United Nations ST/IC/2003/31

Secretariat

9 May 2003

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 2003, and annual enrolment campaign, 2-6 June 2003**

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), Empire Blue Cross preferred provider organization (PPO), HIP Health Plan of New York (HIP) and CIGNA dental preferred provider organization (PPO)), which will come into effect on 1 July 2003 (see chart on p. 2, and annexes I-IV);

(b) Modifications in plan benefits are as follows: With effect from 1 July 2003, the following benefit modifications have been made with respect to the Blue Cross PPO plan: (i) **In-patient** and out-patient hospitalization on an out-of-network basis will be reimbursed at 100 per cent when the hospitalization occurs **outside of the United States**; (ii) up to 200 visits per calendar year in respect of home health care shall be reimbursed out-of-network at 100 per cent when such care occurs **outside of the United States**; (iii) up to 120 days per calendar year in respect of admission to a skilled nursing facility shall be reimbursed at 80 per cent out-of-network after satisfaction of the deductible when such care occurs **outside of the United States**; (iv) an annual physical exam will be reimbursed out-of-network at 80 per cent after satisfaction of the deductible; (v) well-child care will be reimbursed on an out-of-network basis at 100 per cent;

(c) World Access, the emergency facility heretofore available to Aetna and Empire Blue Cross subscribers, providing international travellers with 24-hour hotline assistance for obtaining medical care abroad or within the United States (when at least 100 miles from one's normal place of residence), has been replaced by a new company called MEDEX. MEDEX will provide worldwide medical and

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Headquarters medical and dental insurance schedule of monthly premiums[a] and contribution rates[b]
(Effective 1 July 2003)

	Aetna Open Choice		*Empire Blue Cross PPO*		*HIP*		*CIGNA Dental with Medical Plan*		*CIGNA Dental alone*
Type of coverage	*2002 rates*	*2003 rates*	*2002 rates*	*2003 rates*	*2002 rates*	*2003 rates*	*2002 rates*	*2003 rates*	*2003 rates*
Staff member only									
Premium rate ($)	472.71	535.03	272.22	299.38	289.52	317.61	46.23	47.41	47.41
Contribution rate (per cent)	3.70	3.98	2.14	2.23	2.27	2.37	0.33	0.32	0.43
Staff member and one child									
Premium rate ($)	943.24	1 067.67	543.18	597.43	528.65	579.90	92.46	94.83	94.83
Contribution rate (per cent)	6.47	6.95	3.77	3.94	3.47	3.62	0.59	0.58	0.76
Staff member and spouse									
Premium rate ($)	943.24	1 067.67	543.18	597.43	528.65	579.90	92.46	94.83	94.83
Contribution rate (per cent)	6.47	6.95	3.77	3.94	3.47	3.62	0.59	0.58	0.76
Staff member and two or more eligible family members									
Premium rate ($)	1 180.28	1 336.00	788.65	867.45	841.63	923.25	149.30	153.12	153.12
Contribution rate (per cent)	7.21	7.75	4.84	5.05	4.86	5.06	0.90	0.87	1.32

[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 applicable contribution rate (per cent) above.

[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.

dental referrals; monitor treatments; facilitate with hospital payments; transfer insurance information to medical providers; assist with the provision of appropriate medication; coordinate replacement of corrective lenses or medical devices during travel; dispatch doctors/specialists in an emergency where the participant cannot be assessed by telephone; arrange the transfer of medical records upon the participant's consent; provide updates to family, employer and physician; and make hotel arrangements during convalescence. In addition, MEDEX will assist with medical evacuation and repatriation services, provide a range of travel assistance services, as well as personal security services. Details with respect to the services provided by MEDEX can be found in annex V on page 45 to this circular.

2. Annexes I to IX to the present circular set out plan outlines and benefit summaries. They are listed in paragraph 22.

Annual enrolment campaign

3. The annual enrolment campaign at Headquarters will be held from 2 to 6 June 2003 in the Insurance Service of the Accounts Division, OPPBA, room FF-300 (304 East 45th Street, 3rd Floor), between the hours of 10 a.m. and 5 p.m. **Staff members who are currently enrolled in a United Nations health insurance plan do not need to take any action unless they wish to change plans or add eligible dependants. Staff members at Headquarters who wish to enrol, change their current plan or add eligible dependants must come in person to the Insurance Service to complete the application form and other forms as necessary.** The staff of the Insurance Service 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 2 and 3 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 2004 to enrol in the United Nations medical and dental insurance plans, to change to a different plan or to add eligible dependants, aside from the specific circumstances, such as marriage, birth or adoption of a child, regarding which special provisions for enrolment between campaigns are established (see annex VII, paras. 6-8).

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) Empire Blue Cross PPO (p. 11);

(b) Aetna "Open Choice" Plan (p. 22);

(c) HIP Health Plan of New York (HIP) (p. 35);

(d) CIGNA Dental PPO Plan (CIGNA) (p. 40).

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 2003.

7. In prior years, the decision to switch from one health insurance plan to another during the campaign obliged the participant to meet the annual out-of-network

deductible under the new plan regardless of the amount of deductible reached under the old plan. In compliance with a new procedure which commenced on 1 July 2002, staff members who switch coverage between the Aetna and Blue Cross plans and who have met the annual deductible or any portion thereof under either of these plans during the first six months of the year, may be credited with such deductible payment(s) under the new plan for the second six months of the year under certain conditions. The deductible credit will not occur automatically and can be implemented only if the staff member takes the following actions: (a) formally requests the deductible credit on the special form designed for that purpose; and (b) attaches the original explanation of benefit (EOB) statements attesting to the level of deductibles met for the staff member and/or each eligible covered dependant. The deductible credit application form, which will be available at the office of the Insurance Service during the enrolment campaign, must be submitted to the Insurance Service (**not to Aetna or Blue Cross**) together with the relevant EOB statements **no later than 31 August 2003** in order to receive such deductible credit.

Health insurance costs in the United States

8. The key element underlying this year's renewal of the Headquarters health insurance plans is, **once again**, the overall adverse state of the health insurance marketplace in the United States, driven principally by high utilization and significant cost increases. As New York-based United Nations staff members and their dependants incur medical expenses for hospitalization, surgery, office visits and prescription drugs predominantly in the Headquarters area, the level of these expenses is directly dependent on costs in the medical market.

Renewal premiums

9. As a result of the adverse developments in health insurance trends outlined above, the renewal premium rates for the Headquarters medical plans will, once again, increase. The Aetna premium rates will increase by 13.2 per cent, reflecting the underwriting calculation of the premium increase required if the plan is to break even at the end of the forthcoming 12-month policy period. The premium increase required for the Blue Cross plan will be 10.0 per cent, while the overall premium increase under the HIP/HMO plan will be 9.7 per cent. The CIGNA dental plan will increase by 2.56 per cent.

Eligibility and enrolment rules and procedures

10. 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 annex VII to the present circular will remain in effect.

Mailing address

11. **Participants in the health insurance plans administered at Headquarters are required to provide a mailing address in order to implement enrolment in a selected plan or a change in coverage (e.g., adding an eligible dependant).** Current participants in the Headquarters plans and new enrollees alike are advised that the insurance carriers will only recognize mailing address data that are electronically transmitted to them. While the mailing addresses of many staff members already exist in IMIS, it is important that they be updated as necessary. Staff members should, therefore, contact their personnel or executive offices in order to provide or update their mailing address. **It is essential that the address be entered with universally recognized conventions: that is, the state in which one resides must bear the accepted standard abbreviation, e.g. New York, New Jersey, must be designated as NY, NJ respectively, and zip codes must also be part of the address, otherwise the insurance carriers will reject the address data transmission. In this regard, staff members are advised that the Insurance Service cannot act as a forwarder of communications from insurance companies. Therefore, to ensure the receipt of insurance ID cards, reimbursement cheques and explanation of benefits statements, it is essential that staff members provide precise address data to their personnel or executive officers to be entered into the IMIS mailing address field.**

Effective date of health insurance coverage

12. Provided that application is made within the prescribed 31-day time frame, new coverage for a staff member newly enrolled in a health insurance plan commences on the first day of a qualifying contract (minimum of 3 months for medical insurance and 6 months for dental insurance). If a contract terminates before the last day of a month, coverage will remain in place until the end of the month in question.

Movement between organizations at Headquarters and breaks in appointment

13. Under IMIS, insured staff members who transfer between the United Nations, UNDP or UNICEF must be sure to reapply for health insurance coverage after a Personnel Action has been generated by the receiving organization. Such reapplication for health insurance coverage must be made within 31 days of separation from the releasing organization. Strict attention to this requirement is necessary to ensure continuity of health insurance coverage as termination from an organization results in the automatic termination of insurance coverage at the end of the month. Staff members who transfer between organizations should also ensure that the receiving organization establishes the staff member’s household members and mailing address in its IMIS database so that coverage can be reinstated under the receiving organization.

14. **Staff members should also be aware that under IMIS if there is a separation from service, no matter how short (e.g., three days), insurance coverage will be terminated. Therefore, upon reappointment, the staff member will be obliged to reapply at the offices of the Insurance Services in order to reinstate health and life insurance coverage and to be sure that there will be no break in continuity of coverage.**

Cessation of coverage of staff member and/or family members

15. The Insurance Service 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 Service 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 should communicate with the Insurance Service in writing. It is in the interest of staff members to notify the Insurance Service 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 Service.

Insurance enrolment resulting from loss of employment of spouse

16. Heretofore, a staff member whose health insurance coverage was provided by the employer of his or her spouse was ineligible to apply for United Nations health insurance coverage in the event of the loss of employment of the spouse, except on the occasion of the annual enrolment campaign. In line with the practice of employers in the United States, **loss of coverage under a spouse's health insurance plan owing to the spouse's loss of employment beyond his or her control** is considered to constitute a qualifying event for the purpose of enrolment in a United Nations Headquarters plan, provided that the staff member holds a qualifying contract with the United Nations. Application for enrolment in a United Nations plan under these circumstances must be made within 31 days of the qualifying event. In addition, application for coverage under this provision must be accompanied by an official letter from the spouse's employer, certifying the termination of employment and its effective date.

After-service health insurance

17. 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 health insurance scheme is necessary to qualify for unsubsidized after-service health insurance participation and 10 years of prior coverage for subsidized participation. In both cases, the staff member must be 55 years of age or over as of the date of separation. It should also be noted that only family members enrolled with the staff member at the time of separation are eligible for continued coverage under the programme. **Enrolment in the after-service health insurance programme is not automatic. Application for enrolment must be made within 31 days following the date of separation.** 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. A copy of this administrative instruction is provided for your reference in annex VIII (p. 56).

Conversion privilege

18. 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. **The conversion privilege must be exercised within 31 days of the date of separation.** Details concerning conversion to individual policies under Aetna and Empire Blue Cross may be obtained from the Insurance Service, room FF-300. Details concerning conversion to individual policies under the HIP Health Plan of New York should be obtained from HIP directly. **The CIGNA dental plan does not have a conversion option.**

Claims and benefit inquiries and disputes

19. Although the staff of the Insurance Service 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 IX to the present circular.

20. 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. Care has been taken to ensure that the plan summaries are as comprehensive as possible. A more detailed description of the benefits of each plan, including certain exclusions and limitations, is set out in a Summary Plan Description (SPD) booklet. Updated SPDs are in preparation for each carrier and will be distributed when available. **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.**

Headquarters health insurance plans: outlines and summaries of benefits

How plans are costed

21. The United Nations policies with Aetna, Empire Blue Cross and CIGNA are “experience-rated”. This means that the premium cost each year of the Aetna, Empire 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 the participants in these schemes and the Organization. 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 HIP plan 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.

Plan outlines and benefit summaries

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

23. In addition, information regarding MEDEX, emergency facility for Aetna and Empire Blue Cross subscribers, participating Aetna and Empire Blue Cross pharmacies as well as insurance carrier addresses and telephone numbers are set out in the following annexes:

United Nations Insurance Internet web site

24. The United Nations Insurance Service has implemented an Internet web site which is as follows: www.un.org/insurance. Within this web site, you will be able to access information regarding the United Nations administered plans, retrieve forms and, through computer links, find health-care professionals participating in the various programmes. The site is most intuitive and you should not find any problem in navigating within it.

25. As printed provider directories rapidly become outdated, and as there is limited space to store them, online provider directories should be used to search for health-care providers, physicians, participating hospitals, pharmacies, medical equipment suppliers and dentists. Please refer to the chart on pages 9 and 10, which provides the Internet address for each carrier as well as related instructions. Subscribers may search by location and/or by name.

Finding PPO providers through the United Nations Intranet "Insurance" web site

26. As an alternative to searching for providers directly on the Internet, participants may also initiate a search from the United Nations Intranet web site of the Insurance Service. 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 Service home page. Then follow the instructions set out on pages 9 and 10 of the present circular.

Provider Internet web sites

Online provider directories	Instructions
AETNA www.aetna.com/docfind/index.html	1. Select a search category, such as "Physicians and Other Health Care Professionals" or "Vision One Providers". 2. Select "Open Choice PPO" from the Health Plan menu. 3. Enter the "Geographical Information" and "Search Criteria" to be used. 4. Click on the "Continue" button to see the list of providers. If there are matches for the criteria you selected, you will be presented with a summary list of results.
EMPIRE BLUE CROSS www.empireblue.com	1. Click on "Find a Doctor or Specialist" at the top of the menu in the upper right hand corner of the home page. 2. The screen displayed allows you to select the following options: "New York Provider Search", "Nationwide Provider Search" and "Find A Laboratory". 3. Follow the prompts depending on your selection.
HIP Health Plan of New York www.hipusa.com	1. Click on "provider search" at top right. 2. Select "Plan" type (HIP PRIME) and select continue. 3. Members can search in three ways: a. QUICK: search by using physician name; b. PROXIMITY: search by zip code; c. COMPREHENSIVE: search by language, specialty, county, zip code and/or board certified.

Online provider directories	Instructions
CIGNA www.cigna.com/providerdirectory	1. Select “Dentist” on the “Select the type of provider” search. 2. Select “Search by name”, and “Enter zip code OR city and state” if you already know the name of the dentist. 3. If you are searching for the name of a new dentist, select “Enter zip code OR city and state” and select the distance you are willing to travel. 4. Click on “Continue” button. 5. Select “Managed care plan with open access to dentists CIGNA Dental PPO”. 6. Select “Specialty” on drop-down menu (i.e., Endodontics, General Dentistry, etc.). 7. Select “Language spoken” preference. 8. Click on “Continue” button to view search results.

Annex I

Empire Blue Cross PPO

Plan outline

The Empire Blue Cross 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 Blue Cross PPO plan and accept as payment a fee schedule arranged with Empire 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 and subject to the providers' fees falling within reasonable and customary norms.** 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 Blue Cross PPO 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

Effective 1 July 2003, premiums for the Blue Cross plan will increase by 10.0 per cent. The premiums and related percentages of salary contribution are shown on page 2 of the present circular.

Benefits

The package of benefits under the Empire Blue Cross PPO plan is itemized in the plan summary (pp. 14-17). Effective 1 July 2003, the following benefit changes will come into effect:

In-patient and out-patient hospitalization. Currently, the plan provides 100 per cent reimbursement for in-network hospital benefits. Out-of-network hospital benefits are subject to the deductible and 20 per cent co-insurance. Effective 1 July 2003, the plan will reimburse at 100 per cent on an out-of-network basis both for in-patient and out-patient hospitalization which **occurs outside of the United States**.

Home health care. The current home health care benefit reimburses at 100 per cent up to 200 visits per calendar year on an in-network basis. On an out-of-network basis, the plan reimburses up to the same number of visits annually after application of the 20 per cent co-insurance (deductible does not apply). Commencing 1 July 2003, on an out-of-network basis, the plan will reimburse 100 per cent for up to 200 visits per calendar year when they are incurred **outside of the United States**.

Skilled nursing facility. On an in-network basis, the plan reimburses 100 per cent for up to 120 days annually in a skilled nursing facility. To date, there has been no out-of-network benefit, i.e. only in-network benefits have been available. Commencing 1 July 2003, the plan will, on an out-of-network basis, reimburse up to 120 days per calendar year in a skilled nursing facility after application of the deductible and 20 per cent co-insurance when incurred **outside of the United States**.

Annual physical exam. The current benefit for an annual physical exam is provided for on an in-network basis only and is reimbursed at 100 per cent after payment of a $10 co-pay. Commencing 1 July 2003, an out-of-network benefit will be available in respect of an annual physical exam upon satisfaction of the deductible and 20 per cent co-insurance. Whether on an in-network or out-of-network basis, the benefit provides for one annual physical exam.

Well-child care. The current benefit for well-child care provides for 100 per cent reimbursement in-network, while out-of-network, the benefit is subject to the deductible and 20 per cent co-insurance. Commencing 1 July 2003, the out-of-network benefit will reimburse well-child care at 100 per cent.

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 receiving air ambulance service;

– 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 Empire 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 Blue Cross PPO plan, provide no coverage for custodial care.

Worldwide participating Blue Cross hospitals

Subscribers to Empire Blue Cross health insurance plans have the benefit of a network of hospitals worldwide which accept the Empire Blue Cross ID card and which bill Empire Blue Cross directly for any medical services rendered. A list of these hospitals may be obtained by going to the following Internet site: www.bcbs.com/healthtravel/worldwide.html. Upon accessing Blue Cross worldwide hospitals, you will obtain instructions regarding how to proceed when you need health care outside of the United States, in addition to being able to view a list of Blue Cross worldwide hospitals.

EMPIRE BLUE CROSS PPO BENEFITS SUMMARY		
BENEFITS	**IN-NETWORK**[a]	**OUT-OF-NETWORK**
ANNUAL DEDUCTIBLE	$0	$150 Individual $450 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 benefits	
DEPENDENT CHILDREN	Covered to end of calendar year in which child reaches age 25	
HOSPITAL BENEFITS		
In-patient[b] **(except behavioural health)** - Unlimited days – semiprivate room & board - Hospital-provided services - Routine nursery care	$0	Deductible and 20% co-insurance within the United States $0 outside the United States
Out-patient - 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 within the United States $0 outside the United States
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)
OTHER FACILITY BENEFITS		
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) within the United States - $0 outside the United States - Covered in-network only
Out-patient Kidney Dialysis Home, hospital based or free-standing facility treatment	$0	Deductible and 20% co-insurance

BENEFITS	IN-NETWORK	OUT-OF-NETWORK
Skilled Nursing Facility[b] Up to 120 days per calendar year	$0	In-network only within the United States Deductible and 20% co-insurance outside the United States
Hospice[b] Up to 210 days per lifetime	$0	In-network only
Physical Therapy[b] Up to 60 in-patient days per calendar year	$0	Deductible and 20% co-insurance
PREVENTIVE CARE BENEFITS		
Annual Physical Exam	$10 co-payment	Deductible and 20% co-insurance
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	$0
MEDICAL BENEFITS		
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
Anaesthesia[f]	$0	Deductible and 20% co-insurance
In-patient 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 out-patient or physician's office	$0	Deductible and 20% co-insurance

BENEFITS	IN-NETWORK	OUT-OF-NETWORK
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]
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		
Physical Therapy[b] - 60 in-patient visits, and - 60 visits combined in home, office or out-patient facility	$0 $10 co-payment	Deductible and 20% co-insurance In-network only
Occupational, Speech, Vision[b] 30 visits combined in home, office or out-patient facility	$10 co-payment	In-network only
BEHAVIOURAL HEALTH CARE BENEFITS		
Mental Health Care[d,,j] - Up to 90 in-patient days per calendar year - Up to 60 out-patient visits in office or facility - Up to 90 professional visits per calendar year while in an in-patient facility	$0 $25 co-payment per visit $0	Deductible and 20% co-insurance
Out-patient Alcohol and Substance Abuse[d,,j] Up to 60 out-patient visits which include 20 family counselling visits per calendar year	$0	Deductible and 20% co-insurance
In-patient Alcohol and Substance Abuse[d,,j] Up to 7 days detoxification and 30 days rehabilitation per calendar year	$0	Deductible and 20% co-insurance
OTHER BENEFITS		
Acupuncture	$10 co-payment	Deductible and 20% co-insurance
Chiropractic Care	$10 co-payment $1,000 annual limit	Deductible and 20% co-insurance $1,000 annual limit
Hearing Exam (every 3 years) **Hearing Appliance**	$10 co-payment Not covered	Deductible and 20% co-insurance Not covered

BENEFITS	IN-NETWORK	OUT-OF-NETWORK
Ambulance	$0 up to the allowed amount	
Prescription Drugs (Card and Mail Order Programme)	- 15% co-payment up to a maximum of $15 per prescription - $10 co-payment for mail order	*Within US:* 40% co-insurance after deductible *Outside US:* 20% co-insurance after deductible (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 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 Blue Cross BlueShield Plan through the BlueCard Program, or a participating provider with another Blue Cross 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 anaesthesiologist 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 the Medical Management Program.
[h] If arranged through the 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 and substance abuse visits must be pre-certified. In-network mental health services are those from providers that participate with Magellan Behavioral Health.

Discount prescription drug programme (Empire Pharmacy Management)

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

Significant cost savings are being passed on to participants by utilizing either a participating pharmacy or the 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 AdvanceRX 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 Blue Cross PPO card** (please refer to 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 AdvanceRX mail order facility, which will charge a fixed $10 co-payment per prescription. The AdvanceRX claim form supplied with the Empire Blue Cross PPO 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:

AdvanceRX
P.O. Box 961066
Fort Worth, TX 76161-0066

Tel. No. (888) 266-5691

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 AdvanceRX 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 prescription drug programme is administered separately by Empire Pharmacy Management, the annual deductible under the Empire Blue Cross PPO 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 AdvanceRX 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 Service, room FF-300. **Claims submitted to the prescription drug 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

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 Empire Blue Cross PPO 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, **or visit their web site at www.davisvision.com**.

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.

Laser vision correction: Though not a new benefit, participants should be aware that discounts are now available for laser vision correction from Davis Vision. To receive information regarding the laser vision correction savings, go to www.davisvision.com on the Internet and click on “laser vision correction” and proceed to “laser vision correction programme”, which will require your Blue Cross member ID number (the number on your Blue Cross card) or login name and password. If you have not yet established a login name and password, go to www.empireblue.com and register by entering “member” in the “I am a:” drop-down menu and clicking on the “register” button (see also paragraph on Empire’s Internet site as set out below). For more information on the laser vision correction programme, contact Davis Vision at 1-(877)-92DAVIS.

Exclusions and other provisions

Certain expenses are not covered under the Empire Blue Cross PPO plan. These comprise expenses for services or supplies not deemed by Empire 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 Empire Blue Cross as reimbursable under the plan, Empire Blue Cross should be contacted at (800) 342-9816 prior to commencement of treatment. In addition, the Empire Blue Cross policy contract document is on file in the offices

of the Insurance Service and may be consulted and photocopied, as necessary. An appointment should be made for this purpose.

Recourse if a claim is denied

If Empire Blue Cross denies a claim in whole or in part, the subscriber has the right to appeal the decision. Empire 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. Empire Blue Cross will send a written decision with an explanation within 60 days of receiving the appeal. If special circumstances require more time, Empire 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 Blue Shield
PPO Member Services
P.O. Box 1407
Church Street Station
New York, NY 10008-1407

Time limit for filing a claim

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

Empire's Internet site

Subscribers in the Empire Blue Cross PPO plan are encouraged to activate an account on Empire Blue Cross' web site which permits participants to more effectively manage their coverage. The site is called **Empireblue.com** and can be accessed directly at www.empireblue.com.

Empireblue.com allows you to access the following services 24 hours a day, 7 days a week:

- Check and resolve claims
- Change your phone number
- Request ID cards
- Research and choose doctors
- Print an explanation of benefits
- Update your address*

* If you update your address on the Empire Blue Cross site, please also update your **mailing** address change in IMIS with your Executive Office so that the change becomes permanent in both systems.

To register on the Empire Blue Cross site:

- Click on "Register" in the Member Services window
- Enter your name, member ID number and date of birth
- Create your own personal password and login ID
- Request, and then enter your personal activation key

If you have any problems registering, please call Empire Blue Cross at 1-877-603-0923. Each member of your household over the age of 18 must register separately, and members under 18 can access their information through their parents' or guardians' personal home page.

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 and subject to the providers’ fees falling within reasonable and customary norms**. 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 24.

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

Effective 1 July 2003, premiums for the Aetna plan will increase by 13.2 per cent. The premiums and related percentages of salary contribution are shown on page 2 of the present circular.

Benefits

The package of benefits under the Aetna “Open Choice” plan is itemized in the plan summary (pp. 24-27).

Participants are reminded of the following particular provisions in the plan:

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 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 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 that (a) 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.

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 OPEN CHOICE SUMMARY OF BENEFITS		
BENEFITS	**IN-NETWORK**	**OUT-OF-NETWORK**
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 towards 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	100% Up to 365 days per year for restorative care as determined by medical necessity.	
Private Duty Nursing (in-home only)	100% subject to a $5,000 maximum per year and $10,000 lifetime Must be determined to be medically necessary and supported by a doctor's prescription/medical report. Pre-certification is strongly recommended.	
Home Health Care Up to 200 visits per year	100% Must be determined to be medically necessary and supported by a doctor's prescription/medical report. Pre-certification is strongly recommended.	

BENEFITS	IN-NETWORK	OUT-OF-NETWORK
Hospice (210 days) Plus 5 days bereavement counselling	100%	
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
Anaesthesia	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
Family Planning - Office visits including tests and counselling - Surgical sterilization procedures for vasectomy/tubal ligation (excludes reversals)	100% after $10 co-pay 100%	80% after deductible 80% (deductible waived)

BENEFITS	IN-NETWORK	OUT-OF-NETWORK
Infertility Treatment - Office visits including testing and counselling - 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	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
PRESCRIPTION DRUG BENEFITS		
Retail Programme (1-888-792-8742) **(30-day supply)**	15% co-pay up to a maximum of $15 per prescription	*Within US:* 60% after deductible *Outside US:* 80% after deductible The co-payment will not count towards $1,000/$3,000 out-of-pocket limit
Mail Order Programme (1-866-612-3862) **(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.		

BENEFITS	IN-NETWORK	OUT-OF-NETWORK
VISION AND HEARING CARE		
Eye Exam (once every 12 months)	100% after $10 co-pay	80% after deductible
Optical Lenses (including contact lenses once every 12 months)	80%, deductible does not apply; $100 maximum for any two lenses and frames purchased in a 12-month period	
Vision One Programme (1-800-793-8616) **Discount information for laser surgery (1-800-422-6600)**	Save up to 65% on frames, up to 50% on lenses, and about 20% on contact lenses at participating Cole Vision Centers. Discounts available for laser surgery.	
Hearing Exam Evaluation and Audiometric exam	100% after $10 co-pay (one exam every three years; exam must be performed by otolaryngologist or state certified audiologist)	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%, deductible does 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, Diagnostic 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]*	
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	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	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 12 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 www.aetna.com/docfind/index.html and click on “Vision One Providers”. 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.

Vision One Lasik (laser vision corrective procedure discount programme)

1. A 15 per cent discount off the vision provider's usual retail charge for Lasik surgery is offered by Cole/LCA — Vision LLC through the national Lasik network of LCA Vision. Included in the discounted services are patient education, an initial screening, the Lasik procedure and follow-up care. Members not found to be suitable candidates for this procedure will not be charged for the initial consultation.

2. There are currently 100 providers in 59 designated market areas in 32 states. To find the closest surgeon, participants may call 1-(800)-422-6600 to speak with a customer service representative. Contact is made with a provider for an initial screening, at which time, the participant presents the Aetna ID card. If Lasik surgery is scheduled, the Lasik Customer Service office needs to be called (at the above number) with the date of the surgery in order to arrange to pay a deposit. An authorization number is provided by Lasik Customer Service in order to receive the discount. The surgeon will also receive written confirmation verifying the discount and the amount of deposit. At the time of treatment, the discount and deposit will be deducted from the surgeon's fee.

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. 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 (behavioural health)

A. In-patient benefits

All hospitalization for mental and nervous and substance abuse conditions (behavioural health) 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 an employee of the Aetna FPR team. The telephone call may be placed by the subscriber, 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 (behavioural health)

The full cost (semi-private accommodation) of 30 days of hospitalization for the treatment of mental and nervous disorders (behavioural health). 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 (behavioural health)

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)

Aetna has replaced Express Scripts Inc. (ESI) with its own mail-order company, Aetna Rx Home Delivery. To request a new mail order prescription, utilize the Aetna Rx Home Delivery form available on the United Nations or Aetna Internet web sites, or from the Insurance Service Office, room FF-300. Please complete the new form, including the confidential Patient Profile section, and mail the order form with your original written prescription from your physician, as well as your co-payment to Aetna Rx Home Delivery, P.O. Box 417019, Kansas City, MO 64179-9892. If you are requesting the refill of a mail order prescription, please call the Aetna Rx Home Delivery toll-free number, (866) 612-3862, and give the refill prescription number to the customer service representative. Once you have initiated your first refill by calling this toll-free number, you may continue to call the toll-free customer service number to request subsequent refill, or you may reorder through the Aetna Rx Home Delivery web site at www. aetnarxhomedelivery.com. You may also link to Aetna Rx Home Delivery through Aetna's web site at www.aetna.com. Prescriptions for maintenance drugs may provide for up to a 90-day supply and are most economically filled through Aetna Rx Home Delivery which will charge a fixed $10 co-payment.

The Aetna Pharmacy Management (APM) prescription drug programme, along with its mail order service, Aetna Rx Home Delivery, reimburses, at significant savings, the cost of prescription drugs obtained from participating pharmacies.

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 Aetna Rx Home Delivery 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** (please refer to 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 Aetna Rx Home Delivery mail order facility even though it has not been specifically prescribed, Aetna Rx Home Delivery 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 Service and may be consulted and photocopied, as necessary. An appointment should be made for this purpose.

Aetna claims

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

Aetna Inc.
P.O. Box 981106
El Paso, TX 79998-1106

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.**

Aetna's Navigator™ Internet site

Subscribers in the Aetna plan are encouraged to activate an account on Aetna's Navigator™ web site which permits participants to more effectively manage their coverage. The site can be accessed through a link at Aetna's web site at www.aetna.com, or directly at www.aetnanavigator.com/.

Aetna's Navigator™ is a self-service web site packed with valuable health and benefits information. Subscribers can:

- Review who is covered under their plan
- Check claim status and review Explanation of Benefits (EOB) statements
- Locate doctors and hospitals using Aetna Docfind
- Request ID cards
- Contact Aetna member services

To register, go to www.aetna.com and click on Aetna Navigator™ in the "Quick Tools" drop down box, or access Aetna Navigator™ directly at www.aetnanavigator.com/. Members can follow easy instructions for registering to use personal tools. Members and non-members can "point and click" on Docfind to search for doctors and other health-care providers.

Annex III

HIP Health Plan of New York (HIP)

Plan outline

The HIP 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. 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 participating pharmacies and are prescribed by HIP physicians or any physician in a covered emergency. HIP participants may select a physician at a HIP medical centre or from a listing of 19,000 affiliated physicians for primary care services. The affiliated physician is visited in his or her private office. If you require specialty care, your primary care physician will refer you to a HIP specialist with a referral form. To select an affiliated physician, the HIP participant should call HIP at (800) HIP-TALK, go to the web site at www.HIPUSA.com or call the physician you wish to visit. The web site is available in Spanish, Chinese and Russian. Any language may also be accessed through (800) HIP-TALK. Additional information regarding HIP providers will be provided to participants during the annual enrolment campaign and also mailed by HIP to all participants upon request.

Premium

The premiums and related percentages of salary contribution are shown on page 2 of the present circular.

Benefits

Benefits under the HIP plan will remain unchanged in the renewal period. The package of benefits under the HIP plan is itemized in the plan summary (pp. 37-39).

Worldwide emergency care

Participants are covered 100% for emergency treatment anywhere in the world. The member needs to call his primary care physician. In some cases air transport would also be covered to return to New York.

Discount prescription drug programme

Prescriptions for maintenance drugs are $2.50 per month through the Express Scripts Mail Order Service. Up to a 90-day supply can be requested. Once you have an account at Express Scripts, your physician may call to re-order or place another maintenance prescription order. The address and telephone number is:

Express Scripts
3684 Marshall Avenue
Bensalem, PA 19020

Telephone: 800-224-5502

Vision care

Participants are covered 100% for a routine annual eye examination at affiliated optometrists. Prescription lenses and frames from a select group cost $45 and are available every 24 months. Participants are not required to purchase the eyewear from the same provider rendering the eye examination. Lasik surgery discounts are available through Davis Vision.

Dental

Participants are able to have cleanings every six months for a $10 co-payment. Children additionally may receive fluoride treatment for a $10 co-payment. All other services are covered based on a discounted fee schedule. The fee schedule is available with new member information or by consulting the HIPUSA.com web site.

HIP's Internet site

Subscribers in the HIP plan are encouraged to activate an account on the HIP web site which permits participants to more effectively manage their coverage. The site is: www.HIPUSA.com. Participants can access their benefits and perform the following tasks:

- Request an ID card
- Change primary care physician
- Change phone number and address
- Research physicians
- View alternative medicine providers
- View and print the drug formulary

HIP HEALTH PLAN	
BENEFITS	**CO-PAYMENT**
HOSPITAL BENEFITS	
In-patient (except behavioural health) - Unlimited days – semiprivate room & board - Hospital-provided services - Routine nursing care	$0
Out-patient - Surgery and ambulatory surgery - Pre-surgical testing (performed within 7 days of scheduled surgery) - Chemotherapy & radiation therapy - Mammography screening and cervical cancer screening	$0
Emergency Room/Facility (initial visit) - Accidental injury - Sudden and serious medical condition	$0
Ambulance	$0
OTHER FACILITY BENEFITS	
Home Health Care - Up to 200 visits per calendar year - Home Infusion Therapy	 $0 $0
Out-patient Kidney Dialysis Home, hospital based or free-standing facility treatment	$0
Skilled Nursing Facility Up to 120 days per calendar year	$0
Hospice Up to 210 days per lifetime	$0
Physical Therapy Up to 60 in-patient days per calendar year	$0
PREVENTIVE CARE BENEFITS	
Annual Physical Exam	$0
Diagnostic Screening Test	$0
Prostrate Specific Antigen (PSA) Test	$0
Well-woman Care (no referral needed)	$0
Mammography Screening	$0

Well-child Care (including recommended immunizations) - 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
MEDICAL BENEFITS	
Office or Home Visits/Office Consultations	$0
Surgery	$0
Surgical Assistant	$0
Anaesthesia	$0
In-patient Visits/Consultations	$0
Maternity Care	$0
Artificial Insemination Procedures	$0
Diagnostic X-Rays	$0
Lab Tests	$0
MRIs	$0
Cardiac Rehabilitation	$0
Second Surgical Opinion	$0
Second Medical Opinion for Cancer Diagnosis	$0
Allergy Testing and Allergy Treatment	Included in the office visit co-pay if applicable
Prosthetic, Orthotic and Durable Medical Equipment	$0
Medical Supplies	$0
THERAPY BENEFITS	
Physical Therapy - 90 in-patient visits, and - 90 visits combined	 $0 $0
Occupational Speech, Vision 30 visits combined	$0
BEHAVIORAL HEALTH BENEFITS	
Mental Health Care - Up to 90 in-patient days per calendar year - Up to 60 out-patient visits in office or facility	 $0 $0
Out-patient Alcohol and Substance Abuse Up to 60 out-patient visits which include 20 family counselling visits per calendar year	$0

In-patient Alcohol and Substance Abuse Up to 7 days detoxification and 30 days rehabilitation per calendar year	$0
ALTERNATIVE BENEFITS	
Acupuncture/Yoga/Massage	Discounted rates
Chiropractic Care (no referral needed)	$0
PRESCRIPTIONS	
Prescription Drugs — Pharmacy	$5 for generic/brand per 30-day supply
Prescription Drugs — Mail Order Programme	$2.50 for generic/brand per 30-day supply
Vision Care Programme Through a designated group of providers	$0 for 1 exam every 24 months $45 for frames and lenses from a select group

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

Effective 1 July 2003, premiums for the CIGNA plan will increase by 2.56 per cent. The premiums and related percentages of salary contribution for the CIGNA plan are shown on page 2 of the present circular.

Benefits
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 53,000 dentists, with approximately 18,000 in New York State (9,000 in New York City), 9,000 in New Jersey and 3,500 in Connecticut.

Participants who choose Option A may also visit non-participating (or out-of-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 out-of-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 43.

Option B

The key feature of Option B is the reimbursement allowance formula for participants who wish to utilize out-of-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 44.

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 Service 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 Service on the United Nations Intranet. In addition, the CIGNA dental provider directory can be accessed directly from the CIGNA Internet web site at: www.cigna.com/providerdirectory.

Benefit summaries

The benefit summaries on pages 43 and 44 highlight the many benefits which are available under the CIGNA Dental PPO 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 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 2003-30 June 2004 (Class I, II and III expenses)	$2,000		$2,000	
Plan Year Deductible – 1 July 2003-30 June 2004	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 Lifetime Maximum (in addition to the Class I, II and III maximum)	100% $2,000 Dependent children up to age 19[d]	No Charge	100% of in-network contracted fee $2,000 Dependent children up to age 19[d]	Remainder of dentist's fee

[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] The orthodontia benefit ends on the dependent child's 19th birthday.

OPTION B

CIGNA DENTAL PPO SUMMARY OF BENEFITS

BENEFITS[a]	IN-NETWORK[b]		OUT-OF-NETWORK[b]	
Plan Year Maximum – 1 July 2003-30 June 2004 (Class I, II and III expenses)	$2,000		$2,000	
Plan Year Deductible – 1 July 2003-30 June 2004				
Individual	None		$50 per person	
Family	None		$150 per family	
Reimbursement Levels	Based on reduced contracted fees		Based on Reasonable and Customary Allowances	
	Plan Pays	***You Pay***	***Plan Pays***	***You Pay***
Class I – Preventive & Diagnostic Care	100%	No Charge	90%	10%
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				
Class II – Basic Restorative Care[c]	90%	10%	80%[d]	20%[d]
Fillings Root Canal therapy Osseous Surgery Periodontal Scaling and Root Planing Denture Adjustments and Repairs Extractions Oral Surgery				
Class III – Major Restorative Care[c]	90%	10%	80%[d]	20%[d]
Crowns Dentures Bridges				
Class IV – Orthodontia	80%	20%	70%[d]	30%[d]
Lifetime Maximum (in addition to the Class I, II and III maximum)	$2,000 Dependent children up to age 19[e]		$2,000 Dependent children up to age 19[e]	

[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.

[e] The orthodontia benefit ends on the dependent child's 19th birthday.

Annex V

MEDEX Assistance Corporation

MEDEX Assistance Corporation (MEDEX) replaces World Access and is a facility available to Aetna and Empire Blue Cross subscribers. The $0.205 per month per subscriber cost is built into the premium schedule for Aetna and Empire Blue Cross as set out on page 2 of the present circular.

MEDEX is a programme providing emergency medical assistance — including emergency evacuation and repatriation — and other travel assistance services when 100 or more miles from home. Below is a summary of the services provided.

Medical Assistance Services

Worldwide medical and dental referrals are provided to help the participant locate appropriate treatment or care.

Monitoring of treatment: MEDEX Assistance Coordinators will continually monitor the participant's case and its Regional Medical Advisors will provide the participant with consultative and advisory services, including the review and analysis of the quality of medical care being received.

Facilitation of hospital payment: Upon securing payment or a guarantee to reimburse, MEDEX will either wire funds or guarantee the required emergency hospital admittance deposits.

Transfer of insurance information to medical providers: MEDEX will assist the participant with hospital admission, such as relaying insurance benefit information, to help prevent delays or denials of medical care. MEDEX will also assist with discharge planning.

Medication, vaccine and blood transfers: In the event medication, vaccine or blood products are not available locally, or a prescription medication is lost or stolen, MEDEX will coordinate their transfer to the participant upon the prescribing physician's authorization, if it is legally permissible.

Replacement of corrective lenses and medical devices: MEDEX will coordinate the replacement of corrective lenses or medical devices if they are lost, stolen, or broken during travel.

Dispatch of doctors/specialists: In an emergency where the participant cannot adequately be assessed by telephone for possible evacuation, or cannot be moved, and local treatment is unavailable, MEDEX will send an appropriate medical practitioner to the participant.

Medical records transfer: Upon the participant's consent, MEDEX will assist with the transfer of medical information and records to the participant or to the treating physician.

Continuous updates to family, employer, and physician: With the participant's approval, MEDEX will provide case updates to appropriate individuals designated in order to keep family, employer and physicians informed.

Hotel arrangements for convalescence: MEDEX will assist with the arrangement of hotel stays and room requirements before and after hospitalization.

Medical Evacuation and Repatriation Services

Emergency medical evacuation: If the participant sustains an injury or suffers a sudden and unexpected illness and adequate medical treatment is not available locally, MEDEX will arrange for a medically supervised evacuation to the nearest medical facility. The participant's medical condition and situation must be such that, in the professional opinion of the health-care provider and MEDEX, the participant requires immediate emergency medical treatment, without which there would be a significant risk of death or serious impairment. **Please note that the cost of the evacuation is not covered by MEDEX, only the arrangements.**

Transportation to join a hospitalized member: If the participant is travelling alone and is or will be hospitalized for more than seven days, MEDEX will coordinate economy round-trip airfare for a person of the participant's choice to join the participant.

Return of dependent children: If the participant's dependent child(ren) age 18 or under are present but left unattended as a result of the participant's injury or illness, MEDEX will coordinate for one-way economy airfare to send them back to the participant's home country. MEDEX will also arrange for the services and transportation expenses of the participant's qualified escort, if required.

Transportation after stabilization: Following emergency medical evacuation and stabilization, MEDEX will coordinate for one-way economy airfare to the participant's point of origin. If following stabilization MEDEX determines that hospitalization or rehabilitation should occur in the participant's home country, MEDEX will alternatively coordinate for the participant's transportation there.

Repatriation of mortal remains: MEDEX will assist in obtaining the necessary clearances for the participant's cremation or the return of the participant's remains. MEDEX will coordinate the expenses for preparation and transportation of the participant's mortal remains to the participant's home country.

THE FOLLOWING SERVICES DO NOT FALL WITHIN THE PURVIEW OF HEALTH INSURANCE, BUT ARE, NEVERTHELESS, INCLUDED IN THE MONTHLY FEE PAID BY PARTICIPANTS IN THE AETNA AND BLUE CROSS PLANS:

Travel Assistance Services

Pre-travel information: Upon request, MEDEX can provide continuously updated destination intelligence for more than 180 countries covering ten subject areas: security, health, transportation, entry/exit, finance, culture, language, communication, legal and weather/environment.

Emergency travel arrangements: MEDEX will make new reservations for airlines, hotels, and other travel services in the event of an illness or injury.

Transfer of funds: MEDEX will provide an emergency cash advance subject to MEDEX first securing funds from the participant or participants.

Replacement of lost or stolen travel documents: MEDEX will assist in taking the necessary steps to replace passports, tickets, and other important travel documents.

Legal referrals: Should legal assistance be required, MEDEX will direct the participant to an attorney and assist in securing a bail bond.

Translation services: MEDEX's multilingual Assistance Coordinators are available to provide immediate verbal translation assistance in a variety of languages in an emergency; otherwise MEDEX will provide referrals to local interpreter services.

Message transmittals: The participant may send and receive emergency messages toll-free, 24 hours a day, through MEDEX Assistance Centers.

Emergency pet housing and/or pet return: MEDEX will coordinate arrangements for temporary boarding or the return of a pet left unattended as a result of the participant's injury or illness.

Personal Security Services

Real-time security intelligence: In the event threat is felt by political unrest, social instability, weather conditions, or health or environmental hazards, MEDEX will provide the latest authoritative information and guidance for over 180 countries and select cities. MEDEX's global intelligence database is continuously updated and includes destination intelligence from over 5,000 worldwide sources.

Security evacuation services: In the event of a threatening situation, MEDEX will assist in making evacuation arrangements, including flight arrangements, securing visas, and logistical arrangements such as ground transportation and housing. In more complex situations, MEDEX will assist in making arrangements with providers of specialized security services.

Conditions and Limitations

The services described above are available to the participant only during the participant's enrolment period and only when the participant is 100 or more miles away from his/her residence.

HOW TO ACCESS MEDEX ACCESS SERVICES 24 HOURS A DAY, 7 DAYS A WEEK, 365 DAYS A YEAR

If participants have a medical problem, call the toll-free number of the country you are in (see list below), or call collect one of the following two Assistance Coordination Centers at:

Baltimore, Maryland — 410-453-6330
Brighton, England — 44-1273-223000
Internet: www.medexassist.com
E-mail: info@medexassist.com

A multilingual assistance coordinator will ask for your name, your company or group name, the group number (7173 for United Nations), and a description of your situation.

If the condition is an emergency, go immediately to the nearest physician or hospital without delay and then contact one of the above Assistance Coordination Centers. It will then take the appropriate action to provide assistance and monitor care.

INTERNATIONAL TOLL-FREE TELEPHONE ACCESS NUMBERS

Listed below are the telephone numbers for the worldwide MEDEX Assistance network. If you have a medical or travel problem, call MEDEX. Call the toll-free number for the country you are in if one is available. If you are in a country that is not listed or if the call will not go through, please call the Brighton, England or Baltimore, Maryland coordination centers *collect*. Be prepared to give MEDEX your name, identification number, organization's name, and a brief description of your problem.

Australia and Tasmania	1-800-127-907
Austria	0-800-29-5810
Belgium	0800-1-7759
Brazil	000-811-471-0551
China	10811-800-527-0218
Egypt* (inside Cairo)	**510-0200-1-877-569-4151**
Egypt* (outside of Cairo)	02-510-0200-1-877-569-4151
Finland	0800-114402
France and Monaco	**0800-90-8505**
Germany	0800 1 811401
Greece	00-800-4412-8821
Hong Kong	800-96-4421
Indonesia	001-803-1471-0621
Israel	1-800-941-0172
Italy, Vatican City and San Marino	800-877-204
Japan	00531-11-4065
Mexico	001-800-101-0061
Netherlands	0800-022-8662
New Zealand	0800-44-4053
Philippines	1-800-1-111-0503
Portugal	800-84-4266
Republic of Ireland (Eire)	1-800-409-529
Republic of South Africa	0800-9-92379
Singapore	800-1100-452
South Korea	00798-1-1-004-7101
Spain and Majorca	900-98-4467
Switzerland and Liechtenstein	0800-55-6029
Thailand	001-800-11-471-0661
Turkey	00-800-4491-4834
UK & N. Ireland, Isle of Jersey and Isle of Man	0800-252-074
United States, Canada, Puerto Rico, US Virgin Islands, Bermuda	1-800-527-0218

NOTES:

When a toll-free number is not available, travellers are encouraged to call MEDEX collect. The toll-free numbers listed are only available when physically calling from within the country.

The toll-free ISRAEL line is not available from payphones and there is a local access charge.

The toll-free ITALY, VATICAN CITY and SAN MARINO number has a local charge for access.

The toll-free JAPAN line is only available from touchtone phones (including payphones) equipped for international dialling.

If calling from MEXICO on a payphone, the payphone must be a La Datel payphone.

International callers who are unable to place toll-free calls to MEDEX:

Many telephone service providers, such as cell phone, payphone and other commercial phone venues, charge for, or outright bar, toll-free calls on their networks. These callers should be instructed to try calling collect. If that is not an option, they will need to dial the MEDEX number directly and provide a number to which MEDEX may immediately call back.

Annex VI

Aetna, Empire Blue Cross and HIP Plans: participating pharmacies

Aetna

The most up-to-date information regarding participating Aetna pharmacies is obtained through the Internet. Set out below is Aetna's Internet web site. In addition, if a participating pharmacy is needed while travelling, referral information is available from Aetna by calling 888-792-8742 toll-free.

www.aetna.com/docfind/index.html

Empire Blue Cross

Empire's partnership with AdvanceRX includes more than 57,000 participating pharmacies nationwide. Listed below are just some of the major participating chain pharmacies. For additional information about participating pharmacies in your area, please call 800-839-8442.

A&P	Acme Pharmacy	Arbor
Bartell Drug	Bi-Lo	Bi-Mart
Big B	Biggs Pharmacy	Bolger Pharmacy
Brooks	Brookshire's	Costco
Cub Pharmacy	CVS	Dillons
Duane Reade	Eckerd	Epic Pharmacies
Finast	Genovese	Giant
Grand Union Pharmacy	Harvest Foods	Kmart
Kash N Karry	Keystone/Medicine Chest	Kinney Drugs
Kroger	Mays	Medicap Pharmacy
Medisave	Pathmark	Rite Aid Pharmacy
Safeway	Sav-On Pharmacy	Shopko Stores
Shoprite	Snyder Drug Stores	Stop & Shop
Target	Thrift	Tops
Twin Valu Pharmacy	United Managed Care Pharmacies	United Supermarkets
Wal-Mart	Walgreens	

HIP

Many national chains participate with HIP as well as many smaller pharmacies. These include: A&P; Acme Pharmacy; Brooks; CVS; Eckerd; Duane Reade; Genovese; Kmart; King Kullen; Pathmark; Revco; Rite Aid; Sav-On Pharmacy; Stop & Shop; Walgreens; Waldbaum's. More information can be found through www.HIPUSA.com or through 1-800-HIP-TALK.

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/2001/2, dated 15 March 2001. 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 administered by J. Van Breda & Co. International; information regarding this insurance programme can be obtained from the Insurance Service, room FF-300.

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 Service. 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.

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);

(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 Service 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 Service as follows:

Insurance Service
Office of Programme Planning, Budget and Accounts
United Nations
Room FF-300
304 East 45th Street
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 Service and will be returned.** Staff members who for any reason may be uncertain about the continuity of any 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 Service 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 Service 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 Service 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 Empire Blue Cross. These two plans provide benefits on a worldwide basis. Enrolment in the Aetna or Empire Blue Cross 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 Empire Blue Cross, 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 Empire Blue Cross 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 Service, room FF-300;

(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 Service 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 Service of the mission assignment and its duration.**

Annex VIII

ST/AI/394 — After-Service Health Insurance

1. The present administrative instruction sets out the established policy in regard to the provision of after-service health insurance coverage under specified conditions as well as the related administrative procedures. Administrative instruction ST/AI/172 of 27 March 1967 and the related addendum and amendments are hereby superseded.

Persons eligible for after-service health insurance coverage

2. After-service health insurance coverage is optional. It is available only as a continuation of previous coverage without interruption in a contributory health insurance plan of the United Nations. In this context, a contributory health insurance plan of the United Nations is defined to include a contributory health insurance plan of another organization in the common system under which staff members may be covered by special arrangement between the United Nations and that organization. In order to be enrolled in the after-service health insurance programme, the former staff member and his or her spouse and eligible dependent children, or the surviving spouse and eligible dependent children of the former staff member, must all have been covered under such an insurance scheme at the time of the staff member's separation from service or death. A child born within 300 days of the staff member's separation from service or death is eligible for coverage, provided that the other eligibility requirements are met.

3. Coverage under the after-service health insurance programme is available to persons in the following categories:

(a) A staff member who, while enrolled in a United Nations contributory health insurance plan, as defined in paragraph 2 above, was separated from service, other than by summary dismissal:

(i) With a disability benefit under the Regulations of the United Nations Joint Staff Pension Fund (UNJSPF) or with compensation for disability under appendix D to the Staff Rules; or

(ii) At 55 years of age or later, provided that he or she had been a participant in a contributory health insurance plan of the United Nations or a specialized agency or the International Atomic Energy Agency (IAEA) for a minimum of five years and is eligible to receive a retirement, early retirement or deferred retirement benefit under the Regulations of UNJSPF. Except in cases of extension of appointment beyond the normal age of retirement, only participation in a United Nations health insurance plan prior to the attainment of the normal age of retirement shall count towards meeting the five-year participation requirement;

(b) The spouse and eligible dependent children of a former staff member, as defined in subparagraph 3 (a) above, who were enrolled in the same contributory health insurance plan as the former staff member at the time of the former staff member's separation from service, provided they are eligible for a periodic benefit awarded under the Regulations of UNJSPF or appendix D to the Staff Rules, or both;

(c) The surviving spouse and eligible dependent children of:

(i) A staff member who died in service while participating in a United Nations contributory health insurance plan; or

(ii) A former staff member who died while participating in the after-service health insurance programme;

provided that the surviving spouse and dependent children were participating in the same health insurance plan at the time of death of the staff member or former staff member, and are eligible for a periodic benefit awarded under the Regulations of UNJSPF or appendix D to the Staff Rules, or both.

4. Except in cases in which both the former staff member and the surviving spouse are deceased, dependent children may be covered under the after-service health insurance programme until the end of the calendar year in which they reach 25 years of age, provided that they are not married or in full-time employment. Where the former staff member and surviving spouse are both deceased, the surviving children will no longer be eligible to participate in the after-service health insurance programme upon cessation of the periodic benefit awarded under the Regulations of UNJSPF and/or appendix D to the Staff Rules, normally when they have attained 21 years of age.

Contributions to the cost of after-service health insurance

5. The cost of participating in a United Nations after-service health insurance plan shall be governed by the following conditions:

(a) The cost of participation under the provisions of subparagraphs 3 (a) (i) and 3 (c) (i) shall be borne on the basis of joint contributions by the United Nations and the participants concerned;

(b) The cost of participation under the provisions of subparagraph 3 (a) (ii) shall be borne on the basis of joint contributions by the United Nations and the participants concerned provided that the former staff member had participated in a contributory health insurance plan of the United Nations or a contributory health insurance plan of a specialized agency or IAEA for a total period of contributory participation of at least 10 years;

(c) The cost of participation under the provisions of subparagraph 3 (a) (ii) for all those not meeting the conditions in subparagraph 5 (b) will be borne in full by the participants concerned. When the former staff member's combined participation as a staff member and as an after-service health insurance participant has reached a total of 10 years, the cost of participation shall be borne thereafter jointly by the Organization and the participant concerned;

(d) Joint contributions by the United Nations and the after-service health insurance participants, as indicated in subparagraphs 5 (a), 5 (b) and 5 (c) above, shall be computed in accordance with the established contribution and subsidy scales for the particular health insurance plan concerned. The participants' contributions shall be calculated on the basis of the higher of the following two rates:

(i) One third of the remuneration used for calculating the health insurance subsidy of the staff member concerned at the date of separation; or

(ii) The total of the periodic benefits payable on the staff member's account under the Regulations of UNJSPF or under appendix D to the Staff Rules, or both, whether or not part of such benefits has been commuted to a lump sum or reduced by the exercise of any other permissible option, including early retirement;

(e) The cost of participation in an after-service health insurance plan for those individuals eligible under subparagraphs 3 (b) and 3 (c) (ii) will be determined on the same basis as would have been used for participation by the former staff member concerned, taking into account the length of his or her participation in a United Nations health insurance plan as a staff member and as a participant in an after-service health insurance plan.

Payment of contributions to the cost of after-service health insurance coverage

6. Participants in the after-service health insurance programme are required to pay their contributions in advance of the period of coverage under the applicable health insurance plan. Contributions must be made in a currency acceptable to the Organization for the purposes of the insurance plan chosen. In the case of health insurance plans administered at Headquarters, the only currency acceptable is the United States dollar. In addition, staff members and their surviving spouses and/or eligible dependent children who enrol in a health insurance plan administered at Headquarters shall have their contributions deducted on a monthly basis from their periodic pension benefit. An authorization form permitting UNJSPF to effect such monthly deduction from the periodic pension benefit is an integral component of application for after-service coverage under any of the health insurance plans administered at Headquarters; this form must be executed as part of the application process for the after-service health insurance benefit (see also para. 15).

7. In some instances, there may be a delay in the process of completing the after-service health insurance enrolment requirements, as the separated staff member must be recorded in the Pension Fund, and the final pay statement must be furnished, before enrolment in the after-service health insurance programme can be completed. Where such a delay occurs, participation in the after-service health insurance programme shall commence retroactively on the first day of the month following cessation of coverage on an in-service basis. In such cases, the after-service health insurance participant will be billed for the required contribution amount for the initial period of coverage.

8. There may be instances in which the monthly pension benefit paid to the retiree may be insufficient to meet the full monthly cost of the health insurance coverage. This may arise, principally, in cases in which the after-service health insurance applicant has not met the 10-year requirement and is, therefore, not yet eligible to benefit from the organizational subsidy towards the cost of after-service health insurance. In such cases, payment of the requisite contribution must be made in advance, in amounts up to six months' premium.

9. After-service health insurance participants whose premium contributions are payable on the basis of an invoice, rather than through the automatic pension deduction mechanism, must remit full payment of the amount billed by the due date indicated on the invoice. Failure to remit the premium in full by the date indicated will result in suspension of insurance coverage, without further notice. Insurance

benefits may be reinstated provided that the full required premium payment is remitted within three months of the date of suspension of coverage. Failure to reinstate coverage by the latter date will result in termination of eligibility to participate in the after-service health insurance programme.

Cessation of coverage

10. Eligibility for after-service health insurance coverage shall cease when:

(a) Enrolment is terminated under the conditions set out in paragraph 9 above;

(b) The periodic disability or compensation benefits awarded to a former staff member are stopped;

(c) Upon the remarriage of a surviving spouse who is otherwise eligible for after-service health insurance coverage;

(d) When a covered child no longer qualifies as a result of marriage, full-time employment or cessation of a pension or compensation benefit, whichever comes first.

11. After-service health insurance participants are responsible for promptly informing the office administering their insurance plan whenever a covered family member ceases to be eligible for participation in the after-service health insurance programme by virtue of divorce in the case of a spouse, or the marriage, full-time employment or attainment of 25 years of age in the case of a dependent child. No retroactive adjustments in the insurance contribution amount will be made as a result of failure to provide timely notification of any change in the status of covered family members to the administering office concerned.

12. A participant in the after-service health insurance programme who chooses to cancel his or her coverage, for reasons of alternative insurance arrangements or otherwise, must provide written notice of the intention to cancel coverage to the office administering his or her United Nations health insurance plan. Cancellation of coverage will be made effective on the first day of the month following receipt of the written notification. Notwithstanding such notification of cancellation of coverage, the after-service health insurance participant will be responsible to remit promptly to the United Nations any contribution amounts which may be unpaid at the time of cancellation of coverage. If the contribution account of the after-service health insurance participant has a credit balance, the United Nations will refund such credit to the individual concerned. It should be noted that coverage, once cancelled, cannot later be reinstated.

Staff member married to another staff member

13. 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 while both are in service. In the event of divorce or the death of the spouse who pays the insurance contributions, a staff member who was enrolled as a spouse under the coverage of the other spouse maintains individual participation status for the purpose of any subsequent after-service health insurance benefits.

14. If one spouse retires from service with the Organization before the other spouse, the spouse remaining in active service must become the subscriber. This applies even if the retired spouse had been the subscriber up to the date of retirement and is otherwise eligible for after-service health insurance benefits following separation from service. If both staff members have separated from service and if each individually is eligible for after-service health insurance benefits, the cost of the contribution towards the after-service health insurance coverage must be borne by the former staff member with the higher pension.

Application for after-service health insurance benefits

15. The application documents relating to enrolment in the after-service health insurance programme must be submitted to the office administering the after-service health insurance plan within 31 days following the date of separation. Application forms may be submitted before the date of separation, but not more than 31 days before that date. In cases in which eligibility for after-service health insurance benefits accrues as a result of the death of a staff member, the surviving spouse and/or eligible dependent children must normally apply for after-service health insurance benefits within three months of the date of death of the staff member. Application forms will be receivable only if they are completed accurately and in full. In the case of an application for a plan administered at Headquarters, the forms must also be accompanied by an executed pension deduction authorization form.

16. Staff members separating from service at Headquarters may submit the relevant application forms directly to the Insurance Section, Office of Programme Planning, Budget and Finance, room S-2765.[1] Staff members at other duty stations who apply for after-service health insurance coverage under a plan administered at Headquarters must submit the relevant application forms through their administrative office, not directly to the Insurance Service at Headquarters.

17. Staff members who are close to retirement or early retirement should ensure that they are provided with all relevant information concerning the after-service health insurance programme. Such information is available from the office administering their in-service health insurance coverage.

Transfer from one health insurance plan to another

18. At the time of retirement, a staff member may switch from the insurance plan which he or she had on an in-service basis to a health insurance plan which is more appropriate to the location of residence following separation from service, under certain conditions. Thus, a staff member who, while in active service, participated in a Headquarters health insurance plan, may switch to a non-United States-based plan if he or she will reside outside the United States following separation from service, provided that covered dependants will also not reside in the United States.

19. After-service health insurance participants who change their country of residence may also transfer from one insurance plan to another if a different plan is more appropriate to the new country of residence. In such cases, the change in plan will become effective on the first day of the month following receipt of written

[1] Since issuance of ST/AI/394 the designation has changed to Insurance Service, Office of Programme Planning, Budget and Accounts, room FF-300.

notification regarding the change in country of residence. A transfer from one health insurance plan to another in this case will normally be permissible only after one year's coverage under any one of such health insurance plans. With respect to health insurance plans available to after-service participants who reside in the United States, transfer from one plan to another may be made subject to the condition that there must normally be two years' coverage under any such plan before a change can be made.

Annex IX

Insurance carrier addresses and telephone numbers for claims and benefit inquiries

I. Aetna "Open Choice" Plan (medical and out-of-network pharmacy claims)	Aetna Inc. P.O. Box 981106 El Paso, TX 79998-1106
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.: (866) 612-3862	Aetna Rx Home Delivery (mail order drugs) P.O. Box 417019, Kansas City, MO 64179-9892
Tel.: (888) 792-8742	Maintenance drug automated refills (credit card)
Tel.: (800) 424-1601	Focused Psychiatric Review (FPR)
Tel.: (800) 793-8616	Vision One
Tel.: (800) 422-6600	Discount Information on Lasik Surgery
II. Empire Blue Cross PPO Plan	Empire Blue Cross Blue Shield PPO Member Services P.O. Box 1407 Church Street Station New York, NY 10008-1407
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) 266-5691	AdvanceRX (maintenance drug mail order) P.O. Box 961066, Fort Worth, TX 76161-0066
Tel.: (800) 839-8442	Empire Pharmacy Management Program/AdvanceRX (prescription card programme and pharmacy network information)
Tel.: (888) 393-2583 (877) 92DAVIS	Davis Vision (vision care programme)
III. HIP	HIP Member Services Department 7 West 34th Street New York, NY 10001
Tel.: (800) HIP-TALK {(800) 447-8255}	Member Services HIP Member Services Dept. (walk-in service available) 6 West 35th Street New York, NY 10001

Tel.: (888) 447-4833	Hearing/Speech Impaired
Tel.: (877) 774-7693	Chiropractor Hotline
Tel.: (888) 447-2526	Mental Health Hotline
Tel.: (888) 447-2563	Alternative Medicine Hotline
Tel.: (800) 290-0523	Dental Hotline
Tel.: (800) 743-1170	Lasik Surgery (Davis Vision) Hotline
IV. CIGNA Dental PPO Plan	CIGNA Healthcare Service Center P.O. Box 188003 Chattanooga, TN 37422-8003
Tel.: (800) 355-5965	Claim Submission, ID Card Requests and Customer Service
Tel.: (888) DENTAL8	for participating provider referrals
V. MEDEX	MEDEX Assistance Corporation P.O. Box 19056 Baltimore, MD 21284
Tel.: (800) 527-0218	Within the United States
Tel.: (410) 453-6330	Assistance Coordination Center Baltimore, MD (*collect call*)
Tel.: 44-1273-223000	Assistance Coordination Center Brighton, England (*collect call*)
International toll-free access numbers	See detailed listing contained in annex V