Douglas Drug	Edwards
Edwards Phcy	Drug World	Edwards Phcy	Finast
Fay's	Duane Reade	F & M Distributors	Foodtown
Finast Phcy	Eckerd Drugs	Genovese	Freddy's
Freddy's	Food Town Phcy	Grand Union Phcy	Genovese
Genovese	Foodmax Phcy	K Mart Phcy	Grand Union
Grand Union Phcy	Genovese	The Medicine Shoppe	JC Penney Prescription Ctr
Great American Drug	Grand Union Phcy	NPSC/EPIC	K Mart
K Mart Phcy	Happy Harry's	Pathmark Phcy	Phar-Mor
King Kullen Phcy	K Mart Phcy	Purity Phcy	Pharmhouse
Kinney Drugs	The Medicine Shoppe	Rite Aid	Price Chopper
Leroy Phcy	Pathmark Phcy	Shop Rite Phcy	Price Club
The Medicine Shoppe	Phar-Mor	Super X Drug Store	Revco
Pathmark Phcy	Pharmhouse	The RX Place	Rite Aid
Peterson Drug Co.	Quick Check	Stop & Shop	Safeway
Phar-Mor	Revco	Waldbaum's Phcy	Sav-On
Pharmhouse	Rite Aid	Walgreens	Shop'N Save

Aetna participating chain pharmacies			*Blue Cross participating chain pharmacies*
New York	*New Jersey*	*Connecticut*	
Price Chopper Phcy	RXD Phcy	Wal-Mart	Shop Rite Phcy
Revco	Sav-On		SupeRx
Rite Aid	Shop Rite Phcy		Target
Rockbottom Phcy	Super X Drug Store		The Medicine Shoppe
Shop'N Save Phcy	The RX Place		Thrift Drug Store
Shop Rite Phcy	Thrift Drug		Tick Tock Drugs
The RX Place	Thrift RX		Tops
Stop & Shop	Waldbaum's Phcy		Vons
Thrift Drug	Walgreens		Wal-Mart
Tops Phcy	Wal-Mart		Waldbaum's Phcy
Vix Phcy			Walgreens
Waldbaum's Phcy			Weis
Walgreens			
Wal-Mart			
Wegmans Phcy			
Weis Phcy			

Annex VII

Eligibility and enrolment rules and procedures

1. All staff members holding appointments of three months or longer (or six months or longer for dental coverage) under the 100 series of the Staff Rules whose duty station is New York and who are not enrolled in a Headquarters medical/dental insurance plan may enrol during this annual campaign. Medical insurance provisions pertaining to technical assistance project personnel are set out under staff rule 206.4. 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 line with the relevant provisions of administrative instruction ST/AI/395, dated 2 June 1994. Currently enrolled staff members may take the opportunity of the annual enrolment campaign to review their coverage and change from one plan to another, or change their coverage in respect of members of their family. The medical scheme applicable to staff holding appointments of less than three months under the 100 series of the Staff Rules or who hold short-term appointments under the 300 series of the Staff Rules is described in information circular ST/IC/86/44 of 15 September 1986.

2. 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. Eligible family members may also be enrolled at this time, provided that evidence of the status (Personnel Action form) of such family members is presented to the Insurance, Claims and Compensation Section. Interested staff members should carefully review the current status of their family's enrolment, both as to the continued eligibility of their children and/or inclusion of those newly eligible or not covered at present.

3. "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 engaged in full-time employment; disabled children may be eligible for continued coverage after the age of 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".

4. Staff members, particularly those who have no coverage under a United Nations plan or through another family member, are strongly urged to obtain medical insurance coverage for themselves and their eligible family members, especially since the high cost of medical care could result in financial hardship for individuals who fall ill and/or are injured and have no such coverage.

5. **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.

Enrolment between annual campaigns

6. Between annual campaigns, staff members and their family members may be allowed to enrol in the Headquarters medical and dental insurance plans only if at least one of the following events occurs and application for enrolment is made within 31 days thereafter:

(a) In respect of medical insurance coverage, upon receipt of an initial appointment of at least three months' duration at Headquarters under the 100 or 300 series of the Staff Rules or upon appointment under the 200 series of the Staff Rules;

(b) In respect of dental insurance coverage, upon receipt of an initial appointment of at least six months' duration at Headquarters under the 100 or 200 series of the Staff Rules;

(c) Upon transfer to Headquarters from another duty station;

(d) Upon return from special leave without pay, but only under the health scheme in which insured prior to taking leave (see para. 9 below);

(e) Upon assignment to a mission, under certain conditions (see para. 10 below); and/or

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

(g) Upon the provision of evidence that the staff member was on mission or annual or sick leave for the entire duration of the annual campaign, staff members may enrol within 31 days of their return to Headquarters.

7. In all the cases cited in paragraph 6 above, the completed application for enrolment or re-enrolment must be certified by the appropriate personnel or administrative officer and received by the Insurance, Claims and Compensation Section within 31 days of the occurrence of the event giving rise to entitlement to enrol. Applications and inquiries with regard to changes relating to such events occurring between campaigns should be directed to the Insurance Section as follows:

Insurance, Claims and Compensation Section
Office of Programme Planning, Budget and Accounts
Room S-2765
United Nations Headquarters
New York, NY 10017

8. **Applications between enrolment campaigns based on any other circumstances or not received within 31 days of the event giving rise to eligibility will not be receivable by the Insurance, Claims and Compensation Section and will be returned.** In this regard, it should be noted that termination of health insurance coverage under a scheme not offered by the United Nations 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 campaigns, the staff member must wait until the next campaign 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 enrolling in a United Nations scheme during the present campaign.

Staff on special leave without pay

9. Staff members who are granted special leave without pay are reminded that they may retain coverage for medical and dental insurance 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 must be informed directly by the staff member of his or her intention at least one month in advance of the commencement of the special leave, in person if at Headquarters, or in writing if stationed away from Headquarters. At that time, the Insurance, Claims and Compensation Section will require evidence of the approval of the special leave, together with payment covering the full amount of the cost of the coverage(s) 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(s) 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(s) during a period of special leave without pay, it is essential that he or she re-enrol in the plan(s) with the Insurance, Claims and Compensation Section upon return to duty, in person if at Headquarters, or in writing if away from Headquarters. This must be done **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(s) until the next annual enrolment campaign in the month of June.

Staff members assigned on mission

10. In view of the large number of staff members who go on mission assignment, a special medical/dental plan enrolment opportunity is extended 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 any United Nations health insurance 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 a health insurance plan in these circumstances must be completed prior to the departure of the staff member on mission assignment;

(b) Staff members assigned to a mission who are enrolled in HIP, a plan which does not offer full services at locations away from Headquarters, may switch to either Aetna or BlueChoice. These two plans provide benefits on a worldwide basis. Enrolment in the Aetna or BlueChoice plans under this provision must be completed prior to the departure of the staff member on mission assignment;

(c) Staff members who, at the time of commencement of the mission assignment, do not have dental coverage but who are already enrolled, together with eligible family members, in Aetna or BlueChoice, may enrol themselves and family members covered under their medical insurance plan in the dental plan. Such

enrolment must be completed prior to the departure of the staff member on mission assignment;

(d) Staff members who elect to enrol in a health insurance plan in the circumstances provided under subparagraphs (a) to (c) above forgo the right to make any further change during the annual enrolment campaign 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 campaign of the following year;

(e) Staff members who are already enrolled in Aetna or BlueChoice at the time of the mission assignment must retain their existing coverage until the next annual enrolment campaign;

(f) Staff members who will be on mission assignment for six months or more **and who will not have eligible covered family members residing in the United States** for the duration of the mission assignment may opt for coverage under the Van Breda Medical, Hospital and Dental Insurance plan for staff overseas. Details of this plan are available in the offices of the Insurance, Claims and Compensation Section, room S-2765;

(g) Staff members returning to Headquarters from mission assignment, other than those who qualified and opted for the Van Breda plan, may not change their insurance coverage until the next annual enrolment campaign. **Staff members who switched to the Van Breda plan, as provided under subparagraph (f) above, must revert, upon return to Headquarters, to the insurance plan that they had prior to the mission assignment, at least until the next annual enrolment campaign.** It is essential that such staff members advise the Insurance, Claims and Compensation Section within 31 days of their return to Headquarters. **Failure to re-enrol in the prior Headquarters plan within 31 days of return to duty from mission assignment will result in suspension of health insurance coverage.**

11. **In all cases, staff members going on mission assignment who wish to enrol in a health insurance plan or change their present coverage, as provided above, must present evidence to the Insurance, Claims and Compensation Section of the mission assignment and its duration.**

Annex VIII

Insurance carrier addresses and telephone numbers for claims and benefit inquiries

I. Aetna "Open Choice" Plan (medical and out-of-network pharmacy claims)		Aetna Life Insurance Company Unit 73 3541 Winchester Road Allentown, PA 18195-0501
Tel.:	(800) 784-3991	Member Services (benefit/claim questions)
Tel.:	(800) 333-4432	Pre-registration of hospital/institutional services
Tel.:	(888) 792-8742	Participating pharmacy referral
Tel.:	(877) 849-5521	Express Scripts (ESI) (mail order drugs)
Tel.:	(888) 792-8742	Maintenance drug automated refills (credit card)
Tel.:	(800) 424-1601	Focused Psychiatric Review (FPR)
Tel.:	(800) 793-8616	Vision One
II. Blue Cross Empire Deluxe Plan		Empire Blue Cross 622 Third Avenue New York, NY 10017
Tel.:	(800) 342-9816	Member Services (benefit/claim questions)
Tel.:	(800) 982-8089	Medical Management Program (pre-certification for hospital admissions, elective surgery, home care, skilled nursing facilities, second opinion referrals)
Tel.:	(800) 626-3643	Behavioral Health Care Management Program (prior approval of mental health/substance abuse care)
Tel.:	(888) 624-5376	Express Pharmacy Services, Inc. (maintenance drug mail order)
Tel.:	(800) 839-8442	Empire Pharmacy Management Program/MedImpact (prescription card programme and pharmacy network information)
Tel.:	(888) EYE-BLUE {(888) 393-2583)}	Davis Vision (vision care programme)
III. HIP/HMO		HIP Member Services Department 7 West 34th Street New York, NY 10001
Tel:	(800) HIP-TALK ((800) 447-8255)	
IV. CIGNA Dental PPO Plan		CIGNA Healthcare Service Center P.O. Box 182539 Chattanooga, TN 37422-7539
Tel.:	(800) 355-5965 (claim submission and customer service)	
Tel.:	(888) DENTAL8 (for participating provider referrals)	

V. World Access

Tel.: (800) 645-1901 (in the United States, Canada, Puerto Rico and the Virgin Islands)

Tel.: (800) 673-1159 (collect from Alaska, Washington, D.C. and all other locations)

Fax: (804) 673-1179