WORLD BANK GROUP

MEDICAL INSURANCE PLAN 2018

As amended and restated

JANUARY 1, 2018

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WORLD BANK GROUP
Human Resources

MEDICAL INSURANCE PLAN (MIP)

PLEASE KEEP THIS DOCUMENT FOR EASY REFERENCE

This document, together with the attached **benefit summaries**, is the written plan document and summary plan description for the World Bank Group Medical Insurance Plan (**MIP**). The bolded terms in this document are defined in Section 12 of this document, the Glossary. Changes and updates to the **MIP** may occur at any time and will be posted on the internal website for staff, http://mip, and on the external website for families, www.worldbank.org/humanresources.

The **MIP** is a self-funded plan that is funded by staff member contributions and the **World Bank Group**. The **World Bank Group** contracts with **Insurance Administrators** who have fiduciary responsibility for processing plan claims in accordance with the MIP's benefits. The Insurance Administrators also provide clinical policies, which are used to determine benefit decisions. In their capacity as plan fiduciaries, the **Insurance Administrators** manage **MIP** claims and are responsible for appeals. The basis for most **MIP** claim decisions is **medical necessity**, and the determination of **medical necessity** is solely the responsibility of the **Insurance Administrator**. There is no internal grievance process within the **World Bank Group** for **MIP** claims.[1] **MIP members** may, however, appeal adverse claims determinations through the **Insurance Administrators** as set forth in Section 11.

The **MIP** relies on **members** to understand their coverage and responsibilities and to contact the **Insurance Administrator** whenever there is a question or concern about coverage. To protect **member** confidentiality, the **World Bank Group** does not intervene in claims decisions.

Limited benefits, such as acupuncture and chiropractic visits, are covered without a **medical necessity** review, but the **MIP** limits coverage of these services each year to a predetermined number of visits. Once the stated limit is reached, the benefit ends for the defined period. The **World Bank Group** will not waive visit limits.

The **World Bank Group** subsidizes the **MIP** as part of its commitment to staff and their families to help them meet their insurance needs. We hope **members** will find this document useful in helping them understand the global and comprehensive medical care coverage offered by the **MIP**.

When reading a printed version of this document, members may not be reviewing the most current information. The **World Bank Group** maintains the current version online on the **World Bank Group's** intranet at http://mip and on the internet at www.worldbank.org/humanresources. When launched, this document can be printed in full, or **members** can search for a specific topic, and print only that information. Printed versions are available upon request.

[1] Disputes concerning eligibility to participate in the MIP are subject to review through the Bank Group's internal grievance mechanisms, except for disputes arising out of the Insurance Administrator's decision relating to the sufficiency of evidence of good health in the case of late entrants and to the requirements relating to mental retardation or physical handicap in the case of eligible dependents.

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01 INTRODUCTION

The World Bank Group Medical Insurance Plan (**MIP**) provides worldwide comprehensive medical and prescription drug insurance to eligible staff and their eligible family members.

The **MIP** does not cover all medical and prescription drug services and purchases, even if performed or prescribed by **physicians**. Coverage extends only to **"medically necessary"** services as defined in the Glossary.

MIP benefits are designed by the **World Bank Group** and are subject to change. The **World Bank Group** has contractually provided fiduciary responsibility to process MIP claims and appeals to **Insurance Administrators**. These **Insurance Administrators** adjudicate claims according to the MIP plan design and disburse MIP funds on behalf of the MIP to pay claims. The **Insurance Administrators** have no financial incentive related to claims decisions (except to process them quickly and accurately). They are paid a service fee based on the number of MIP members, not on how many claims are processed, reduced or denied.

The **MIP** is self-funded. This means that the **World Bank Group** and staff members participating in the **MIP**, and not an insurance company, fund the **MIP** and pay the claims for eligible medical expenses of **members**. Participating staff members pay monthly contributions deductibles, **coinsurance** and **co-payments**, but most funding comes from the **World Bank Group**. Generally, the **World Bank Group** pays $3 for every $1 in premiums paid by enrolled staff members.

01.01 This Document

This document supersedes any other prior plan document or summary plan description for the **MIP**.

This document describes the general benefits available under the **MIP**. Medical and pharmacy services not explicitly listed in this document may or may not be **covered expenses**. If you cannot find what you are looking for in this document, contact your **Insurance Administrator**.

01.02 MIP Plan Year

The **MIP Plan Year** is January 1 to December 31.

01.03 Coverage Changes and Plan Termination

The **World Bank Group** reserves the right to change the benefits of the **MIP** and the eligibility for the **MIP** at any time. The **World Bank Group** also reserves the right to terminate the **MIP** at any time. The **World Bank Group** reviews coverage continually to control costs, and may amend aspects of the **MIP** in response to changes in medical norms, advances in research, changes in health economics and any other change. **MIP members** will be notified of all changes made and will be informed of these changes predominantly via e-mail.

01.04 How the MIP Works

The **MIP** is a fee for service plan[2] that provides health coverage in which doctors and other providers receive a fee for each service such as an office visit, test, procedure, or other health care service. The plan will either pay the medical provider directly or reimburse members for **covered services** after members have paid the bill and filed an insurance claim. When medical attention is needed, **members** can visit the doctor or **hospital** of their choice; the amount paid by the plan and the member's **co-payment** may depend on whether the chosen provider has a

[2] The term "Medical Insurance Plan" or "MIP" means medical insurance under the contract of insurance between the Bank Group and the Insurance Administrator as amended from time to time and for which staff members contribute at rates established periodically by the Bank Group. The term "Insurance Administrator" means the company with whom the Bank Group has contracted to administer and adjudicate claim reimbursements for the MIP.

participation agreement with the plan. The **MIP** offers coverage for **medically necessary** services through three separate options, A, B and C, that are differentiated by the premium and the portion of the cost of the medical expenses borne by the insured. As used in this document, **Plan** means coverage under the MIP, as follows:

- "Employee plus Spouse/Domestic Partner" and "Employee plus Child" Plans respectively mean coverage for the staff member and spouse or registered domestic partner only, or for a single staff member who has one dependent child. **These Plans are not available to retired staff members.**
- "Family Plan" means coverage for the staff member and more than one eligible dependent up to four eligible plan participants, or for the staff member and one or more eligible dependents.
- "Family Plan Plus" means coverage for the staff member and four or more eligible dependents .
- "Individual Plan" means coverage under the MIP for the staff member only.

The **MIP** does not have a lifetime maximum benefit. This means no overall lifetime limit applies to the covered benefits in the **MIP**, however, some **covered services** may have a benefit-specific lifetime maximum benefit.

For **covered services** provided in the U.S., members have access to a network of **participating providers** including specialists and **hospitals** that meet strict requirements for quality and service. These network providers are independent **physicians** and facilities that are monitored by the **MIP Insurance Administrators** for quality of care, patient satisfaction, cost-effectiveness of treatment, office standards and ongoing training.

For **covered services** provided outside of the U.S. and for providers outside of the network the coverage is provided under the **out-of-network benefits**. **Members** generally pay upfront for services and file for reimbursement. For inpatient care, direct billing agreements may be made with the facility. **Members** can contact the **Insurance Administrator** for assistance in such cases.

01.05 Online Tools

Each of the **MIP's Insurance Administrators** has developed extensive online tools using internet and e-mail to support member services, in addition to phone and fax contact numbers. Use of these services can increase health awareness and maximize **MIP** utilization.

01.06 Patient Confidentiality

Patient confidentiality is a cornerstone feature of the **MIP**, as with all **World Bank Group** benefits programs. The **MIP** and the **World Bank Group** comply with Staff Rule 2.01, Confidentiality of Personnel Information, and Staff Rule 2.02, Confidentiality of Medical Information and Medical Records.

Insurance Administrators are prohibited from sharing personal information with the **World Bank Group**. However, **Insurance Administrators** may provide the **World Bank Group** with the financial aspect of claims if there is a need to investigate fraud or misconduct, or to recover funds disbursed for expenditures of ineligible **MIP members**.

02 ELIGIBILITY AND ENROLLMENT

02.01 MIP Eligibility

02.01.01 Active Staff (General)

Staff are eligible for **MIP** coverage if classified as:

- The President.
- An Executive Director, an Alternate Executive Director, a Senior Advisor to an Executive Director, or an Advisor to an Executive Director.
- A Regular (**headquarters**) appointment.
- An Open or Term staff member appointed to a headquarters position.
- Staff under an Extended Term Consultant or Extended Term Temporary appointment. Extended Term Consultants and Extended Term Temporary staff, including their eligible dependents, are eligible for MIP option "B" only.
- Staff in Country Offices on Local Regular, Open or Term, appointments are not eligible for the **MIP**, but participate in the separate World Bank Group Medical Benefits Plan (MBP). The provisions of this document do not apply to MBP participants.
- Staff holding a Short Term Consultant, Short Term Temporary, Contractor, Special Assignment or other appointment are not eligible for **MIP** coverage.

02.02 Coverage for Eligible Dependents, i.e., family members

Refer to definition of 'Eligible Dependents' in the Glossary.

02.02.01 Spouse/Domestic Partner

Staff members may cover one legal spouse or registered and HR-approved domestic partner under the **MIP**. Domestic partner, in the case of a staff member, means a person registered as such with the **World Bank Group** who meets the **World Bank Group**'s otherwise applicable definition of a domestic partner, as found in Section 3.01(i) of Staff Rule 1.01, "General Provisions."

02.02.02 Children and Grand Children

Biological, foster or legally adopted children under age 26 of a staff member or the spouse or domestic partner of the staff member (i.e., a stepchild) who are registered with the World Bank Group are eligible to participate in the MIP. Please note that eligibility for dependency allowance for children per Staff Rule 6.02 differs from eligibility for MIP coverage.

A grandchild of a staff member is eligible to participate in the MIP only if he or she is the child of that staff member's dependent child per Staff Rule 06.02 Dependency (Tax Equivalency) Allowances, and only for the duration the child (the parent of the grandchild) meets the criteria of a dependent child under Staff Rule 06.02 Dependency (Tax Equivalency) Allowances.

If a **member** has a handicapped child, the child's coverage may be continued past the **MIP's** maximum age for dependents (age 26). The child is considered handicapped if:

He or she is unmarried;

- He or she is incapable of self-sustaining employment because of a mental or physical handicap that started when the child was the **member's** dependent and before he or she reached age 26; and
- He or she depends mainly on the **member** for support and maintenance.
- **Members** must provide the **Insurance Administrator** with proof of their child's handicap no later than 31 days after the child reaches age 26. The **Insurance Administrator** may require periodic health evaluations of the handicapped child after the initial acceptance of the handicap. Such examinations would be at the **Insurance Administrator's** expense. A handicapped child's coverage ends on the earliest of the following:
    - The date the **member's MIP** coverage ends;
    - The date the child no longer meets the **MIP's** criteria for being considered handicapped;
    - The date the **member** fails to provide medical evidence that the handicap continues;
    - The date the **member** fails to have any required exam performed.

02.03 When Both Spouses/Domestic Partners Are Eligible

When a spouse or registered domestic partner is eligible for **MIP** coverage in his or her own right, he/she may choose coverage as the primary insured or as a family member under the spouse/domestic partner primary insurance. **Members** may not be covered under the **MIP** both as an insured and a family member. **Members** or their spouse or registered domestic partner, but not both, may enroll children who are joint eligible family members.

When one spouse or registered domestic partner is eligible for **MIP** coverage, and the other spouse or registered domestic partner is eligible for coverage under the World Bank Group Medical Benefits Plan (MBP), either staff member may choose to become enrolled in the **MIP** or the MBP, but not both, as either the primary insured or as a family member. Members or their spouse or registered domestic partner, but not both, may enroll children who are joint eligible family members.

02.04 Surviving Family Members Eligibility

If an active staff member dies in service, his or her spouse, registered domestic partner and/or children will be eligible to continue subsidized coverage, as described in Section 2.04 of the Summary Plan Description for the World Bank Group Retiree Medical Insurance Plan (**RMIP**).[3]

Surviving dependents may not add individuals to their survivor coverage unless the surviving spouse or domestic partner is pregnant at the time of the member's death.

02.05 When MIP Coverage Begins

02.05.01 Staff

Coverage under the **MIP** for a staff member is effective from the entry on duty date of an appointment eligible for **MIP** coverage.

All staff are automatically enrolled in individual coverage under **MIP coverage option B** when they commence **Qualifying Service**. Unless a staff member elects coverage (other than the default enrollment) or waives coverage under the **MIP** within 60 days of the commencement of **Qualifying Service**, the staff member will be responsible

[3] For a death in service, the World Bank Group provides optional coverage for the surviving spouse/domestic partner for life through RMIP 2. The amount of the subsidy will vary depending on the years of service of the staff member at the time of death, with a minimum 25% subsidy and a maximum 75% subsidy. There will be no discounting of the subsidy for early retirement.

for payment of the corresponding premium for **MIP coverage option B** (at the individual coverage level) retroactive to his or her entry on duty date.

02.05.02 Family Members

Each person who is a staff member's eligible family member on the day the staff member becomes eligible for the **MIP** is also eligible for **MIP** coverage on that day. Family members are not, however, automatically enrolled and their enrollment requires completion of an **MIP** enrollment form within 60 calendar days of entry on duty, except in cases of birth or adoption, for which enrollment forms must be submitted within the first year, with premiums calculated retroactively to the date of the event.

In the case of children fathered by or born to **MIP members**, the **MIP** covers the newborn child (or children in the case of multiple births) for the first 60 days of life even if the newborn child is not eligible for coverage (for example, in cases of **MIP** Continuation where no new family members are permitted to be enrolled).

In the case of adoption, coverage begins when a **member** takes physical custody of a child for purposes of legal adoption, which must be documented accordingly. All adoptions are reviewed and approved by HR Operations. If coverage is granted for a prospectively adopted child and the adoption is later cancelled or not approved, coverage for the child is cancelled retroactively and any claims paid on behalf of the child must be refunded to the **MIP**.

Coverage for eligible dependent children born or adopted after the first child (or stepchildren due to remarriage) is automatic under family coverage if the new child will be the fourth family member to be covered under family plus coverage (for families of five or more members). **Members** must still notify the HR Service Center so the child can be added to the **World Bank Group** eligibility records for the **Insurance Administrators**.

Newly eligible staff must also enroll their eligible family members (spouse, domestic partner and/or their eligible children) within 60 days of initial eligibility, except in the case of a new birth or adoption, for which the enrollment window is extended to the first year, with premiums calculated retroactively to the date of the event.

02.06 Enrollment Due to Loss of or Curtailment of Other Coverage

02.06.01 Enrollment Due to Staff Member's Lost or Curtailed Coverage

A staff member who is currently not covered under the MIP and who has lost other medical insurance coverage, or who had such coverage significantly curtailed or increased in cost outside the Bank Group because of legal separation, divorce, dissolution of a registered domestic partnership, spouse's death, domestic partner's death, spouse's loss of employment, or significant reduction in hours worked, or domestic partner's loss of employment, or significant reduction in hours worked may apply within 60 calendar days of loss of coverage and elect to enroll in Individual, Employee plus Spouse/Domestic Partner or Employee plus Child or Family Plan or Family Plus Plan coverage without evidence of good health. The staff member must submit to the Benefits Administration Unit:

- either a death certificate, divorce decree, legal separation agreement, or
- a statement from the spouse's or domestic partner's employer or prior employer confirming the loss of employment or significant reduction in hours worked and
- a statement from the previous Insurance Administrator confirming the loss of or significant reduction of coverage or increase in cost of coverage. Coverage is effective the first day of the month following acceptance of the application by the Benefits Administration Unit. Retired staff members and their eligible dependents are not eligible for enrollment as a result of lost, significantly curtailed or more costly coverage.

02.06.02 Enrollment Due to Family Member's Lost or Curtailed Coverage

A staff member who has Individual or Employee plus Spouse/Domestic Partner or Employee plus Child Plan coverage, and whose spouse, domestic partner, or eligible dependent child loses other medical coverage or who had such coverage significantly curtailed or increased in cost due to loss of employment, or significant reduction in hours worked, or death may apply within 60 days of loss of coverage to elect to change coverage to Employee plus Spouse/Domestic Partner or Employee plus Child, Family Plan, or Family Plus coverage without evidence of good health. The staff member must submit to the Benefits Administration Unit:

- either a death certificate, or
- a statement from the spouse's domestic partner's employer or former employer confirming the loss of employment or significant reduction in hours worked and
- a statement from the previous Insurance Administrator confirming the loss or significant reduction of or increase in cost of coverage. Coverage is effective the first day of the month following acceptance of the application by the Benefits Administration Unit.

02.06 Annual Open Enrollment

Before the beginning of each **Plan Year** the **World Bank Group** will offer an open enrollment period for active staff members during which a staff member may enroll, make new elections, or change existing elections (including changing his or her **MIP coverage options**) for the next **Plan Year**. The **World Bank Group** will specify the deadline for enrolling and/or making annual elections, which will be no later than December 31 of the year before the year to which the enrollment and elections apply. Staff enrolled in the **MIP** in active service may elect to switch their **MIP coverage option** to another Option during open enrollment. The effective date of the new option will be the following January 1.

If **members** fail to make a new election on or before the due date specified by the **World Bank Group**, enrollment and **MIP coverage options** remain unchanged for the following calendar year.

02.07 Election Changes during the Plan Year

Elections made during open enrollment are generally irrevocable during the entire **Plan Year** to which they apply. Coverage may, however, be added or dropped, as provided below.

- If a staff member terminates employment with the **World Bank Group** during a **Plan Year**, their elections will be deemed revoked for the remainder of the **Plan Year**.
- A staff member may change their election if they experience a "change in status" as defined by the **World Bank Group's** "Premium Conversion Plan"[4], provided, however, such change is consistent with the change in status. Change in status events include, but are not limited to, a change in marital status, the birth of a child, a change in employment status, etc.
- If a staff member declines enrollment because of health coverage under another plan, and eligibility for such coverage is subsequently lost for certain reasons (including divorce, death, termination of employment, reduction in hours, or exhaustion of the Continuation coverage period), the staff member

[4] Premium conversion is an arrangement that allows staff subject to U.S. income tax to make a pretax contribution to an employer sponsored health or welfare plan. Premium conversion is a tax benefit. It uses federal tax rules to allow the deduction of health insurance premiums from taxable income, thereby reducing personal income tax.

may be able to elect coverage under the **MIP** for themselves and their family members who lost such coverage, provided that such enrollment is requested within 60 calendar days after the applicable event.

- Staff members can enroll a new family member as a result of marriage,[5] birth, legal adoption of a child, placement of a child for legal adoption, or change in legal custody of a child. Staff members may also be able to elect coverage for themselves, their spouse or domestic partner, and their newly acquired family members, provided that enrollment is requested within 60 calendar days after the marriage or change in legal custody, and within the one year of the date of any addition resulting from a birth, adoption or placement for adoption.

- Staff members can enroll themselves or their family members if they or their family member becomes eligible for assistance under a Medicaid plan under Title XIX of the Social Security Act or under a State child health plan under Title XXI of the Social Security Act. Members may elect coverage under the **MIP** for themselves and their family member who became eligible for such coverage, provided that enrollment is requested within 60 days of the date when the determination of eligibility for such assistance was made.

- Staff members may make any election change during the **Plan Year** that is permitted under the Premium Conversion Plan.

Please note that Staff members may not change their **MIP coverage Option** during the year even if they experience one of the events listed above. Changes are limited to the addition or deletion of dependents.

02.08 Other Individuals

Parents, siblings, and children for whom the staff member (or the spouse or registered domestic partner) is a legal guardian but not an adoptive parent, and any other individuals are not eligible for coverage in the **MIP**. An unmarried parent or parent-in-law residing in a staff member's household who meets the dependency and other eligibility criteria may be eligible for individual coverage in the World Bank Group Sponsored Medical Insurance Plan. Contact the HR Service Center for details.

[5] Marriage to a registered domestic partner does not create a new eligibility window for enrollment if that domestic partner is not covered by the **MIP**.

03 COVERAGE UNDER CHANGED CIRCUMSTANCES

03.01 General Rule

MIP coverage ends on the earliest of:

- The last day of the month that a staff member ends employment with the **World Bank Group**,
- The last day of the month following notice from a member that he/she wishes to withdraw from the **MIP**,
- The date of death, or
- The date the **MIP** is terminated.

The **World Bank Group** can also terminate coverage as provided in Section 03.03.

03.02 Family Member's Coverage

Family member's coverage under the **MIP** ends:

- When the staff member's coverage ends, or
- When eligibility ends, including:
    - Legal Separation, divorce or the termination of a registered domestic partnership; and
    - a child's attainment of age 26, unless determined by the **Insurance Administrator** to be handicapped before age 26.
- Upon the death in service of the staff member. However, covered spouses, registered domestic partners and children (including orphaned children) who meet the eligibility requirements will be eligible for coverage under the **RMIP**, as outlined in Section 2.04 above. Covered spouses, domestic partners and children who do not meet eligibility requirements for the **RMIP** can continue coverage under **MIP** Continuation, as outlined in Section 3.05 below.

Absent a life event that ends eligibility, staff members may not drop a dependent from coverage without the written consent of the dependent, or his/her parent, if the dependent is a child.

03.03 Fraud or Failure to Reimburse Overpayment of Claims

Coverage can be terminated at the **World Bank Group's** discretion in cases of fraud committed against the **MIP**, intentional misrepresentation of material fact, refusal to refund **MIP** overpayments in case of enrollment error or otherwise, or if a member does not pay the required monthly contribution. Coverage can be retroactively terminated with at least 30 days written notice only in the case of fraud, intentional misrepresentation of material fact or failure to pay the required monthly contributions.

03.04 Continuing Coverage if Disabled When Group Coverage Ends

Benefits for a specific medical condition may continue for a person who is totally disabled as a result of that medical condition as determined by the **Insurance Administrator** when his or her coverage ends. "Totally disabled" means:

- For the staff member: the staff member is not able to work at his/her usual occupation, and is not working for pay or profit at any occupation.
- For an enrolled family member: He or she is not able to engage in most of the normal activities of a healthy person of the same age and gender.

Under the conditions above, **MIP** benefits will be available while a person is totally disabled, for up to 12 months following the calendar month in which group coverage ends or the date the person becomes covered under any other group plan for similar benefits, whichever is earliest. This determination of disability for **MIP** benefits is independent of any other determination that may be made as a result of any other disability benefit program, e.g., disability determination in accordance with Staff Rule 6.22, Disability Insurance Program.

03.05 MIP Continuation

A **MIP member** who loses eligibility (for example, if employment ends or if a staff member or retiree divorces) may continue coverage for up to 36 months from the day coverage ends. Coverage generally ends on the last day of the month during which the event occurred. **MIP** continuation is not available for **MIP members** whose coverage was terminated for fraud, intentional misrepresentation of material fact, or misconduct.

03.05.01 Applying for MIP Continuation

Staff members must contact HR Operations to register an event that ends **MIP** eligibility for themselves or a covered family member, or when members resign from active employment and do not immediately enroll in the World Bank Group Retiree Health Insurance Plan:

- In cases of ending employment, staff members will receive a **MIP** Continuation application as part of the outplacement benefits counseling.
- In case of divorce, a **MIP** Continuation application for the spouse will be sent to the staff member, the staff member's ex-spouse, or the staff member's ex-spouse's attorney upon processing of the divorce after the member has notified HR Operations. The staff member is obligated to facilitate **MIP** Continuation for an ex-spouse by timely notifying HR Operations of the divorce by providing the appropriate forms in a timely manner.
- In case a child loses eligibility, staff members must notify HR Operations promptly. If less than 60 days have passed since the child's coverage ended (not the date of notification), staff members will receive an **MIP** Continuation application for him or her.

An applicant has 60 calendar days from the end date of **MIP** coverage (and not the date of notification, even if later) to enroll for **MIP** Continuation coverage and pay for at least the first month of coverage. The form and payment must be returned to the **Insurance Administrator** at the address on the form. If this deadline is missed, the **MIP** Continuation application is rejected without possibility of later submission.

03.05.02 Cost of MIP Continuation

The **member** pays the entire cost of **MIP** Continuation coverage. This cost is adjusted each year at the same time **MIP** premiums are adjusted (generally January 1). The monthly cost of **MIP** Continuation coverage is included with the **MIP** Continuation form.

03.05.03 Payment of Premiums for MIP Continuation

MIP Continuation premium payments are billed monthly, and payment for the full month is required and non-refundable, even if coverage is required for only a part of the month being paid for. Billing arrangements are made directly between the **Insurance Administrator** and the member. The member is responsible for informing the **Insurance Administrator** of billing address changes. **Members** can pay in advance for future coverage, but non-payment for any reason cancels **MIP** Continuation coverage without possibility of reinstatement. The **World Bank Group** cannot and will not intervene in any billing dispute.

03.05.04 Covered Services under MIP Continuation

Under **MIP** Continuation, all **MIP** provisions and benefits remain in effect, and members participating in **MIP** Continuation are subject to the same periodic plan design changes and premium adjustments as any other **MIP member**.

03.05.05 Continuation While On Leave Without Pay

A staff member on leave without pay may continue coverage under the MIP as provided in Staff Rule 6.06, "Leave," as long as the staff member pays the required, unsubsidized contributions. A staff member who suspends coverage during leave without pay may not reinstate coverage until active work status is regained. Within 31 days of return to active work status, a staff member may reinstate participation without evidence of good health. After 31 days, evidence of good health will be required as determined by the **Insurance Administrator**.

If the staff member does not return to active work status at the end of the leave without pay, then coverage can be continued as described under Section 03.05 above.

03.05.06 Continuation While On External Service

A staff member on external service may continue coverage under the MIP as provided in Staff Rule 5.02, "External Service," as long as the staff member pays the subsidized, staff contributions. A staff member who suspends coverage during external service may not reinstate coverage until active work status is regained. Within 31 days of return to active work status, a staff member may reinstate participation without evidence of good health. After 31 days, evidence of good health will be required as determined by the **Insurance Administrator**.

If the staff member does not return to active work status at the end of the external service, then coverage can be continued as described under Section 03.05 above.

03.05.07 Changes in MIP Continuation Coverage

Members may reduce coverage (e.g., Family to Individual) at the time **MIP** Continuation is elected, but all members must remain in the same **MIP coverage option** in which they participated as of their loss of coverage under the **MIP**.

MIP Continuation applicants may reduce coverage (e.g., drop a family member) but may not add family members. If a **member** gains a new dependent through childbirth, marriage or registration of a domestic partnership during the **MIP** Continuation coverage, that individual cannot be added.[6]

03.05.08 Potential Consequences of Not Electing MIP Continuation

In considering whether to elect **MIP** Continuation, **members** should take into account that a failure to continue group health coverage may affect their future ability to enroll in other health insurance coverage under United States law.

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[6]Two exceptions exist. If a female **member** is pregnant at the time **MIP** coverage ends, the **MIP** Continuation can be purchased at a higher level of coverage to include the child after birth; provided, however that the premiums for the higher level of coverage will apply immediately. Those enrolled in **MIP** Continuation in Family or Family Plus coverage can add natural children born during the **MIP** Continuation period. In either case, the **member** must notify his or her **Insurance Administrator** of the childbirth. Note: If **members** are in Family coverage when coverage ends and a child is expected that will move the **member** to the Family Plus level (5 or more **members**), **members** must enroll in Family Plus coverage in **MIP** Continuation and immediately begin making premium payments for Family Plus coverage.

03.06 Conversion to Limited Coverage under an Individual Plan

03.06.01 Non–U.S. residents

Individual conversion benefits will differ significantly from **MIP** benefits and may vary depending on the country of residence for non-U.S. residents. Non-U.S. residents need to contact the international **Insurance Administrator** 30 days prior to the end of the **MIP** continuation.

03.06.02 U.S. residents

Terminating staff and staff with dependents losing MIP eligibility and living in the United States should be aware of and consider alternatives to the MIP Continuation. The Patient Protection and Affordable Care Act (Health Care Reform) may provide access to more appropriate and less expensive coverage than the MIP Continuation through public exchanges. For more information, please go to www.healthcare.gov/.

03.06.03 Exclusion

Conversion is not available to those who have committed fraud against the **MIP**.

04 PLAN OPTIONS, COVERED EXPENSES, DEDUCTIBLES AND CO-PAYMENTS

04.01 Introduction

This section describes the **MIP's** plan options, deductibles, co-payments, coinsurance, covered expenses and limits, the medical out-of-pocket maximum, in-network versus out-of-network benefits, an overview of pharmacy services, case management, and requirements for **prior authorization** of medical services.

04.02 Benefit Summaries

Benefit summaries describe the general coverage for each option provided by the **MIP**. Specific details on each option's deductibles, copayments, coinsurance, limits and maximums can be found in those benefit summaries in the Annex below or online at http://mip for staff and at www.worldbank.org/humanresources for eligible family members.

04.03 Covered Expenses

Covered expenses must be medically necessary for the member's specific medical condition as determined by the MIP Insurance Administrators. The MIP does not cover all medical and prescription drug services and purchases, even if performed or prescribed by a doctor. The Insurance Administrators determine reimbursement for a claim in accordance with the terms of the MIP. The World Bank Group establishes the benefits design of the MIP, but the Insurance Administrators determine coverage on each claim. The World Bank Group cannot instruct the Insurance Administrator on how to process an individual claim.

This document describes which expenses are limited or not covered by the **MIP**. The **benefit summaries** contain information about general coverage, **deductibles** and **coinsurance** percentages. The **Insurance Administrator** also can confirm coverage of specific services and explain how a claim was reimbursed.

The **MIP** does not pay insurance benefits for expenses incurred before coverage starts. The **MIP** does not pay insurance benefits after coverage ends, even if the expenses were incurred because of an accident, injury or disease that began or existed while the coverage was in effect.

If a series of services are billed with a lump-sum fee, each service is assigned a pro rata share (determined by the **Insurance Administrator**) of the total expense based on the average time or number of visits needed to provide the services. Only the pro-rata share of the expense will be considered as incurred on the date of the service.

04.04 Prior Coverage

Prior coverage may affect the benefits provided through the **MIP**. The **World Bank Group** reserves the right to select a new company to administer the medical care plan, or to replace one plan of benefits with a different plan. In such cases, the **prior coverage** may affect the benefits under the new plan:

- The new plan will replace all privileges and benefits provided under any "**prior coverage**".
- Any benefits provided under **prior coverage** may reduce the new plan's benefits. For example, the use of orthodontia benefits with its lifetime maximum under the prior coverage would reduce benefits subsequently accessed under the new plan.

04.05 Deductibles and Co-Payments

For some out-of-network care, and certain types of in-network care, staff members and their enrolled family members must meet an annual deductible before the MIP starts to pay benefits.

There are two types of deductibles: individual and family. The individual deductible applies to each covered family member, with two exceptions.[7] Once covered expenses of two or more members in one family reach the family deductible, no other deductible will be required from any other family member for the rest of the calendar year.

For certain **in-network-services**, a **co-payment** is required (a fixed dollar amount) rather than a **deductible**. The **benefit summaries** show individual and family **deductible** amounts and those services that require a **co-payment** rather than a **deductible**.

If a **member** is confined in a **hospital** for an uninterrupted period that continues from one calendar year to another, the **deductible**, if any, will be considered satisfied with respect to **covered expenses** that are incurred by the patient during such period of confinement, provided that:

- The hospital makes a room and board charge; and
- The period of confinement began in a calendar year in which the hospitalized family member had satisfied the deductible.

If the deductible had not been satisfied in the calendar year in which the period of confinement began, then the **deductible** requirement for subsequent calendar years must be met from **covered expenses** incurred during or after the end of such uninterrupted period of confinement.

For staff members (and associated dependents) that retire during the course of a plan year, charges applied towards the MIP annual deductible during the plan year will be applied towards the RMIP annual deductible for that same year.

04.06 Medical Out-of-Pocket Maximum

- The **MIP** includes an annual limit on the amount of **covered expenses members** must pay out of their own pocket each year. This is known as the "**out-of-pocket maximum**" or "stop-loss limit," and it protects all **members** against the cost of very high medical expenses by shifting all covered costs to the **MIP** after **members** have paid a certain amount in a given year. The annual **out-of-pocket maximums** for each option are shown in the **benefit summaries**. Certain charges do not accrue toward the **out-of-pocket maximum** and will not be covered after the **out-of-pocket maximum** is met (Section 06).
- There are two types of **out-of-pocket maximums**: individual and family.

Individual: When an individual's share of **covered expenses** (in-network and out-of-network combined) reaches the individual **out-of-pocket maximum**, the **MIP** pays 100% of his or her **covered expenses** for the rest of that year. Individual **out-of-pocket maximum** expenses also contribute to the family **out-of-pocket maximum**.

Family: When the **covered expenses** (in-network and out-of-network combined) of two or more family members reach the family **out-of-pocket maximum**, the **MIP** pays 100% of the family's **covered expenses** for the rest of that year.

[7] A single **deductible** applies to all covered children born of the same pregnancy who receive care for (i) an illness within the first 31 days of life; (ii) an abnormal congenital condition; or (iii) a premature birth. After that medical event, each child reverts to his or her own **deductible**. Also, a common accident **deductible** limit provides that an additional benefit may be paid if two or more of the covered family members are injured in the same accident and have **covered expenses** for care of their injuries. Only one **deductible** will apply to all **covered expenses** for all family members who receive care for their injuries due to that accident.

For staff members (and associated dependents) that retire during the course of a plan year, charges applied towards the MIP out of pocket maximum during the plan year will be applied towards the RMIP out of pocket maximum for that same year.

04.07 In-Network Medical Benefits in the U.S.

04.07.01 Payments

The **MIP Insurance Administrator** pays **in-network benefits** directly to the provider. Members may pay certain up-front charges such as an office visit **co-payment**, but the provider will bill the **Insurance Administrator** directly and receive reimbursement directly for the claim. The provider may bill members for a **deductible**, **coinsurance** for the service, or for non-covered services and **members** are obligated to pay these invoices.

04.07.02 In-Network Providers in the U.S.

When members use a participating or "in-network" provider, members maximize benefits available under the MIP. These providers have agreed to accept negotiated rates for services.

Members are responsible for office visit **co-payments**, any **coinsurance**, and in some cases the **member** must meet **deductibles** as well, depending on the **MIP coverage option**.

04.07.03 How to find In-Network Providers

The easiest way to find **in-network providers** is via the internet on each **Insurance Administrator's** website.

04.08 Out-of-Network Benefits

04.08.01 Out-of-Network Medical Services

When **members** receive Out-of-Network services, a **MIP** claim form must be completed by either the **members** or the providers. These forms are available on the **World Bank Group's** intranet at http://mip or on the internet at www.worldbank.org/humanresources or from the **Insurance Administrators**.

A standard claim form from the provider may also be used. If a provider does not file the claim form, **members** must pay for the service in full and then file the claim form with an original, itemized receipt from the provider that contains the patient's name, the date and cost of the service, and a diagnosis (the requirement for a diagnosis is waived for services priced below $500). The **Insurance Administrator** will then reimburse **MIP** benefits to the **member** directly. If **members** pay for a service in full, generally **members** should file the claim. If the provider files the claim on the **member's** behalf, **members** risk overpaying the provider. If the **Insurance Administrator** receives a claim form where the provider states that the "assignment signature is on file," the **Insurance Administrator**, not the **member**, must pay the provider. If the **member** also has paid the provider, then the provider would be paid twice and **members** would need to seek reimbursement from the provider.

04.08.02 Out-of-Network Providers

Members can use out-of-network doctors, facilities, or pharmacies, but this may decrease the level of their coverage under the **MIP**:

- **Members** must satisfy an annual **deductible** before the **MIP** begins to pay benefits.

Once **members** meet the **deductible**, **members** pay a portion of the **covered expenses** incurred (the **coinsurance** share), up to the **out-of-pocket maximum** each year.

- If the provider charges more than the **usual and customary charge** as determined by the **Insurance Administrator**, members must pay any expenses above the **usual and customary charge**. That excess amount does not apply toward the **deductible** or **out-of-pocket maximum**. This amount would be shown on the Explanation of Benefits (EOB) as an "Amount Not Covered."

- Most self-referred services under **MIP coverage option** C are considered **out-of-network benefits**.

04.09 Pharmacy Services

04.09.01 Covered Drugs and Pharmacy

Covered drugs and vitamins are those that may be lawfully dispensed only on a doctor's prescription. Benefits for certain drugs, such as Viagra and Cialis, are available but supplies are limited by the **MIP**. See Section 9 below for information on excluded drugs.

The **MIP** covers the cost of said covered drugs prescribed by a licensed doctor for **medically necessary** treatment of an injury, an illness, a condition or a pregnancy in accordance with the provision of the **MIP** and established medical norms.

All members are provided pharmacy coverage in the United States through a pharmacy network that includes most large retail chain pharmacies. The pharmacy network also provides mail order pharmacy service for most maintenance drugs. There is no pharmacy network outside of the United States.

04.09.02 Prescription Drug Card and Out-of-Pocket Maximum in the United States

MIP members residing in the United States or outside the United States are provided with discount prescription drug benefits through a Prescription Drug Card program when purchasing drugs in the United States. The **out-of-pocket maximum** for drugs purchased using the card is $1,000 for out-of-pocket expenses per individual per calendar year. The **out-of-pocket maximum** for drugs purchased using the card is $2,000 for out-of-pocket expenses per family per calendar year. Once an individual or family has reached the **out-of-pocket maximum**, coverage is at 100% for covered prescription drugs until the end of the calendar year for all purchases with the Prescription Drug Card.

Generic, Preferred Brand and Non-Preferred Brand Drugs purchased in the United States at a **participating network** or **mail order pharmacy** using the Prescription Drug Card respectively require that members pay increasing levels of coinsurance or copays up to specified maximums. **See Section 8 below and the Pharmacy Benefits' sections of the Benefit Summaries in the Annex for details**.

04.09.03 Prescription Drugs Outside of the United States

Members residing in international locations and purchasing their prescription drugs outside of the United States without the benefit of the prescription drug card need to file their prescription drug expenses as a medical claim and are reimbursed accordingly. When enrolled in the **international option**, **members** do not have a separate **prescription drug out-of-pocket maximum** and prescription drug claims are included in the overall medical **out-of-pocket maximum** for the calendar year.

04.10 Benefit Limits

The only benefit limits are those that apply to specific **covered services** and supplies, as described in the relevant sections of this document (e.g., infertility, orthodonthia, etc.). Such benefit limits are tracked by individual and apply to all coverage through health plans sponsored by the **World Bank Group**. They are not reset upon appointment of a former enrolled family member, or reappointment of a staff member, or a change in medical plan (e.g., moving from the **MIP** to the World Bank Group Retiree Medical Insurance Plan).

All non-emergency hospitalization in the United States should be pre-certified by the Insurance Administrator. **Members** are responsible for ensuring the **prior authorization** has been done by calling the **Insurance Administrator** directly prior to or as close as possible to a hospitalization. The admitting **physician** may do the **prior authorization** on the **member's** behalf, but it is the member's responsibility to ensure the **prior authorization** was made.

04.11 Prior authorization of Hospitalization

All **inpatient** and **outpatient hospital** admissions in the United States should be **pre-certified** including emergency cases and mental health admissions. For additional information about **prior authorization**, please contact the **Insurance Administrator**.

04.12 Case Management

Case management is an important service to members and their covered family members. Entering case management is the most effective method to ensure that the care received is the most appropriate to the medical condition of the patient. Case management is available when important catastrophic medical conditions are identified. It allows the patient, his family or the treating **physician** to benefit from expert assistance from the **Insurance Administrator** and to manage the medical condition in the most effective manner from both a patient care and a cost perspective. Using case management services comes at no additional cost to the **member**, and there is no benefit penalty if members choose not to participate in case management.

For services in the United States, contact the **Insurance Administrator**. An individual case manager professionally trained in management of catastrophic illnesses (including inpatient mental health) or accidents will be assigned to the **member's** case when appropriate.

04.13 MIP Coverage Options A and B

MIP coverage in Options A and B are similar in design; however premium, **deductibles** and **co-payments** are different. Staff members can choose between providing their contribution up front through a higher premium (Option A) or on an ongoing basis as the services are delivered through higher **deductibles** and **co-payments** (Option B).

04.14 MIP Coverage International Options

The **World Bank Group** offers **MIP coverage options** AI and BI for staff participating in the **MIP** and residing outside the United States. This section describes the features and procedures related to these coverage options.

04.14.01 Who May Elect an International Option?

The **international options** are available to staff members whose principal residence is not in the U.S., in the following circumstances.

Extended assignment away from headquarters under Staff Rule 6.17, Benefits on Change of Duty Station	Eligible
Appointment to a headquarters' duty station outside the U.S. (Paris, Tokyo, London, Brussels, Rome, etc.)	
External service (with or without pay) for at least one full calendar year	
Leave without pay for at least one full calendar year	
Telecommuting assignment outside the U.S. of at least one full calendar year	

Short-term assignment as defined in Staff Rule 6.17, Benefits on Change of Duty Station	Not eligible

Staff may not participate in an **international option** if they have a parent or parent-in-law enrolled in the World Bank Group Sponsored Medical Insurance Plan.

Staff and all enrolled family members must participate under the same **MIP coverage option**.

04.14.02 How to Enroll when Eligible

If **members** wish to elect an **international option**, they need to contact HR Operations to confirm their eligibility and for information on open enrollment during which **members** may make this election. Open enrollment usually takes place during November of each calendar year.

04.14.03 Premiums

Staff **MIP** contributions do not differ based on whether an **international option** is elected.

04.14.04 Plan Design Differences

The **international options** of the **MIP** are nearly identical in terms of the coverage of benefits provided within the United States (in other words, **MIP coverage options** A and AI offer largely the same coverage and **MIP coverage options** B and BI offer largely the same coverage). **MIP coverage option** C is not available under an **international option**. The minor plan design differences between the **international options** and the other **MIP coverage options** are summarized below.

04.14.04.01 Application of Out-of-Pocket Maximums

Under MIP coverage options A and B, there are medical expense out-of-pocket maximums, and in-network prescription drug out-of-pocket maximums for brand-name drugs purchased at participating network pharmacies. Under MIP coverage options AI and BI, there is only one medical out-of-pocket maximum. The combined out-of-pocket maximum for any member in MIP coverage option AI or BI is identical to the limit in MIP coverage option A or B (as applicable). Coordination of information among the Insurance Administrators ensures consistent and identical application of the out-of-pocket maximum to all MIP members, including international option members, regardless of where prescription drugs are purchased.

04.14.04.02 Care Outside the U.S.

As indicated in the Benefit Summaries, services provided outside the U.S. in all international coverage options are reimbursed at non-network benefit levels. Staff members who elect an international option and who receive care outside the U.S. are encouraged to use providers (usually hospitals and clinics) that have an agreement with the Insurance Administrators. Participating hospitals, clinics and other providers that have an agreement with the international Insurance Administrator offer direct payment to MIP members. This means that such services do not require prepayment by the patient, and the providers bill the Insurance Administrator directly first, and then bill the member for any portion of the cost that is not covered by the MIP. If members use one of these direct payment providers, members will receive medical care simply by showing their insurance card and will not be required to complete claims forms, prepay for medical services, or provide a certificate of guarantee of their insurability. The provider will bill the Insurance Administrator directly.

The international Insurance Administrator has in some cases also negotiated discounted fees with many providers in many countries, including many of the same providers with whom they have direct payment arrangements. Using such providers offers members and the MIP savings, since the costs of any given procedure are lower for persons associated with the Insurance Administrator through the MIP than for other persons.

Members in MIP coverage options AI and BI are reimbursed in accordance with the MIP, based on medical necessity and subject to the "usual and customary" level of fees for that service. The international Insurance Administrator maintains an extensive database of the cost of all medical and dental procedures in countries and cities around the world that reflects their international claims payment experience. Under the provisions of the MIP, charges that exceed the usual and customary charges are reduced, and reimbursement will be based on the maximum usual and customary charges.

04.14.04.03 Care within the U.S.

Members who elect an **international option** will have an opportunity to use **in-network providers** when in the United States. Use of **in-network providers** offers significant advantages:

- Only a **co-payment** is charged for **physician** office visits, regardless of the cost. Expenses other than the office visit fee for additional services such as x-rays, lab tests, etc., will be reimbursed at the appropriate percentage for that benefit category.
- Lower-cost medical services.

04.15 MIP Coverage Option C

MIP coverage option C is a "point-of-service" plan under which each **member's** non-emergency room medical care is coordinated by an in-network Primary Care Physician or PCP. **MIP coverage option** C is not available to **members** electing an **international option** because the plan design and administration are specific to the United States

Unlike Option A, Option C does not require that a deductible be satisfied for in- network services.

04.15.01 Introduction

Use of a Primary Care Physician for primary medical care and referrals to specialty medical care is a key feature of Option C benefit. Option C provides members 100% coverage of most in-network services in exchange for **members** using a Primary Care Physician in the **Insurance Administrator**'s U.S. Managed Choice Point of Service network to diagnose and treat their medical conditions. If a condition requires a specialist consultation, the **member** must receive a referral from their PCP to visit the specialist. The PCP will also make referrals for lab tests, x-rays, and non-emergency hospital admissions. When **members** do not use their PCP for care and referrals, the benefit is reduced to the **out-of-network benefit** level.

04.15.02 Choosing and Registering a Primary Care Physician (PCP)

The **Insurance Administrator** website displays Primary Care Physicians enrolled in the Managed Choice POS network by their location. **Members** can choose a PCP for the family or select a different doctor for each enrolled family member. Contact the **Insurance Administrator** to register each **member's physician**. An ID card will be issued by the **Insurance Administrator** with the PCP's name listed on the member's card. **Members** may change PCPs at any time with no restriction on the number of changes or minimum time between changes. Register a PCP change immediately with the **Insurance Administrator**.

04.15.03 Choosing a Specialist as a Primary Care Physician

A **member** with a serious condition such as cancer may request approval from the **Insurance Administrator** to use their treating specialist as their PCP. Members need to complete an application for the **Insurance Administrator** to approve this status change for the specialist. Until approval has been given by the **Insurance Administrator** to the specialist to act as the PCP, care from the specialist may be covered under the **out-of-network benefit**.

04.15.04 Referrals to Care in the United States by a Primary Care Physician

The **member's** PCP will provide an in-network referral to a specialist for specific conditions that require consultation, diagnosis or treatment by a specialist. Referrals can be for a single consultation, or more comprehensive for ongoing specialist visits. For example, a PCP might issue a long-term "consult and treat" referral to an endocrinologist for a patient with diabetes, so that the patient can access the endocrinologist's care continuously for the diabetic condition without returning to the PCP until the end of the "consult and treat" period.

For ongoing treatment, a new referral is required each **Plan Year**.

04.15.05 Member Referral to Care in the United States

If a PCP does not make the referral for the **member** to visit a specialist or receive lab tests or other diagnostic tests and scans, the medical services will be paid under the **out-of-network benefit**, even if the specialist or facility is part of the Managed Choice POS network.

04.15.06 When a referral from a PCP is *not required:*

- Emergency room care;
- In-network annual OB/GYN preventive care office visits;
- In-network annual routine eye exams by optometrists and ophthalmologists (**NOTE: These items are covered under the vision benefit**).
- Mental health and substance abuse **outpatient** services (**prior authorization** for inpatient care is required); and
- Dental services, including oral surgery.

If an issue is detected during the routine visit, a PCP referral is required to maximize **in-network benefits** for specialist care such as surgery.

04.15.07 Emergency Care and Option C

Option C **members** are covered at 100% for emergency room services after a **co-payment**. This **co-payment** is waived if the emergency room visit results in a hospital admission. The **member's** PCP should coordinate follow-up care. Follow-up care with **non-participating providers** is only covered with a referral authorization from the **member's** PCP and pre-approval from the **Insurance Administrator**.

Remember: For follow-up care, members must obtain a referral from their Primary Care Physician or the follow-up care will be considered out of network.

Suture removal, cast removal, x-rays and clinic and emergency room revisits are some examples of follow-up care.

NOTE: Option C and the Managed Choice POS network are not available to retirees or **members** participating in a **MIP international option**.

04.16 Switching Between U.S. Options and International Options

If staff members participate in an **international option** and are reassigned to the U.S., their participation in the **international option** will end, and the staff member and enrolled family members, if applicable, will be automatically enrolled in the corresponding U.S. coverage option (in other words, option AI **members** are enrolled in option A and option BI **members** are enrolled in option B). Within 31 days of a transfer to a U.S. option, **members** may elect **MIP coverage option** C by contacting the HR Service Center.

Staff members may elect an **international option** within 31 calendar days of the start date of an extended assignment away from the Washington, D.C. office that makes them eligible to elect an **international option**. Thereafter, as long as the staff member remains eligible to participate in an **international option**, the staff member will have the opportunity to elect an **international option** each year during the open enrollment period.

05 MEDICAL BENEFITS

The **MIP** covers expenses for the following care, subject to the provisions of Section 06, and all other provisions in this document. To be covered by the **MIP** the following services must be provided by a licensed, certified, or otherwise recognized provider who is authorized to provide said service in the concerned field of expertise.

Although a specific service may be listed as a benefit, it will not be covered by the plan unless the **Insurance Administrator** determines it is **medically necessary** to prevent, diagnose, or treat the illness, disease, injury or condition.

05.01 Acupuncture Care

The maximum benefit is 30 treatments per calendar year per **member**.

05.02 Chiropractic Care

The maximum benefit is 30 visits per calendar year per **member**.

05.03 Durable Medical Equipment and Medical Supplies

05.03.01 Durable Medical Equipment

The **MIP** covers charges made for rental or purchase (if a purchase is shown to be more cost effective) of **durable medical equipment** of a medical or surgical nature such as hospital beds, wheelchairs, respirators and oxygen equipment, artificial limbs, prosthetics.

Durable medical equipment must be prescribed by a medical professional and related to an illness or injury. **Durable medical equipment prescribed in the United States** must be **pre-certified** by the **Insurance Administrator** in writing.

See the list of exclusions regarding covered equipment in section 7.06 below.

05.03.02 Medical Supplies

The **MIP** covers charges made for:

- Blood or blood plasma not donated or replaced;
- Prosthetic appliances, including adjustable brassieres following partial or total mastectomy;
- Wigs or hairpieces as a prosthetic for hair loss due to injury, disease or treatment of a disease;
- Splints, crutches, braces, and other medical and nursing supplies.

05.04 Emergency Services

05.04.01 Coverage

If the **member's** condition is an **emergency condition,** the **MIP** claim will be processed as **in-network benefits**, regardless of where the treatment was performed and received. However, if the **emergency care** is provided by **non-participating providers** in an in-network facility, the benefit will be processed at the higher in-network rate, but charges will be reviewed and are subject to **usual and customary charges**.

05.04.02 Ambulance Service

Ground ambulance service to the nearest location where the condition can be treated is covered for the patient only. Air Ambulance may also be provided when necessary, as authorized by the **Insurance Administrator**.

Remember! Use an emergency room for emergencies only. If members use an emergency room for non-emergency care, benefits will be processed at a lower coverage level and the deductible will apply, even at in-network facilities.

05.05 Hearing Care

The **MIP** covers expenses for one audiometric exam per calendar year per **member** and the cost of hearing aids, up to $4,000 per person, once every five **Plan Years**.

05.06 Home Health Care

05.06.01 Home Health Care Agency

The **MIP** covers up to 120 visits per **Plan Year** per condition for home health care expenses when care is provided by a **home health care agency** as part of a **home health care plan**, and the care is provided in the **member's** home. Each visit by a nurse or a therapist is considered one visit, and one visit consists of up to four hours in one day. Covered expenses include:

- Physical therapy and occupational therapy;
- Medical supplies, including drugs and medicines prescribed or ordered by the attending physician for symptom control, and their administration; and
- Psychological and dietary counseling.

05.06.02 Physicians and Private Duty Nursing Services

The **MIP** covers charges made by a **physician** for **covered expenses**. Coverage includes private duty nursing charges made by a Registered Nurse (RN) or a Licensed Practical Nurse (LPN) up to 24 hours per day, but not including charges made by:

- The same nurse for more than one 8-hour shift during any day, or
- A nurse who resides in the insured patient's home or is related to the insured patient by blood or marriage.

05.07 Hospice Care

The **MIP** offers a **hospice care** benefit for **members** admitted to a **hospice care program** (inpatient, **outpatient** or in-home) when a **physician** has confirmed a life expectancy for the patient of twelve (12) months or less. **Hospice care** benefits provide a higher level of coverage than standard medical benefits as detailed below:

05.07.01 Hospice Facility Expenses

Hospice care facilities, **hospitals** or **convalescent facilities** providing hospice services are covered for:

- Room and board, and other services and supplies provided to a **member** while he or she is a full-time inpatient for pain control or other acute and chronic symptom management (refer to section 5.10.1 below for reimbursement under inpatient **hospital**); and
- Services and supplies provided on an **outpatient** basis.

05.07.02 Other Hospice Care Agency Expenses

The **MIP** covers charges made by a **hospice care agency** for part-time or intermittent nursing care by a Registered Nurse (RN) or Licensed Practical Nurse (LPN), or a Home Health Aide.

Charges by a Registered Nurse or Licensed Practical Nurse for private duty nursing are covered, up to 24 hours a day if the charges are not made for more than one 8-hour shift by the same nurse in any day, and the charges are not made by a nurse or family member who resides in the insured patient's home.

05.07.03 Medical or Social Services under a Physician's Direction for Hospice Care

MIP coverage includes:

- Assessment of the patient's social, emotional and medical needs, and the home and family situation;
- Identifying community resources available to the patient;
- Helping the patient make use of these resources;
- Psychological and dietary counseling, including bereavement counseling for the patient;
- Consultation or case management services provided by a **physician**;
- Physical therapy and occupational therapy;
- Part-time or intermittent home health aide services for up to 8 hours in any one day (these services consist mainly of caring for the patient);
- Bereavement counseling charges for professional services for family counseling prior to or after death of a covered individual (including charges for all insured family members combined for up to $75 per visit for not more than 6 visits in the 3-month period prior to or the 12-month period following the date of death);
- Medical supplies; and
- Drugs and medicines prescribed by a **physician**.

Charges made by a **physician** for consulting or case management services, and charges made by a physical or occupational therapist are also covered if the provider is not an employee of a **hospice care agency** and as long as a **hospice care agency** is still responsible for the patient's care.

05.08 Immunizations

The **MIP** covers all types of immunizations, including rabies vaccine. However, the **MIP** will not reimburse for any immunization provided by the **World Bank Group** at no charge to an enrolled **MIP member**.

The **MIP** covers immunizations for allergies and travel immunizations. Travel immunizations are considered **preventive care** and are covered at 100% when provided by an **in-network provider**.

05.09 Infertility Services

The **MIP** covers the diagnosis and treatment of the underlying cause of infertility. Benefits are payable like any other medical expense subject to the following limits:

- Artificial insemination is limited to six courses of treatment in a patient's lifetime.
- Ovulation induction with ovulatory stimulant drugs, subject to a maximum of six courses of treatment in a **member's** lifetime. (A course of treatment is one cycle of treatment that corresponds to one ovulation attempt.) The woman must have a condition that (i) is a demonstrated cause of infertility, (ii) has been

recognized by a gynecologist or infertility specialist, and (iii) was not caused by her partner's voluntary sterilization or hysterectomy.

The **MIP** also covers Advanced Reproductive Technology (ART), payable like any other medical expense. ART includes:

- Invitro fertilization (IVF).
- Assisted hatching.
- Zygote intra-fallopian transfer (ZIFT).
- Gamete intra-fallopian transfer (GIFT).
- Tubal embryo transfer (TET) and pronuclear stage tubal embryo transfer (PROUST).
- Cryo-preserved embryo transfers, including thawing.
- Intracytoplasmic sperm injection (ICSI) or ovum microsurgery.
- Oocyte retrieval via laparoscope or transvaginal needle aspiration of follicles, including insemination in a laboratory dish.

Care is covered for a member associated with a donor IVF program, including fertilization and culture and services to obtain the sperm of a partner who is also a member of the **MIP**. The **MIP** does not cover certain aspects of infertility services (see Section 07.12).

The **MIP** has a $50,000 lifetime limit for all professional services and prescription drugs under ART. When applying this lifetime limit, the **Insurance Administrator** will take into account only services rendered under the **MIP** while the **member** was enrolled in either the **MIP** or the World Bank Group Retiree Medical Insurance Plan. Once the limit is reached, prescription drug coverage for ART also ends.

05.10 Hospital Services

05.10.01 Inpatient Hospital, Extended Care and Skilled Nursing Facilities

The **MIP** covers room and board charges based on the semi-private room rate unless the patient is confined to an Intensive Care Unit or the confinement in a private room is required because of a contagious disease. If the **hospital** or extended care facility does not provide semi-private room arrangements, the **MIP** uses 80% of the private room rate as the semi-private room rate, and applies the **MIP** benefit percentage to that amount.

The **MIP** covers charges incurred in connection with a **hospital** confinement, including charges for **hospital** services and supplies other than room and board, general nursing services, special nursing care, other professional services, or any other care, treatment, services or supplies that are included in the room and board charges.

05.10.02 Skilled Nursing Facility Services

The **MIP** covers skilled nursing facility charges up to 60 days per person per condition per calendar year, provided the confinement is in lieu of a **hospital** confinement and the treatment provided is for skilled nursing services and not custodial care services. These services need not immediately follow a hospitalization.

05.10.03 Convalescent Facility Care

In addition to skilled nursing facility services, **convalescent facility** care for up to 60 days per person per condition per calendar year is provided to a patient who had been confined as an inpatient immediately prior to admission

to the **convalescent facility**, and who is recovering from a disease or injury. The **MIP** covers charges made by a **convalescent facility** for the services and supplies listed below:

- Room and board (as per 5.10.01 above),
- Use of special treatment rooms;
- X-ray and laboratory work;
- Physical, occupational or speech therapy;
- Oxygen and other gas therapy;
- Other medical services provided by a **convalescent facility**. This does not include private or special nursing, or **physician** services; and
- Medical supplies.

05.11 Laboratory Services and Supplies

The **MIP** covers:

- Anesthesia and Oxygen and its administration,
- Chemotherapy and Radiation Therapy,
- Laboratory Tests and Services.

05.12 Mammography, Including Screening and Related Physician's Fees

The MIP covers charges incurred for mammography, including screening and related physician's fees. Computer-aided detection (CAD) mammography is considered an integral part of mammography.

05.13 Maternity

The **MIP** covers charges by a licensed physician or nurse midwife, resulting from childbirth or miscarriage.

The **MIP** also covers at least a 48-hour **hospital** stay following a normal vaginal delivery and at least a 96-hour **hospital** stay following a cesarean section.

05.14 Mental Health, Autism Spectrum Disorder and Chemical Dependency

Section 07.15 below lists mental health charges not covered by the **MIP**.

05.14.01 Office Visits

The **MIP** covers office visits, including office visits via telemedicine (including Skype and telephone counseling), for mental/nervous conditions. In-person office visits are also provided for substance abuse and chemical dependency treatment, and marriage counseling.

05.14.02 Psychiatric Day Treatment Programs

Charges made for full or partial day therapy, under an **outpatient** psychiatric treatment program or Intensive Outpatient Program (IOP), are covered for treatment of chemical dependency or mental/nervous conditions.

05.14.03 Treatment Programs for Autism Spectrum Disorder

The plan provides coverage for medically necessary treatment for Autism Spectrum Disorder to an annual maximum of $50,000 per patient per year.

05.14.04 Inpatient Treatment Chemical Dependency and Substance Abuse

Charges are covered for a licensed institution engaged primarily in treating alcoholism or drug addiction. **Prior authorization** of inpatient care by the **Insurance Administrator** is not required.

05.14.05 Inpatient Treatment at Institutions Licensed as a Hospital or Medical Facility

Up to five days of inpatient care for evaluation and stabilization are covered without **prior authorization**. Additional days of inpatient care require **prior authorization** by an **Insurance Administrator**.

Benefits for the approved inpatient care for the treatment of mental/nervous conditions are applied in the same manner as approved inpatient care for medical conditions.

05.15 Outpatient Hospital Services

The **MIP** covers charges by a **hospital** for **outpatient** services, including:

- **Outpatient** medical care and treatment due to surgery;
- Services rendered in a **physician's** office or **urgent care facility**, clinic or ambulatory surgery center;
- **Outpatient** diagnostic x-ray and laboratory tests; and
- All other **outpatient** services.

05.16 Preventive Care

The **MIP** covers in-network preventive care services at 100% without applying a **deductible**, **co-payments** or **coinsurance**. For purposes of preventive care, the MIP incorporates the U.S. preventive care guidelines with respect to covered items and services. Examples of preventive care services can be found at the following web address: https://www.healthcare.gov/coverage/preventive-care-benefits/

If the associated laboratory tests, x-rays and immunizations are billed separately from the routine office visit fee, they will be processed at the otherwise applicable coverage level. The **MIP** does not cover venipuncture fees.

05.17 Prescription Drug Benefits

See Section 8 below.

05.18 Short-Term Therapies

Short-term rehabilitation services are physical therapy, occupational therapy and speech therapy provided on an inpatient or **outpatient** basis. *Restorative* short-term rehabilitation helps the patient regain function following an illness, stroke, or accident. Restorative services are subject to **medical necessity** review by the **Insurance Administrator** after an initial sixty (60) visits per member per condition per calendar year.

Charges made by licensed or certified occupational therapist, physiotherapists, physical therapists, speech therapists are covered by the **MIP**.

Up to 60 visits per calendar year for occupational, physical, and speech therapies combined for enrolled children with a diagnosis of developmental delay or related to developmental delay are covered.

05.19 Surgery

The **MIP** covers charges made for inpatient or **outpatient** surgical services.

05.19.01 Cosmetic Surgery

The **MIP** covers:

- Reconstructive surgery to correct the results of an injury;
- Surgery to treat congenital defects (such as cleft lip and cleft palate) which will allow normal bodily function;
- Surgery to reconstruct a breast after a mastectomy that was performed to treat a disease, or as a continuation of a staged reconstructive procedure; if a member elects breast reconstruction in connection with such mastectomy, the member is also covered for surgery and reconstruction on the other breast to produce a symmetrical appearance, prostheses, and treatment of physical complications of all stages of mastectomy, including lymph edemas. Coverage for reconstructive breast surgery will not be denied or reduced on the grounds that it is cosmetic in nature or that it otherwise does not meet the coverage definition of **medically necessary**. Benefits will be provided on the same basis as for any other illness or injury under the **MIP**; and
- Rhinoplasty or other nasal reconstruction, and cosmetic surgery, whether or not such surgery is performed because of emotional or psychiatric reasons, provided such surgery is for (a) injuries sustained by the **member** in an accident and the surgery commences within 180 days of the date of the accident, or (b) a congenital malformation. Requests for surgery commencing later than 180 days must be justified by a medical report specifying the details of the recovery.

All other cosmetic surgery services are not covered as outlined in section 7.02 below.

05.19.02 Second Surgical Opinion

The **MIP** covers charges for a second opinion on the **medical necessity** of a surgical procedure. The proposed surgical procedure must be covered by the **MIP**, must be recommended by a **physician** who also proposed to perform the surgery, and cannot be for an **emergency condition** (so that a **member's** health is not threatened by delay in an emergency situation). A second opinion involves an examination of the patient, x-ray and lab work, and a written report by the **physician** providing the second opinion. The second opinion must be provided by a doctor certified by the American Board of Surgery or similar organization, and must be completed prior to the proposed surgery being performed.

The **MIP** also covers a third surgical opinion, in the case where a second opinion does not confirm the opinion of the **physician** who proposed the surgery initially, subject to the above limits.

The **MIP** will not cover the second or third opinion from a **physician** who is in the same practice or office or legally connected to the **physician** who initially recommended the surgery or who rendered a prior opinion.

05.19.03 Surgery on Mouth, Jaws, Teeth

Procedures Covered Under the **MIP**:

- Biopsy of hard and soft tissues of the oral cavity,
- Bony impacted teeth,
- Jaw fracture care,
- Soft tissue lesions,
- Use of general anesthesia when circumstances require such,
- Freeing of muscle attachments, correction of cleft lip, cleft palate or protruding mandible, and

- Accidental injury to natural teeth.

05.19.04 Sterilization and Abortion

The **MIP** covers abortion for female **members** and voluntary sterilization for male and female **members** (i.e., vasectomy), but not the reversal of such surgery. To the extent such procedures constitute **preventive care**, they are covered at 100% when performed by an in-network provider.

05.19.05 Transplants

The **MIP** covers harvest costs incurred by patients relating to donation of organs or bone marrow for transplantation to a **MIP member**. Donor costs related to infertility treatment are not **covered expenses**.

05.20 Transportation Charges

Charges for railroad or regularly scheduled airline service for one round-trip per calendar year per condition are also covered for the patient only, if approved by the **Insurance Administrator**. The transportation must be for services that are **medically necessary** as determined by the **Insurance Administrator** for the transport of the patient to and from the closest facility that can provide needed care or treatment. The **MIP** does not cover a taxi or ambulette in lieu of an ambulance.

05.21 Intravenous Immunoglobulin (IVIG)

Intravenous immunoglobulin (IVIG) includes coverage for the treatment of myasthenia gravis if recommended by a qualified neurologist.

05.22 Virtual Colonoscopy

A standard colonoscopy is recommended for **members** age 50 and over. Services can be authorized for younger **members** when there is history of colon cancer in an immediate family member (parents or siblings). Virtual colonoscopy will be covered only if the attending **physician** certifies it would be medically risky to attempt a standard colonoscopy.

Prior authorization *by the* ***Insurance Administrator*** *is required for a virtual colonoscopy.*

06 MIP COVERAGE EXCLUSIONS AND LIMITATIONS

Coverage is not provided for charges for medical and pharmacy services and supplies that are not **medically necessary**, as determined by the **Insurance Administrator**, for the diagnosis, care or treatment of the disease or injury involved. This limitation applies even if they are prescribed, recommended or approved by the attending **physician** or dentist.

Medical and pharmacy services not explicitly listed in this document may or may not be **covered expenses**. When **members** cannot find what they are looking for in this document, they should contact the **Insurance Administrator**.

For all benefit provisions, no coverage is provided for the following charges for services and supplies:

- Due to an "on-the-job" injury or illness. On-the-job means employment with any employer or self-employment where the member has or could have a compensable workers' compensation claim.
- **Members** would not legally pay if there were no insurance.
- Normally provided free of charge, regardless of the patient's financial ability to pay. This means the **MIP** will not cover charges that are made only because **members** have medical insurance, unless otherwise prohibited by law.
- For non-emergency care furnished or paid for by a government or government agency.
- For custodial care except as provided under covered expenses of **hospice care** (Section 05.07).
- For services furnished by persons who are related to the **member** in any way by blood, marriage or domestic partnership.
- For services that exceed the **usual and customary charges** for that service charged by most providers in the same 3-digit zip code area. For services rendered outside the U.S., the **Insurance Administrator** will use the usual and customary charge for the area of service, if known to the **Insurance Administrator**. Otherwise, the **Insurance Administrator** will use the charges made by providers for that service in New York City (zip code 100xx).
- For services specified by the **Insurance Administrator** as not covered for a specific condition or diagnosis, unless specifically listed as a **covered expense** elsewhere in this document or determined as standard medical practice in the country of service by the **Insurance Administrator**. To find out if a specific service is covered, **members** need to contact the **Insurance Administrator**.
- Services or benefits received when the patient has not met a **MIP** eligibility condition.
- Registration fees or advance payment fees that are used to guarantee care by, reduce costs of care from, or facilitate delivery of care by the provider, regardless of whether the patient has received or will receive treatment from the provider.
- Services or benefits received in excess of an annual or lifetime limit (e.g., chiropractic visits in excess of 30 visits per patient per calendar year, treatment for Autism Spectrum Disorder in excess of the $50,000 annual limit referred to in section 05.14.03 above, orthodontia or infertility treatments in excess of the lifetime limits, etc.).

- Excluded services do not accrue toward the **out-of-pocket maximum**. Additionally the following charges do not apply toward the **out-of-pocket maximum**:
    - Charges that are not **covered expenses**, such as charges listed as an exclusion from coverage and charges in excess of the **usual and customary charges**; and
    - Charges that are **covered expenses** but for which no benefit is payable because the dollar or use limit on that benefit has been exceeded (e.g., the annual chiropractic visit limit).

- **Co-payments** for office visits, medical or mental health.

- **Eligible out of pocket** in-network prescription drug expenses, since these expenses are subject to the separate annual **Prescription Drug Out-of-Pocket Maximum.**

07 MEDICAL EXPENSES NOT COVERED

07.01 Convalescent Facilities

Convalescent facility expenses do not cover charges for treatment of drug addiction, alcoholism, senility, chronic brain syndrome, mental retardation or any other mental disorder in such facilities.

07.02 Cosmetic Surgery or Products

Cosmetic surgery or surgical procedures or cosmetic products primarily for the purpose of changing the appearance of any part of the body to improve appearance or self-esteem are not covered except as stipulated in Section 05.19.01.

07.03 Counseling

Mental health counseling coverage excludes:

- Religious counseling;
- Sex counseling, including related services and treatment;
- Pastoral counseling;
- Financial counseling; and
- Legal counseling.

07.04 Custodial Services

Except in certain hospice situations (Section 05.07), the **MIP** does not cover custodial services, including:

- Homemaker or caretaker services;
- Sitter or companion services; or
- Respite care for providers of custodial care for a patient.

07.05 Educational or Vocational Training

The **MIP** does not cover care that is provided mainly for purposes of education, training or vocational rehabilitation, educational services, special education, remedial education or job training.

The **MIP** does not cover evaluation or treatment of learning disabilities, minimal brain dysfunction, learning disorders, behavioral training or cognitive rehabilitation.

The **MIP** also does not cover services, treatment, educational testing and training related to behavioral (conduct) problems or learning disabilities.

The **MIP** does not cover educational or associated room and board expenses for attendance at facilities for problems related to adolescence.

07.06 Equipment and Devices

07.06.01 Durable Medical Equipment

The **MIP** does not cover:

- Replacement or repair of **durable medical equipment** due to loss or negligence.

- Replacement or repair of **durable medical equipment** due to normal wear or obsolescence without submission of the attending **physician's** statement justifying the medical need for replacement or repair.
- Educational or experimental **durable medical equipment**.
- **Durable medical equipment** prescribed as a convenience (e.g., blood pressure kit) or accommodation to the patient, even when ordered by a **physician**.

07.06.02 Other Equipment and Services

The **MIP** does not cover items such as, but not limited to:

- Bathroom safety equipment;
- Posture chair/recliner;
- Compression stockings;
- Environmental control equipment (air cleaners, air conditioners, air or water filters, dehumidifiers);
- Exercise equipment;
- Whirlpool equipment;
- Jacuzzi;
- Health club or athletic club fees;
- Professional medical equipment (blood pressure kits, stethoscopes, etc.);
- Non-hospital or water beds;
- Modifications to automobiles or other transportation devices;
- Van and stair lifts;
- Traction devices; and
- Intercoms or communications devices.

07.06.03 Orthopedic Devices

The **MIP** does not cover orthopedic shoes, orthotics unless specifically covered per the **Insurance Administrator**'s coverage criteria, or, for the treatment of a medical condition of the leg, any other supportive devices.

07.07 Environmental Improvements

Coverage excludes care furnished to provide a safe surrounding, including charges for providing an environment free from exposure that could impact a disease or injury.

07.08 Expenses Incurred While Not Eligible for Coverage

The **MIP** does not cover charges incurred before a **member's MIP** coverage begins or after a **member's MIP** coverage ends unless specifically provided in this document.

07.09 Experimental or Investigative Treatment

Experimental or investigational treatment is not covered, including any charges for related services or supplies furnished in connection with such care.

07.10 Funeral Arrangements

The **MIP** does not cover expenses for funeral arrangements, including autopsies, transportation of remains, or cremation.

07.11 Home Health Care Services

Charges for home health care services are not covered if provided by someone who usually lives with the **member** or is a relative by blood or marriage, or for transportation charges of a service provider or for a social worker provided through a **home health care agency**.

07.12 Infertility

The **MIP** does not cover the purchase of donor sperm or storage of sperm, expenses of donors of any kind, care of donor egg retrievals or transfers to storage, gestational carrier programs, and home ovulation predictor kits. The **MIP** does not cover cryo-preservation (freezing) or storage of cryo-preserved embryos, except in cases where the storage was necessitated by the medical condition of the **member** at the time of the initially scheduled embryo transfer. In such cases, the **MIP** will pay for cryo-preservation and embryo storage until the earlier of the date of embryo transfer or 90 calendar days, as long as:

- The cryo-preservation is performed expediently following the determination that the patient's medical condition could not sustain the originally scheduled embryo transfer attempt;
- Cryogenic thawing procedures are performed expediently following the medical recovery of the patient and within 90 calendar days after the cryo-preservation; and
- The patient was a **MIP member** at both the time of the initially scheduled transfer and the time of the second attempt.

07.13 Legal Fees

The **MIP** does not cover legal fees, including those related to medical services, appeals, claims, and subrogation.

07.14 Massage Therapy and Spa Treatments

The **MIP** does not cover aqua therapy or spa treatments. Massage therapy is covered only as a modality of physical therapy.

07.15 Mental Health

The **MIP** does not cover school tuition or expenses, boot camps, wilderness programs, equine therapy programs, custodial expenses in halfway houses, or similar charges relating to mental health care. Also see Section 07.05.

07.16 Orthopedic Services

The **MIP** does not cover treatment of weak, strained or flat feet, instability or imbalance of the feet, unless specifically covered per the **Insurance Administrator's** coverage criteria. Charges for cutting, removal or other treatment of corns, calluses or toenails are not covered unless needed because of diabetes or other similar disease. The **MIP** does cover charges made for open cutting operation of metatarsalgia or bunion, or partial or complete removal of nail roots.

07.17 Personal Comfort Items

The **MIP** does not cover personal comfort items (e.g., television or telephone).

07.18 Postage and Documentation
The **MIP** does not cover fees relating to photocopying, mail, translation, delivery or similar services, including those relating to diagnoses, claims or eligibility.

07.19 Sexual Dysfunction
The **MIP** does not cover the treatment for sexual dysfunctions or inadequacies, including therapy, supplies and counseling unless the dysfunction has a physiological or organic basis (e.g., benign prostatic hypertrophy).

07.20 Speech Therapy
The **MIP** does not cover speech or other therapy to treat lisps, stuttering or accents. Coverage of speech therapy is described in Section 5.18.

07.21 Sterilization Reversal
The **MIP** does not cover charges for the reversal of male or female sterilization.

07.22 Telephone Including Fax and E-mail
The **MIP** does not cover costs relating to telephone, fax, e-mail, etc., including those relating to diagnoses, claims or eligibility correspondence.

07.23 Therapy and Rehabilitation
The **MIP** does not cover alternative or experimental therapy or rehabilitation, including (but not limited to), primal therapy, chelation therapy, Rolfing, psychodrama, megavitamin therapy, purging, bio-energetic therapy, vision perception training, and carbon dioxide therapy.

07.24 Transportation Charges
The **MIP** does not reimburse transportation costs, including but not limited to mileage, fuel costs, parking, tolls, car rental, etc., even if such expenses relate to the transportation of **MIP members** to or from medical or pharmacy providers.

The **MIP** does not cover evacuation or repatriation charges. However, the **MIP** will cover professional ambulance services and charges for railroad or regularly scheduled airline service for one round-trip per calendar year per condition and per **member**, if approved by the **Insurance Administrator,** as outlined in Section 05.20.

07.25 Gender Reassignment Surgery
The MIP does not cover gender reassignment surgery or related services to address gender identity disorder (gender dysphoria) where the condition is the health care provider's primary diagnosis. The MIP covers those accepted services necessary to establish the primary diagnosis.

07.26 Volunteer Services
The **MIP** does not cover charges made by a volunteer in connection with services furnished to a **member** while part of a **hospice care program**.

08 PRESCRIPTION DRUG BENEFITS

Prescription drug benefits are payable for covered drugs a **member** obtains while insured.

08.01 Brand-Name Drugs versus Generic Drugs

Prescription drugs are of two fundamental types--generic and brand-name. A generic drug is therapeutically equivalent and contains the same active ingredients, in the same dosage form, as the brand name drug. Both types are approved by the U.S. Food and Drug Administration (FDA).

The **MIP** encourages the selection of generic prescription drugs in the United States and provides greater coverage and lower copay amounts for generic drugs when drugs are purchased from a retail **participating network pharmacy** or through a **participating mail-order pharmacy**.

Brand-name drugs include preferred and non-preferred drugs. The former include carefully selected brand-name drugs that can assist in maintaining quality care for members. The **Insurance Administrator** has its own list of such drugs and can be contacted to determine if a prescribed medication is considered preferred or non-preferred. Most non-preferred drugs cost more than preferred drugs.

It is important to discuss all treatment options with a **physician**.

08.02 Dispense As Written (DAW) Rule

The Dispense As Written (DAW) rules provide an additional incentive for members to use lower-cost generic drugs instead of brand name drugs where there are generic equivalents available. When a generic equivalent is available, members will pay more for the cost of their medicines, based on the applicability of the DAW rules.

If:

- *the prescribing physician writes "DAW" on the prescription and has not documented medical necessity for the brand-name drug*; or
- *If the member asks the pharmacist to dispense the brand-name drug when a generic equivalent is available*

Then, the member pays the difference between the price of the equivalent generic drug and the price of the preferred/non-preferred brand-name drug, plus the cost share of the brand drug, as appropriate.

Under either scenario, the member's total cost share shall not exceed the price of the brand name drug.

This additional amount does not apply to the **Out of Pocket Maximum**.

08.03 Network Pharmacies

08.03.01 Retail

In-network prescription benefits are managed by **Insurance Administrators, and not by the World Bank Group**. Prescriptions obtained at a **participating network pharmacy** are delivered upon presentation of the **member's** insurance card. The negotiated discount and **MIP** coverage are applied at the point of purchase and no claim forms are required. **Members** will pay the annual **brand-name drug coinsurance**, if applicable.

Purchases made at a **participating network pharmacy** without presenting the insurance card will be treated as out-of-network. **Members** will have to pay the full cost of the prescription at the time of purchase and file a medical claim with the medical claims **Insurance Administrator** and the **member's** benefits will be reduced accordingly.

08.03.02 Mail Order

The pharmacy **Insurance Administrator** offers mail order service within the United States. Mail order service is not available to mailing addresses outside of the United States. Mail order provides additional discounts and is suited to long-term maintenance prescriptions for ongoing or chronic conditions.

08.03.03 Specialty Drugs

Specialty drugs are high-cost biotech drugs, usually injectables, used to treat serious, chronic conditions, which can be dispensed only under close medical supervision. These specialty drugs are shipped free to the patient's home or doctor's office. The **Insurance Administrator** provides refill reminders, nurse and care coordinators to answer questions about the drug/condition, ancillary supply such as syringes, and other services. Examples of specialty drugs include chemotherapy drugs, infertility drugs, human growth hormone drugs, drugs for multiple sclerosis, and drugs for rheumatoid arthritis.

08.03.04 Prescription Drug Tiers

The **MIP** utilizes a three-tiered benefit for prescription drug purchases at **network pharmacies** in the United States. **Members** retain free choice of prescription drugs, but **members** maximize savings by using generic and preferred **brand-name drugs**. Benefits for generic, preferred brand, and non-preferred brand prescription drugs are shown in the **benefit summaries**.

08.04 Out-of-Network Pharmacies

Members, who purchase prescriptions from an out-of-network pharmacy or outside of the United States, must pre-pay the entire cost, and then submit a medical claim to the **Insurance Administrator** for reimbursement.

08.05 Prior Authorization

08.05.01 General Information

The **Insurance Administrator** is authorized to obtain any information deemed necessary to fill or reimburse a prescription. The **Insurance Administrator** may review any prescription for **medical necessity** and compliance with the provisions of the **MIP** and established medical norms.

08.05.02 Infertility Drugs

Infertility drugs require preauthorization and are not covered if the **member** has exceeded any lifetime limit for corresponding medical infertility services as specified in the **benefits summaries**.

08.05.03 All Other Drugs

Certain covered drugs require preauthorization prior to dispensing at a **participating network pharmacy**, or prior to reimbursement by the **Insurance Administrator**.

08.06 Dispensing Limit

08.06.01 Dispensing Limit Generally

The dispensing limit when using a participating **network** or **mail-order pharmacy** is a 90-day supply when supported by a corroborating prescription from a doctor or dentist. A vacation override can be made for up to a 180-day supply by seeking prior authorization from the **Insurance Administrator**. Requests for supplies of 181 days to 365 days must be approved by the **Insurance Administrator** and the **World Bank Group**. The supply cannot exceed 365 days.

08.06.02 Dispensing Limit for Members in MIP Continuation

The dispensing limit for all prescription drug purchases by **members** in **MIP** Continuation is 90 days, regardless of whether the purchase is from a retail pharmacy or through the mail-order service.

09 PRESCRIPTION DRUG EXCLUSIONS AND LIMITATIONS

Prescription drug expenses not covered include:

- Over-the-counter products (including over-the-counter vitamins and nicotine products) other than diabetic supplies or products defined as preventive care. This applies even if a **physician** prescribes the over-the-counter product.
- Therapeutic devices or appliances (i.e., hypodermic needles, syringes, etc., other than diabetic supplies).
- Anorexics or appetite suppressants available over the counter are excluded.
- Beauty aids.
- Blood and blood plasma. This is covered as a medical expense. See Section 05.03.02.
- Cosmetics and cosmetic drugs.
- Dietary supplements other than those administered internally, or those that may be lawfully dispensed only with a doctor's prescription (such as prescribed prenatal vitamins and vitamins available only by prescription for specific medical conditions).
- Experimental or investigative drugs or substances which the U.S. Food and Drug Administration (FDA) has not approved for general use, or for drugs labeled "Caution: Limited by Federal law to investigational use." This exclusion includes the "off-label use" of drugs for an indication or in an age group, dosage, or route of administration not approved by the FDA.
- Topical Rogaine or Minoxidil, or any other drug used for cosmetic purposes other than to treat an illness or injury.
- Hair loss drugs, unless the hair loss is due to an illness or injury sustained in an accident that takes place while the **member** is covered under the **MIP**.
- Charges that are incurred before the **member's** coverage under the **MIP** begins, or after the **member's** coverage under the **MIP** ends.
- Any prescription refill in excess of the number or supply specified by the doctor or dentist.
- Any prescription dispensed more than one year after the doctor's or dentist's order.
- Any drug that may be obtained without charge under any government program in which the member is eligible to participate.
- Any drug for which a **member** would not legally have to pay if there were no insurance for prescription drugs.
- Any drug or its administration for which a terminally ill **member** is entitled to benefits under the **MIP's hospice care** coverage. See Section 05.07.
- Any drug prescribed for treatment of an on-the-job injury or illness, where the insured has a compensable workers' compensation claim for that injury or illness.
- Any drug that is not **medically necessary**. For prescribed drugs that requires the **Insurance Administrator** to determine **medical necessity**, the **Insurance Administrator** requires evidence of an existing medical

condition that meets the **MIP** criteria. Such documentation must be submitted by a **physician**, including the **member's** name, date of birth, diagnosis (if applicable), statement as to the medication, benefits of the prescribed medicine and other medications which have proved to be ineffective in the **member's** treatment.

- Charges made by an out-of-network pharmacy which are in excess of **usual and customary charges**.
- Drugs approved by the U.S. Food and Drug Administration for a class of patient different from the insured, e.g., a drug approved for children taken by an adult, unless specifically approved by the **Insurance Administrator**.

NOTE: Amounts paid for these items do not apply to the **Out of Pocket Maximum**.

10 COORDINATION OF COVERAGE

Coverage under more than one health plan is not unusual. For example, a member may have coverage under a spouse's health plan as well as the MIP. Or, if over age 65, a member may be covered under the **MIP** and Medicare in the U.S. When more than one health plan pays benefits, these benefits must be coordinated to ensure that the total benefits paid for a health care service by all insurers do not exceed what the **MIP** recognizes as a **covered expense**. The following information explains how benefits are coordinated with other plans that cover **members** and their eligible family members.

10.01 What "Other Plans" Means

An "other plan" is any other type of health expense coverage under:

- Government-provided or government-subsidized national health plans such as Medicare in the U.S.
- Group health insurance.
- Any other type of health coverage for persons in a group. This includes plans that are insured and those that are not.

There is no coordination with individual health plans.

10.02 Coordination Method

To ensure that benefits paid by multiple parties do not exceed what the MIP considers the total cost of a covered service, benefits are coordinated in such as manner as to ensure that the **MIP** will pay either:

- its regular benefits in full; or
- a reduced amount of benefits.

10.02.1 Coordination Details

The "coordination" method compares the amount of allowable expenses the **MIP would have paid** to the amount the other insurance coverage actually paid. The **MIP** will pay either the balance of all unpaid expenses, including the other insurance coverage's **deductibles** and **co-payments**, up to the limit it would have otherwise paid or a reduced amount of benefits. **Therefore, under the coordination method, it is possible for a member to receive 100% reimbursement** from all sources for an allowable **MIP** expense.

"Allowable expenses" are any medically necessary and reasonable health expense, part or all of which is covered under any of the plans involved.

For example, the difference between the cost of a private hospital room and the semiprivate rate is not an allowable expense unless a private hospital room is medically necessary, either in terms of generally accepted medical practice or as specifically defined in the **MIP**.

10.03 Determining the Plan That Pays First

The Plan has adopted a coordination of benefits provision that conforms to the Model COB Regulation adopted by the National Association of Insurance Commissioners in June 1985, as modified from time to time.

To find out if **MIP** benefits will be reduced as a result of coordination, the **Insurance Administrator** must first determine which plan pays benefits first. For queries about the order of coverage, members should contact the Insurance Administrator.

The determination of which plan pays first (the "order of coverage") is as follows:

- The plan without a coordination of benefits provision determines its benefits before the plan that has such a provision.
- The plan that covers a person as a staff member employee or retiree determines its benefits before the plan that covers the person as a dependent. If the person is a member and is eligible for Medicare and is not actively working, Medicare pays first.
- Under the Medicare Secondary Payer rules, the order of benefits is as follows:
    - The plan that covers the person as a dependent of a **working** spouse pays first;
    - Medicare pays second; and the plan that covers the person as a retiree pays third.[8]

When coordinating with Medicare, the **Insurance Administrator** may use Medicare's determination of Allowable Expenses (MAE) or the Plan's determination of Allowable Expenses as the basis of determining whether and to what extent additional benefits are payable by the Plan. Three claim situations could arise:

- **Medicare Participating Provider—**The provider's charge cannot exceed MAE. Once paid by Medicare, the claim is processed by the Insurance Administrator using MAE. The Retiree's Medicare out of pocket expense, i.e., coinsurance and deductibles, is based on MAE. The MIP would use MAE to determine what it would pay. With COB, up to 100 percent of MAE could be covered. MIP Allowable Expense is not relevant since there is no charge in excess of MAE.

- **Non-participating Provider**. If a provider chooses not to become a Medicare participating provider, he may either accept or decline assignment of Medicare benefits. If the provider accepts assignment, then COB is as described above for a participating Medicare provider. If the provider does not accept assignment, he cannot by law charge the Medicare Retiree more than 115 percent of the Medicare fee schedule. The Medicare Retiree is not responsible for billed amounts in excess of 115 percent of MAE. Medicare will pay its portion, and the **Insurance Administrator** will process the balance based on the MBP's benefit provisions. The **Insurance Administrator** would use the 115 percent of the fee schedule as the MAE. As with the Medicare participating provider, there is no MIP Allowable Expense to refer to for COB.

- **Providers who opt out of Medicare**. A provider opting out of Medicare enters into private contracts with Medicare Retirees. Under these contracts, the Retirees waive their rights to limit their payments to what Medicare allows, and they agree to pay the provider's full charges. It is our understanding that these claims cannot be submitted to Medicare by the Retiree or the provider. In

[8] This type of situation arises when a person, who is a Medicare beneficiary, is also covered under his or her own group health plan as a retiree and under a group health plan as a dependent of an active employee. In this situation, each of the three plans is secondary to the other as the following illustrates: (1) Medicare is secondary to the group health plan covering the person as a dependent of an active employee as required pursuant to the Medicare secondary payer rules; (2) the group health plan covering the person as a dependent of an active employee is secondary to the group health plan covering the person as a retiree; and (3) the group health plan covering the claimant as a retiree is secondary to Medicare because the plan is designed to supplement Medicare when Medicare is the primary plan.

such cases, the **Insurance Administrator** will pay based on the MIP's Allowable Expense and no COB would occur.

For a dependent child whose parents are married or are living together, whether or not they have ever been married, **the plan of the parent whose birthday occurs earlier in the calendar year pays first**. This means that if a **member** were born in April and the spouse was born in October, the **member's** plan is considered primary and pays benefits first, even if the spouse is older than the **member**. When both parents' birthdays occur on the same day, the plan that has covered the parent the longest pays first. If the other plan does not have the parent birthday rule, the other plan's coordination of benefits rule applies.

When the parents of a dependent child are divorced or separated:

- If there is a court decree which states that the parents will share joint custody of a dependent child, without stating that one of the parents is responsible for the health care expenses of the child, the "birthday rule" described above applies.
- If a court decree gives financial responsibility for the child's medical, dental or other health care expenses to one of the parents, the plan covering the child as that parent's dependent determines its benefits before any other plan that covers the child as a dependent. If there is no such court decree, the order of benefits will be that the plan of the parent who has custody pays benefits before the plan of the step-parent with whom the child resides, which pays benefits before the plan of the parent who does not have custody.

If an individual has coverage as an active employee or dependent of such employee, and also as a retired or laid-off employee, the plan that covers the individual as an active employee or dependent of such employee is primary.

The benefits of a plan which covers a person under a right of continuation under federal or state laws will be determined **after** the benefits of any other plan which does not cover the person under a right of continuation.

If the above rules do not establish an order of payment, the plan that has covered the person for the longest time will pay benefits first.

In order to administer the coordination rules, the **Insurance Administrator** can release or obtain data. The **Insurance Administrator** can also make or recover payments.

10.04 Coordination and Prescription Drug Benefits

Prescription drug benefits and out-of-pocket expenses are only coordinated with other plans if the other plan covers prescription drugs as a benefit.

10.05 Right of Recovery and Subrogation

On behalf of a **member**, the **MIP** may recover benefits paid for expenses incurred by a **member** due to an injury or illness for which another person (called the "third party") may be liable. If a **member** incurs expenses that would be covered under the **MIP** on account of an injury, illness or condition caused by the actions or omissions of a third party ("covered expenses"), he or she must notify the **Insurance Administrator** of any claim, right of recovery, demands, actions or lawsuit that the **member** may have against the third party for covered expenses ("third party claims"). Notice must be provided within a reasonable time, but no more than 30 calendar days after the member knows or should have known of the actions, omissions, or events that form the basis for any third party claims.

In this case, the **MIP** has the right to pursue all rights of recovery against the third party or a person's insurance carrier, for example in the event of a claim under the uninsured or underinsured auto coverage provision of an

auto insurance policy. The **MIP** shall be subrogated to any and all third party claims. The **member** may do nothing to prejudice the **MIP**'s right to subrogation or reimbursement. Furthermore, the **MIP** may, but need not, in its sole discretion, require a member as a precondition to payment of covered expenses by the **MIP** to sign a subrogation and reimbursement agreement and to agree, in writing, to assist the **MIP** to secure its right to subrogation and reimbursement from a third party.

The **MIP** also has the right to recover from the **member** amounts received by judgment, settlement, payment or compensation (regardless of fault, negligence or wrong doing) or otherwise from the third party, his or her insurance carrier, or any other person or entity, to the extent of the benefits paid by the MIP. The **MIP** may also recover refunds from providers for services already reimbursed by the **MIP**. The member must execute and deliver any documents required, and do whatever is necessary to secure the **Insurance Administrator's** rights of recovery and will cooperate fully with the **Insurance Administrator** or its subcontractors in recovery attempts.

The **member** has an obligation to notify the **Insurance Administrator** immediately in writing of the receipt of an amount of any recovery. The **member** has a duty to hold the recovery separately and not commingle it with any other assets until the **MIP** is repaid in full. The member also agrees that the **MIP** has an equitable lien by agreement on the portion of any such recovery paid by the **MIP** for **covered expenses** and a constructive trust on the entire recovery.

The **MIP** has the right to be reimbursed first from any such recovery for covered expenses paid or payable in the future by the **MIP** whether or not the **member's** recovery was less than the actual damages incurred and whether or not the **member** has been made whole. These rights of first priority in contravention of the make whole or similar doctrine shall not be affected or limited in any way by the manner in which the **member** or any person or entity paying any recovery designates or characterizes the recovery or any portion of the recovery. The **member** must repay the **MIP** in full out of the recovery for all covered expenses that have been paid by the **MIP** and that are reasonably foreseeable at the time of recovery. Reimbursement to the **MIP** will be without reduction, set-off or abatement for attorneys' fees or costs incurred by the **member** in collecting the recovery.

11 CLAIMS, PAYMENTS AND APPEALS

11.01 Keeping Records of Expenses

Records of health expenses for staff members and all covered family members will be required when filing a claim for benefits. Of particular importance are:

- Names and addresses of doctors, dentists and other care providers;
- Dates on which expenses are incurred; and
- Copies of all health care bills and receipts.

11.02 Claims

11.02.01 Filing Claims

A claim must include an original itemized receipt showing the patient's name, date of service, provider name, and diagnosis (the requirement for a diagnosis is waived for medical claims priced below $500). It should show each service or supply provided with the associated fee.

If an **in-network provider** (including a PCP under **MIP coverage option** C) is used, he or she will file claims on the member's behalf. However, if an out-of-network provider (or, under **MIP coverage option** C, the **member** self-refers except as specified in Section 04.15.06) is used, the **member** (or the **member's** legally authorized representative) is responsible for filing his own claims if the provider does not do so on his behalf.

To file a claim, a claim form must be completed. **MIP** claim forms are available from the **Insurance Administrator** at http://mip, or from the internet at www.worldbank.org/humanresources. The instructions for completing the form and a mailing address are included on each form.

All claims must be filed promptly. A claim that is filed beyond the end of the calendar year following the year in which the service was incurred will not be accepted. For example, if a service is provided during 2016, the corresponding claim may be filed up until December 31, 2017.

11.02.02 Urgent Care Claims

This type of claim includes those situations commonly treated as emergencies. If a treating **physician** believes that a **member** has an urgent care claim, the **member** or his representative must provide notice to the **Insurance Administrator**. If the claim is an urgent care claim, the **member** or his authorized representative will be notified of the **Insurance Administrator's** decision about the claim not more than 72 hours after receipt of a complete claim. If the claim does not include sufficient information for the **Insurance Administrator** to make a decision, the **member** or his representative will be notified of the need to provide additional information within 24 hours after receipt of the incomplete claim. The **member** will have at least 48 hours to respond to this request. The **Insurance Administrator** will inform the **member** of its decision within 48 hours of receipt of the additional information.

11.02.03 Prior Authorization (Pre-Service Claims)

A **prior authorization** claim is a claim for which a **member** must get approval before obtaining medical care or treatment. This process is also often referred to as a pre-service claim. If **prior authorization** is requested, the **Insurance Administrator** will notify the **member** of its initial determination not more than 15 days from the date it receives a complete request for **prior authorization**. If more time is needed, the member will be notified that an additional processing period is required. If an extension is due to a failure to submit all the necessary

information to make a determination, the **member** will have at least 45 days to provide the additional information requested. **Members** are encouraged to request a pre-authorization for services exceeding $500.

11.02.04 Post-Service Claims

A post-service claim is a claim for which payment is requested after medical care or treatment has already been provided. If the claim is a post-service claim, the **member** will be notified if the complete claim is denied in whole or in part within 30 days after it is received. If more time is needed for review, the **member** will be notified that an additional processing period is required. If an extension is due to a failure to submit all of the necessary information to decide the claim, the **member** will have at least 45 days to provide the additional information requested.

11.02.05 Concurrent Care Claims for Ongoing Treatment

A concurrent care decision occurs where the **MIP** approves an ongoing course of treatment to be provided over a period of time or for a specified number of treatments. There are two types of concurrent care claims: (a) where reconsideration of the approval results in a reduction or termination of the initially approved period of time or number of treatments; and (b) where an extension is requested beyond the initially approved period of time or number of treatments.

- Concurrent Care Early Termination. A decision by the **MIP** to reduce or terminate an initially approved course of treatment may be appealed. Notification of a decision by the **MIP** to reduce or terminate an initially approved course of treatment shall be provided sufficiently in advance of the reduction or termination to allow an appeal of this determination and receive a decision on the appeal prior to the reduction or termination. All requests shall be decided in the otherwise applicable time frames for the type of claim (pre-service, post-service, or urgent care).

- Concurrent Care Extension Request. If there is a request to extend a concurrent care decision involving urgent care and if the claim is made at least 24 hours prior to the end of the initially approved period of time or number of treatments, the claim shall be decided within no more than 24 hours after receipt of the claim. Any other request to extend a concurrent care decision shall be decided in the otherwise applicable time frames for the type of claim (pre-service, post-service, or urgent care).

11.03 Review and Denial of Claims - Members in U.S. Plan Options

11.03.01 Review of Claims

The **Insurance Administrator** has fiduciary responsibility to review and process claims in accordance with the **MIP**. The **Insurance Administrator** must process a claim based on material submitted, and if insufficient medical information is provided, they may be obliged to deny a claim. The **Insurance Administrator** cannot "put aside" a claim pending receipt of additional information, so if a claim is incomplete, the member will be notified and provided time (48 hours for urgent care claims and 45 days for pre-service and post-service claims) to provide additional information. If the additional information is not provided within the applicable timeframe, the claim will be denied and that message conveyed on the explanation of benefits. If the **member** obtains the necessary information for a post-service claim after the 45-day period has elapsed, the member can submit the information to the **Insurance Administrator** and the claim will be re-opened and processed.

The **World Bank Group** does not review medical claim information, and cannot and will not instruct the **Insurance Administrator** on specific claim reimbursements. The **World Bank Group's** internal grievance procedure is not available to review **MIP** claim disputes. Resolution of claim disputes is the responsibility of the **Insurance Administrator**.

11.03.02 Denial of Claims

If all or part of a claim is denied, the **Insurance Administrator** will notify the **member** of the denial (also called an **adverse benefit determination**). All denials will be in writing, unless the claim involves urgent care, in which case notice of the denial may initially be made orally. A denial notice will:

- State specific reason(s) for the denial, with specific references to the **MIP** provision(s) on which the denial was based;
- List any additional material or information that may be needed in order to perfect the claim and explain why such material or information is necessary;
- Include any internal rule, guideline, protocol, or other similar criterion relied upon or a statement that a copy of such will be provided upon request and free of charge;
- Include an explanation of the scientific or clinical judgment for a determination based on a **medical necessity**, **experimental treatment** or similar exclusion or limit, applying the terms of the **MIP** to the medical circumstances of the **member**, or a statement that such explanation will be provided upon request and free of charge;
- Include information sufficient to identify the claim, including the date of service, the health care provider, the claim amount, and the denial codes and their meanings, if applicable;
- Include a statement that diagnosis and treatment codes and their meanings, if applicable, will be provided upon request and free of charge; and
- Include a description of the standard, if any, used in making the benefit determination.

The notice will also describe in detail how to have the decision reviewed, the review procedures, how to file an appeal, and the applicable time frame for requesting review (including, in the case of a claim involving urgent care, a description of the expedited review process applicable to such claim). The notice will also describe the external review process.

11.04 Appeals – Members in U.S. Plan Options

11.04.01 Filing an Appeal

In accordance with Staff Rule 6.12, Participation in the Medical Insurance Plan, **MIP** claim decisions are not subject to the **World Bank Group** internal grievance mechanisms, such as the Peer Review Committee or the Administrative Tribunal.

If a claim has been denied, the denial can be appealed to the **Insurance Administrator** and reviewed. The **member** must file the appeal, and the **Insurance Administrator** must review the appeal, within the time frames provided below. An employee of the **Insurance Administrator** other than the employee involved in the initial benefit determination or a subordinate of such individual will be appointed to decide the appeal. Please note that the time frames differ based on the category of benefit and the type of claim.

A **member** has 180 days after the receipt of the denial notice to request a review of the denial. The request for a review must be in writing unless the claim involves urgent care, in which case the request may be made orally and documentation may be provided by facsimile or other expeditious method. The **Insurance Administrator** must respond within the time frames provided below.

- *Urgent Care Claims*. Not later than 72 hours after receiving a request for review.

- *Prior Authorization (Pre-Service Claims)*. Not later than 30 days after receiving a request for a review.
- *Post-Service Claims*. Not later than 60 days after receiving a request for a review.
- *Concurrent Care Claims for Ongoing Treatment*. For early termination claims—before the proposed reduction or termination takes place. For extension request claims—the appeal time frame for urgent care, pre-service, or post-service claims (as described above), as appropriate to the request.

11.04.02 Appeals Process

In connection with the right of a **member** to appeal the denial, in whole or in part, of a claim for benefits, the **member** may request, free of charge, reasonable access to and copies of all relevant documents, records, and other information related to the claim, unless such relevant documents, records or other information are privileged. The **member** can also submit comments, documents, records, and other relevant information regarding why the claim should not be denied. These submissions must be in writing.

If the claim was denied based on a medical judgment, the **Insurance Administrator** will consult with a health care professional with appropriate training and experience. The health care professional consulted for the appeal will not be the professional (if any) consulted during the prior determination, nor a subordinate of such professional.

11.04.03 Decision on Appeal

The decision will be sent to the **member** in writing. A denial will:

- State the specific reasons(s) for the denial, with specific references to the **MIP** provision(s) on which the denial was based;
- Include any internal rule, guideline, protocol, or other similar criterion relied upon or a statement that a copy of such will be provided upon request and free of charge;
- Include an explanation of the scientific or clinical judgment for a determination based on a **medical necessity**, **experimental** treatment or similar exclusion or limit, applying the terms of the **MIP** to the **member's** medical circumstances, or a statement that such explanation will be provided upon request and free of charge;
- Include information sufficient to identify the claim, including the date of service, the health care provider, the claim amount, and the denial codes and their meanings, if applicable;
- Include a statement that diagnosis and treatment codes and their meanings, if applicable, will be provided upon request and free of charge;
- Include a description of the standard, if any, used in making the benefit determination;
- Include a discussion of the final appeal denial decision (also called a **final adverse benefit determination**);
- State that the **member** is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the claim for benefits; and
- Describe the second appeal procedures.

11.05 Second Appeal – Members in U.S. Plan Options

If your appeal is unsuccessful and the coverage denial is upheld, you have the right to request a second level appeal within 60 calendar days after receiving the decision on the first level appeal.

For non-medical necessity reviews, an **Insurance Administrator** appeals analyst that was not involved in the first level appeal will review the claim. Examples of appeals that fall into this category include appeals for usual and customary charges, cutbacks, as well as those expenses not covered in Section 07, Medical Expenses Not Covered, and Appendix Section A03, Dental Expenses Not Covered.

If the first level appeal was denied based on a medical judgment, the **Insurance Administrator** will consult with a health care professional with appropriate training and experience. The health care professional consulted for the second level appeal will not be the professional (if any) consulted during the original claim determination or the first level appeal, nor a subordinate of such professional.

The decision will be sent to the **member** in writing. A denial will:

- State the specific reasons(s) for the denial, with specific references to the **MIP** provision(s) on which the denial was based;
- Include any internal rule, guideline, protocol, or other similar criterion relied upon or a statement that a copy of such will be provided upon request and free of charge;
- Include an explanation of the scientific or clinical judgment for a determination based on a **medical necessity**, **experimental** treatment or similar exclusion or limit, applying the terms of the **MIP** to the **member's** medical circumstances, or a statement that such explanation will be provided upon request and free of charge;
- Include information sufficient to identify the claim, including the date of service, the health care provider, the claim amount, and the denial codes and their meanings, if applicable;
- Include a statement that diagnosis and treatment codes and their meanings, if applicable, will be provided upon request and free of charge;
- Include a description of the standard, if any, used in making the benefit determination;
- Include a discussion of the final appeal denial decision (also called a **final adverse benefit determination**);
- State that the **member** is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the claim for benefits;
- Describe any available voluntary appeal procedures; and
- Describe any external review procedures, describe how to request external review, and provide information about the applicable time frame for requesting review (including any expedited time frame that may apply to an urgent care claim).

11.06 External Review – Members in U.S. Plan Options

MIP members have the right to file an appeal from an **adverse benefit determination** relating to service(s) that were received or could have been received from a health care provider under the **MIP**.

11.06.01 Eligibility for External Review

The external review process under the **MIP** gives **members** the opportunity to have a review of an **adverse benefit determination** (including a **final internal adverse benefit determination**) conducted pursuant to applicable law. A request will be eligible for external review if the following are satisfied:

- The adverse benefit determination is based on a lack of medical necessity, or the treatment at issue is considered experimental and/or investigational; or
- The **Insurance Administrator** does not adhere to all claim determination and appeal requirements under U.S. federal law; or
- The standard levels of appeal have been exhausted; or
- The appeal relates to a rescission, defined as a cancellation or discontinuance of coverage that has retroactive effect; and,
- The amount in dispute exceeds $500.

An **adverse benefit determination** based upon eligibility to participate in the MIP is not eligible for **external review**.

If upon the final standard level of appeal, the coverage denial is upheld and it is determined that the **member** is eligible for **external review**, the **member** will be informed in writing of the steps necessary to request an **external review**.

If external review is requested, an independent review organization will refer the case for review by a neutral, independent clinical reviewer with appropriate expertise in the area in question. The decision of the independent external expert reviewer is binding on the **member**, the **Insurance Administrator** and the **MIP** unless otherwise allowed by law.

11.06.02 Requesting External Review

To request an **external review**, the **member** must request such a review in accordance with the procedures established by the **Insurance Administrator** within 123 calendar days of the date the **member** received the **adverse benefit determination** or **final internal adverse benefit determination** notice. If the last filing date falls on a Saturday, Sunday or federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday or federal holiday. The **member** also must include a copy of the notice and all other pertinent information that supports the request.

If the **member** files a voluntary appeal, any applicable statute of limitations will be tolled while the appeal is pending. The filing of a claim will have no effect on the **member's** rights to any other benefits under the **MIP**. However, the appeal is voluntary and the **member** is not required to undertake it before pursuing legal action.

If the **member** chooses not to file for voluntary review, the **MIP** will not assert that the **member** has failed to exhaust his or her administrative remedies because of that choice.

11.06.03 Preliminary Review

Within 5 business days following the date of receipt of a request for **external review**, the **Insurance Administrator** must provide a preliminary review determining the following: the **member** was covered under the **MIP** at the time the service was requested or provided, the determination does not relate to eligibility, the **member** has exhausted the internal appeals process and the **member** has provided all paperwork necessary to complete the **external review**.

Within one business day after completion of the preliminary review, the **Insurance Administrator** must issue to the **member** a notification in writing. If the request is complete but not eligible for **external review**, such notification will include the reasons for its ineligibility. If the request is not complete, such notification will describe

the information or materials needed to make the request complete, and the **Insurance Administrator** must allow the **member** to perfect the request for external review within the 123 calendar days filing period or within the 48-hour period following the receipt of the notification, whichever is later.

11.06.04 Referral to External Review Officer (ERO)

The **Insurance Administrator** will assign an **ERO** accredited as required under federal law, to conduct the **external review**. The assigned **ERO** will notify the **member** in a timely manner in writing of the request's eligibility and acceptance for **external review**, and will provide an opportunity for the **member** to submit in writing, within 10 business days following the date of receipt, additional information that the **ERO** must consider when conducting the **external review**. Within one (1) business day after making the decision, the **ERO** must notify the **member**, the **Insurance Administrator** and the **MIP**.

The **ERO** will review all of the information and documents received in a timely manner. In reaching a decision, the assigned **ERO** will review the claim and not be bound by any decisions or conclusions reached during the **MIP**'s internal claims and appeals process. In addition to the documents and information provided, the assigned **ERO**, to the extent the information or documents are available and the **ERO** considers them appropriate, will consider the following in reaching a decision:

- The **member's** medical records;
- The attending health care professional's recommendation;
- Reports from appropriate health care professionals and other documents submitted by the **Insurance Administrator**, the **member**, or the **member's** treating provider;
- The terms of the **MIP** to ensure that the **ERO's** decision is not contrary to the terms of the plan, unless the terms are inconsistent with applicable law;
- Appropriate practice guidelines, which must include applicable evidence-based standards and may include any other practice guidelines developed by the U.S. federal government, national or professional medical societies, boards, and associations;
- Any applicable clinical review criteria developed and used by the **Insurance Administrator**, unless the criteria are inconsistent with the terms of the **MIP** or with applicable law; and
- The opinion of the **ERO's** clinical reviewer or reviewers after considering the information described in this notice to the extent the information or documents are available and the clinical reviewer or reviewers consider appropriate.

The assigned **ERO** must provide written notice of the **final external review decision** within 45 days after the **ERO** receives the request for the **external review**. The ERO must deliver the notice of the **final external review decision** to the **member**, the **Insurance Administrator** and the **MIP**.

The ERO's decision will contain:

- Information sufficient to identify the claim, including the date(s) of service, the health care provider, any applicable claim amount, and the diagnosis and treatment codes and their meaning;
- A general description of the reasons for the previous denial and the reasons review was requested;
- The date the **ERO** received the request for review and the date of its decision;

- References to the documentation, specific coverage provisions, and evidence-based standards considered in reaching its decision;
- A discussion of the reasons for its decision and any evidence based-standards it relied on in making its decision;
- A statement that its decision is binding, except to the extent that other remedies are available under state or federal law; and

After a **final external review decision**, the **ERO** must maintain records of all claims and notices associated with the **external review** process for six years. An **ERO** must make such records available for examination by the claimant, the **MIP**, or federal oversight agency, if applicable, upon request, except where such disclosure would violate U.S. federal privacy laws.

Upon receipt of a notice of a final external review decision reversing the **adverse benefit determination** or **final internal adverse benefit determination**, the **MIP** must immediately provide coverage or payment (including immediately authorizing or immediately paying benefits) for the claim.

11.06.05 Expedited External Review

The **MIP** allows a **member** to request an expedited **external review** at the time the **member** receives:

- An **adverse benefit determination** if the **adverse benefit determination** involves a medical condition for which the time frame for completion of an expedited internal appeal would seriously jeopardize the **member**'s life or health or would jeopardize the **member's** ability to regain maximum function and the **member** has filed a request for an expedited internal appeal; or
- A **final internal adverse benefit determination**, if the **member** has a medical condition where the time frame for completion of a standard **external review** would seriously jeopardize the **member's** life or health or would jeopardize the **member's** ability to regain maximum function, or if the **final internal adverse benefit determination** concerns an admission, availability of care, continued stay, or health care item or service for which the **member** received emergency services, but has not been discharged from a facility.

Immediately upon receipt of the request for expedited **external review**, the **Insurance Administrator** will determine whether the request meets the reviewability requirements set forth above for standard **external review**. The **Insurance Administrator** must immediately send the **member** a notice of its eligibility determination.

Upon a determination that a request is eligible for **external review** following preliminary review, the **Insurance Administrator** will assign an **ERO**. The **ERO** shall render a decision as expeditiously as the **member's** medical condition or circumstances require, but in no event more than 72 hours after the **ERO** receives the request for an expedited **external review**. If the notice is not in writing, within 48 hours after the date of providing that notice, the assigned **ERO** must provide written confirmation of the decision to the **member**, the **member's Insurance Administrator** and the **MIP**.

11.07 Review and Denial of Claims – Members in International Plan Options

11.07.01 Review of Claims

The **Insurance Administrator** has fiduciary responsibility to review and process claims in accordance with the **MIP**. The **Insurance Administrator** must process a claim based on material submitted, and if insufficient medical

information is provided at time of submission, the **Insurance Administrator** may be obliged to deny a claim. The **Insurance Administrator** cannot "put aside" a claim pending receipt of additional information, so if a claim is incomplete, it will be denied and the member will be notified within 10 working days of the denial. If the **member** obtains the necessary information for a post-service claim within the MBP deadline for filing claims, the member can submit the information to the **Insurance Administrator** and the claim will be re-opened and processed.

The **World Bank Group** does not review medical claim information, and cannot and will not instruct the **Insurance Administrator** on specific claim reimbursements. The **World Bank Group's** internal grievance procedure is not available to review **MIP** claim disputes. Resolution of claim disputes is the responsibility of the **Insurance Administrator**.

11.07.02 Denial of Claims

If all or part of a claim is denied, the **Insurance Administrator** will notify the **member** of the denial (also called an **adverse benefit determination**). All denials will be in writing. A denial notice will:

- Include information sufficient to identify the claim, including the date of service, the health care provider, the claim amount, and the denial codes and their meanings, if applicable;
- State specific reason(s) for the denial, with specific references to the **MIP** provision(s) on which the denial was based; and
- List any additional material or information that may be needed in order to perfect the claim and explain why such material or information is necessary.

The notice will also describe in detail how to have the decision reviewed, the review procedures, how to file an appeal, and the applicable time frame for requesting review.

11.08 Appeals – Members in the International Plan Options

11.08.01 Completeness of information

If a claim is denied, the **member** should verify that the **Insurance Administrator** possessed and processed complete information with regard to the diagnosis and treatment.

11.08.02 Filing an Appeal

In accordance with Staff Rule 6.12, Participation in the Medical Insurance Plan, **MIP** claims decisions are not subject to the **World Bank Group** internal grievance mechanisms, such as the Appeals Committee or the Administrative Tribunal.

If a claim has been denied, the denial can be appealed to the **Insurance Administrator** and reviewed. A **member** has 60 days after the receipt of the denial notice to request a review of the denial. The request for a review must be in writing unless the claim involves urgent care, in which case the request may be made orally and documentation may be provided by fax or other expeditious method

To obtain a review, the **member** or his/her representative should submit a request to the **Insurance Administrator**. The request should include:

- identifying information, including:
    - the group name (World Bank Group MIP);
    - the staff member's name and UPI number; and

    - the patient's name and date of birth;
- which claim the **Insurance Administrator** should review:
    - provider name;
    - invoice date; and
    - claim processing date.
- the reason that the claim should be reviewed

In connection with the right of a **member** to appeal the denial, in whole or in part, of a claim for benefits, the **member** may request, free of charge, reasonable access to and copies of all relevant documents, records, and other information related to the claim, unless such relevant documents, records or other information are privileged. The **member** can also submit comments, documents, records, and other relevant information regarding why the claim should not be denied. These submissions must be in writing.

11.08.03 Appeals Process

The **Insurance Administrator** must respond within the time frames provided below.

- *Urgent Care Claims*. Not later than 72 hours after receiving a request for review.
- *Prior Authorization*. Not later than 60 days after receiving a request for a review.
- *Post-Service Claims*. Not later than 60 days after receiving a request for a review.
- *Concurrent Care Claims for Ongoing Treatment*. For early termination claims—before the proposed reduction or termination takes place. For extension request claims—the appeal time frame for urgent care, prior authorization, or post-service claims (as described above), as appropriate to the request.

Someone other than an individual involved in the initial benefit determination or a subordinate of such individual will be appointed to decide the appeal. Please note that the time frames differ based on the category of benefit and the type of claim.

If the claim was denied based on a medical judgment, the **Insurance Administrator** will consult with a health care professional with appropriate training and experience. The health care professional consulted for the appeal will not be the professional (if any) consulted during the prior determination, nor a subordinate of such professional.

11.08.04 Decision on Appeal

The decision will be sent to the **member** in writing. A denial will:

- Include information sufficient to identify the claim, including the date of service, the health care provider, the claim amount, and the denial codes and their meanings, if applicable;
- State the specific reasons(s) for the denial, with specific references to the **MIP** provision(s) on which the denial was based;
- Include any internal rule, guideline, protocol, or other similar criterion relied upon or a statement that a copy of such will be provided upon request and free of charge;

- Include an explanation of the scientific or clinical judgment for a determination based on a **medical necessity**, **experimental** treatment or similar exclusion or limit, applying the terms of the **MIP** to the **member's** medical circumstances, or a statement that such explanation will be provided upon request and free of charge;
- Include a description of the standard, if any, used in making the benefit determination;
- State that the **member** is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the claim for benefits, unless such relevant documents, records or other information are privileged;
- Describe any external review procedures, describe how to request external review, and provide information about the applicable time frame for requesting review (including any expedited time frame that may apply to an urgent care claim).

11.09 Payment of Benefits

If **members** pay for a service in full, generally **members** should file the claim. If the provider files the claim on the **member's** behalf, **members** risk overpaying the provider. If the **Insurance Administrator** receives a claim form where the provider states that the "assignment signature is on file," the **Insurance Administrator**, not the **member**, must pay the provider. If the **member** also has paid the provider, then the provider would be paid twice and **members** would need to seek reimbursement from the provider.

Refer to sections 04.07.01 and 04.08.01 for details on how in-network and out-of-network benefits, respectively, are paid by the **Insurance Administrator**.

11.09.01 Domestic Disputes and Estrangement

The **World Bank Group** complies with Staff Rule 2.01, Confidentiality of Personnel Information, which allows disclosure of **MIP** coverage information (including **MIP** identification cards) to a family **member** covered by the **MIP** without authorization by the staff **member**.

In cases of estrangement between staff **members** and their covered family **members**, if a covered family **member** pays a medical expense, and if a claim reimbursement is sent to the staff member for such a claim, the staff member must pay the reimbursed amount to the covered family member within five business days of receipt of the claim reimbursement from the **Insurance Administrator**. Withholding such payments is considered fraud on the **MIP**, and is an ethical violation that could result in penalties imposed by the **World Bank Group** up to and including permanent cancellation of medical insurance coverage.

11.09.02 Claim Payment Options

Claims for **members** with a U.S. address are reimbursed by check in U.S. dollars unless the **member** elects otherwise. U.S. residents and non-residents may elect to have claim reimbursements paid to them via direct deposit by following the process set forth by each Insurance Administrator.

There are no restrictions against making payments in any other currencies, as long as there are no legal restrictions. If a request is received for EFT in a currency other than those mentioned above, the **Insurance Administrator** attempts such arrangements. However, this delays the processing of the claim.

11.10 Adjustment Rule

If a **member** changes his or her **MIP coverage option**, or moves from the **MIP** to the **World Bank Group Retiree Medical Insurance Plan (RMIP)** or vice versa, benefits for claims incurred after the effective date of the change

will be paid according to the provisions for the new **coverage option** selected.[9] Consequently, there are no vested rights to benefits based on provisions in effect before the adjustment date. If benefits increase as a result of an option change, such an increase applies only to claims incurred on or after the effective date of the increase, not to claims incurred prior to that date.

11.11 Misstatement of Fact

If there is any misstatement of fact that affects coverage under the **MIP**, the true facts will be used to determine the coverage that applies. If it is proved that a staff member or his covered family members have committed fraud on the **MIP** or an intentional misrepresentation of a material fact, then the member's **MIP** coverage will be terminated pursuant to Section 03.03. Disciplinary action under Staff Rule 3.01, Standards of Professional Conduct, may also apply.

11.13 Recovery of Overpayment

If the Insurance Administrator makes a benefit payment that exceeds the amount a person is entitled to under the MIP, as a result of errors made by the member, the provider or the Insurance Administrator, the Insurance Administrator has the right to:

- Require that the overpayment be immediately returned on request; or
- Reduce any future benefit payment(s) by the amount of the overpayment (future payments to the person who incurred the original claim, plus payments to covered family members, may be reduced).

If a **member** refuses to repay any owed amount to the **Insurance Administrator**, the **World Bank Group** may suspend or permanently revoke **MIP** coverage.

This right of recovery of overpayment does not affect any other right of recovery or right of subrogation that the **Insurance Administrator** may have.

11.14 Legal Action

No legal action can be brought by a **member** or provider to recover a benefit more than three years after the deadline for filing claims.

[9] If a retiree (and enrolled family members, if applicable) is covered by both the **MIP** and the **RMIP** in the same year, the **RMIP** annual **deductible** and annual **out-of-pocket maximum** must be met (regardless of whether the **MIP** annual **deductible** and annual **out-of-pocket maximum** were previously met for the same calendar year). However, charges applied towards the **MIP** annual **deductible** and annual **out-of-pocket maximum** during such a year will be applied towards the **RMIP** annual **deductible** and annual **out-of-pocket maximum** for that year.

12 GLOSSARY

Adverse Benefit Determination: A denial, reduction, termination of or failure to provide or make payment (in whole or in part) for a service supply or benefit, including any rescission of coverage.

Ambulance: A vehicle that is staffed with medical personnel and equipped to transport an ill or injured person.

Assignment of Benefits: With the **Insurance Administrator**'s written consent, a **member** may have **MIP** benefits assigned to his/her health care provider. This means **MIP** benefits will be paid directly to the doctor (or facility, such as a **hospital** or laboratory), rather than to the **member**. This is normally indicated on a medical claim form.

World Bank Group: The International Bank for Reconstruction and Development, the International Development Association, the International Finance Corporation, and the Multilateral Investment Guarantee Agency.

Benefit Summary: A chart setting forth the coverage levels currently provided under an applicable **MIP coverage option**.

Brand-Name Drug: A prescription drug or medicine that is protected by trademark registration. The patent for brand-name drugs is in effect for 17 years in the United States.

Coinsurance: The percentage of a covered amount **members** need to pay, with or without paying the calendar year **deductible** first.

Convalescent Facility: An institution that is licensed to provide, and does provide, the following on an inpatient basis for persons convalescing from disease or injury:

- Professional nursing care by a Registered Nurse (RN), or by a Licensed Practical Nurse (LPN) directed by a full-time RN;
- Physical restoration services to help patients meet a goal of self-care in daily living activities; and
- 24-hour nursing care by licensed nurses directed by a full-time RN.

The facility must be supervised full-time by a **physician** or RN and keep a complete medical record on each patient. The facility must have a utilization review plan and must not be mainly a place for rest, for the aged, for drug addicts, for alcoholics, for people who are mentally retarded, for custodial or educational care, or for care of mental disorders.

Co-payment: The flat fee **members** pay for certain types of covered services and supplies. The **co-payments** that apply to each **MIP coverage option** are shown in the **benefit summaries'** charts. Additional services such as lab tests or x-rays are typically not included in this office visit **co-payment,** and **members** are responsible for **coinsurance** for such additional **covered expenses**.

Covered Expenses: Expenses that are **usual and customary charges** for specified services and supplies furnished or ordered by a provider, and that are **medically necessary** as defined by the **Insurance Administrator** and the provisions of this document.

Custodial Care: Services and supplies (including room and board and other institutional care) provided to help a person in the activities of daily life. Such services are not medical treatment for the diagnosis or treatment of a disease or injury. The person does not have to be disabled. Such services and supplies are custodial care no matter who prescribes, recommends or performs them.

Deductible: The amount of **covered expenses** each **member** or family of **member** must pay each calendar year before the **MIP** will begin to pay benefits. Some expenses do not count toward a **deductible**, such as office visit **co-payments**.

Dependent Child: An unmarried biological, foster or legally adopted son or daughter of a staff member as defined in Staff Rule 1.01 General Provisions, paragraph 1.02 Definitions, and Staff Rule 6.02 Dependency Allowances, paragraph 1.03 Definitions.

Durable Medical Equipment: Equipment and accessories that are:

- Made to withstand prolonged use;
- Made for and mainly used in the treatment of a disease or injury;
- Intended for use in the home;
- Not normally of use to people who do not have a disease or injury;
- Not for use in altering air quality or temperature; and
- Not for exercise or training.

The **MIP** does not allow for more than one item of equipment for the same or similar purpose. **Durable medical equipment** does not include equipment such as whirlpools, portable whirlpool pumps, sauna baths, massage devices, overbed tables, elevators, stair lifts, communication aids, vision aids, and telephone alert systems.

Eligible Dependent: The term "Eligible Dependent" means a:

- Spouse or registered domestic partner, as described under Section 02.02.01
- Children and Grand Children , as described under Section 02.02.02.

Emergency Care: The treatment given to evaluate and treat an **emergency condition**. In all cases, **emergency care** will include:

- A medical screening examination that is within the capability of the emergency department of a **hospital**, including ancillary services routinely available to the emergency department to evaluate the **emergency condition**; and
- Such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the **hospital** to stabilize the patient.

For this purpose, “stabilize” means to provide such medical treatment of the condition as may be necessary to assume, within reasonable medical probability that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility.

Emergency Condition: A recent and severe medical condition including but not limited to severe pain which would lead a prudent layperson possessing an average knowledge of medicine and health to believe that his or her condition, illness, or injury is of such a nature that failure to get immediate medical care could result in:

- Placing the person’s health in serious jeopardy;
- Serious impairment to bodily function;

- Serious dysfunction of a body part or organ; or
- Serious jeopardy to the health of the unborn child (in the case of a pregnant woman).

ERO: An independent external review organization that conducts reviews of **adverse benefit determinations**.

Experimental or Investigational Treatment: A treatment that the **Insurance Administrator**, at its discretion, determines is not commonly and customarily recognized as safe and effective for the particular diagnosis or treatment, or which requires approval by any government authority and such approval has not been granted before the service or supply is furnished. Furthermore, this includes services or supplies that are determined by the **Insurance Administrator** to be **experimental**.

A drug, device, procedure or treatment will be considered **experimental** if:

- There are insufficient outcome data available from controlled clinical trials published in the peer-reviewed literature to substantiate safety and effectiveness for the disease or injury being treated.
- Required U.S. Food and Drug Administration approval or other national licensing authority has not been granted for marketing as a treatment for that disease or injury.
- A recognized national medical or dental society or regulatory agency has determined in writing that the service or supply is **experimental** or for research purposes.
- The written treatment protocol or the study protocol has stated that the service or supply is **experimental** or for research purposes.
- It is not of proven benefit for the specific diagnosis or treatment of the disease or injury.
- It is not generally recognized by the medical community as effective or appropriate for the specific diagnosis or treatment of the disease or injury.
- It is performed or provided in special settings for research purposes.

External Review: A review of an **adverse benefit determination** by an **ERO**.

Family Deductible: The amount of **covered expense**s a family must pay each calendar year before the **MI**P will begin to pay benefits. If a family incurs **covered expenses** equal to the **family deductible**, the **MI**P will process claims as if each family member's individual **deductible** has been met for the balance of that calendar year. Any amount of **covered expense**s that a staff member or any family member covered by the **MIP** pays during a year for a covered service will contribute towards the **family deductible**.

Expenses paid by or on behalf of a participant in the World Bank Group Sponsored Medical Insurance Plan are not applied toward the **family deductible**.

Final External Review Decision: A determination by an **ERO** at the conclusion of an **external review**.

Final Internal Adverse Benefit Determination: An **adverse benefit determination** that has been upheld by the **Insurance Administrator** at the completion of the internal appeals process.

Generic Drug: When a **drug** has been on the market for at least 17 years and loses its patent protection, other manufacturers may produce a generic version. Generics in the U.S. are safety-tested by the Food and Drug Administration.

Headquarters: The **World Bank Group's** offices in Washington, D.C. and the satellite offices located in Austria, Belgium, France, Germany, Italy, Japan, Switzerland, United Kingdom and any other satellite office the **World Bank Group** may designate.

Home Health Care Agency: An agency that:

- Mainly provides skilled nursing and other therapeutic services;
- Is associated with a professional group (of at least one **physician** and one registered nurse) which makes policy;
- Has full-time supervision by a **physician** or a registered nurse;
- Keeps complete medical records on each person;
- Has an administrator; and
- Meets licensing standards.

Home Health Care Plan: A plan that provides for care and treatment in a person's home. It must be prescribed in writing by the attending **physician** and be an alternative to inpatient **hospital** or **convalescent facility** care.

Hospice Care: Care provided to a terminally ill person by or under arrangements with a **hospice care** agency. The care must be part of a **hospice care** program.

Hospice Care Agency: An agency or organization that:

- Has **hospice care** available 24 hours per day and meets any licensing or certification standards set forth by the jurisdiction in which it operates;
- Provides mainly skilled nursing services, medical and social services and other psychological and dietary counseling;
- Provides or arranges for other services, such as the services of a **physician**, physical and occupational therapy, part-time home health aide and inpatient care in a facility when needed for pain control or acute or chronic symptom management;
- Has personnel employed, including at least one **physician** and one registered nurse (RN) and one licensed or certified social worker;
- Has established policies governing the provision of **hospice care**;
- Assesses the patient's medical and social needs and develops a **hospice care program** to meet those needs;
- Provides an ongoing quality assurance program;
- Permits all area medical personnel to utilize its services for their patients;
- Maintains complete medical records on each patient; and
- Employs a full-time administrator.

Hospice Care Program: A written plan of **hospice care** that is established and reviewed by a **physician** and appropriate personnel of a **hospice care** agency, is designed to provide palliative and supportive care to terminally

ill patients and supportive care to their families and includes an assessment of a patient's medical and social needs and a description of the care to be provided to meet those needs.

Hospice Facility: A facility that mainly provides **hospice care** and provides nursing services 24 hours a day under the direction of a registered nurse (RN) and meets any licensing or certification standards set forth by the jurisdiction in which it operates. It must employ a full-time administrator, **physician** or RN and maintain complete medical records on each patient.

Hospital: A legally operated institution which is engaged primarily in providing medical services for resident patients and which has permanent facilities for diagnosis and for major surgery, continuous nursing service by registered nurses and continuous supervision by a staff of doctors. It is not mainly a place for rest, care for the aged or care for drug addicts or alcoholics, or a nursing home, and must make charges for services provided.

Illness: A pathological condition of the body that presents a group of clinical signs and symptoms and laboratory findings peculiar to the findings that set the condition apart as an abnormal entity differing from other normal or pathological body states.

In-Network Benefits: Benefits for services obtained through a participating medical or prescription drug provider. Generally, covered **in-network benefits** require lower **co-payment** and **coinsurance** amounts, and the fee charged is a pre-negotiated amount agreed upon between the provider and the **Insurance Administrator**.

In-Network Provider: Also called "**participating provider**," any **physician**, **hospital**, skilled nursing facility or other individual or entity delivering health care or ancillary services which contracts with the **Insurance Administrator** to provide covered services to **MIP members** for a negotiated charge. In general, **in-network providers** file all reimbursement requests, and **members** are responsible only for **co-payment** and/or **coinsurance** at the time of service.

Injury: An accidental bodily **injury** that is the sole and direct result of: (i) an unexpected or reasonably unforeseen occurrence or event; or, (ii) the reasonable unforeseeable consequences of a voluntary act by the person. An act or event must be definite as to time and place.

Insurance Administrator: A vendor with whom the **World Bank Group** has contracted to provide administrative services for benefits provided under the **MIP**. The **Insurance Administrators** have fiduciary responsibility to adjudicate claims under the **MIP**.

International Option: MIP coverage options AI or BI.

Medical Necessity: Also called "**medically necessary**," a service or supply furnished by a particular provider necessary and appropriate for the diagnosis, the care or the treatment of the disease or injury involved, as determined by the **Insurance Administrator**. To be appropriate the service or supply must:

- Be care or treatment, as likely to produce a significant positive outcome as, and no more likely to produce a negative outcome than, any alternative service or supply, both as to the disease or injury involved and the person's overall health condition; or
- Be a diagnostic procedure, indicated by the health status of the person, and be as likely to result in information that could affect the course of treatment as, and no more likely to produce a negative outcome than, any alternative service or supply, as to both the disease or injury involved and the person's overall health condition.

In determining if a service or supply is appropriate under the circumstances, the **Insurance Administrator** will take into consideration:

- Information provided on the affected person's health status;
- Reports in peer-reviewed medical literature;
- Reports and guidelines published by nationally recognized health care organizations that include supporting scientific data;
- Generally recognized professional standards of safety and effectiveness in the U.S. (or the country in which care is rendered) for diagnosis, care or treatment);
- The opinion of health professionals in the health specialty involved, and any other relevant information known by the **Insurance Administrator**.

The following services or supplies are never considered **medically necessary**:

- Those that do not require the technical skills of a medical, mental health or dental professional.
- Those furnished mainly for the personal comfort or convenience of the person, any person who cares for him or her, and any person who is part of his or her family, any health care provider or health care facility.

Member: Any individual enrolled in the **MIP** either as the insured or as a dependent of the insured or as another enrolled family member of the insured.

MIP: The World Bank Group Medical Insurance Plan as effective January 1, 2017.

MIP Coverage Option: A level of coverage available under the **MIP**.

Non-Participating Provider: A provider who has not contracted with the **Insurance Administrator** to provide services at a negotiated rate.

Out-of-Network Benefits: Benefits for services obtained through a **non-participating provider.**(For **MIP coverage option** C **members**, **out-of-network benefits** also include self-referred services, except those explicitly allowed in Section 04.06.1.) Generally, covered **out-of-network benefits** require that the **deductible** first be satisfied before reimbursement is made. In addition, the **non-participating provider** may require payment at the time of service, and the **member** must file the claim.

Out-of-Pocket Maximum: Also called a "medical stop-loss," the maximum amount a **member** must pay toward out-of-network expenses in a calendar year. Once the **member** reaches his/her **out-of-pocket maximum**, the **MIP** pays 100% of **covered expenses** for the remainder of the calendar year. Certain expenses do not apply toward the **out-of-pocket maximum**:

- Expenses that exceed the **usual and customary charge** limits;
- Charges for services that are not covered by the **MIP**;
- Penalties for failure to obtain the necessary **prior authorization** for covered hospitalizations if they were to apply in the **MIP**;
- **Co-payment**s for **physician**'s office visits;
- **Co-payments** and **coinsurance** amounts paid for **in-network** prescription drug purchases.

Outpatient: A **MIP member** who is registered at a **physician**'s office or recognized health care facility, but not as an inpatient, or services and supplies provided in such a setting.

Participating Mail-Order Pharmacy: A mail-order pharmacy facility at which **MIP members** may buy prescriptions at a discount in accordance with the **MIP**'s personal prescription drug insurance provisions. Mail-order pharmacies can deliver only to U.S. addresses, and cannot deliver to **World Bank Group** business addresses in Washington, D.C. or elsewhere.

Participating Network Pharmacy: A retail pharmacy that participates in the Prescription Benefit Manager's network throughout the U.S. and at which **MIP members** can buy prescriptions at a discount in accordance with the **MIP**'s Prescription Drug insurance provisions. These are also known as **in-network** pharmacies.

Participating Provider: See "**In-network** Provider."

Patient Management: Free programs designed to assist **MIP members** with large or complex cases to assess opportunities to coordinate care, identify treatment options to improve the quality of care, and quality of life and to control costs. **Patient Management** and Case Management are recommended for all **members**, and required for **members** in **MIP coverage option** C.

Physician: A member of a medical profession, who is properly licensed or certified to provide medical care under the laws of the state where he or she practices, and who provides medical services which are within the scope of his or her license or certificate.

Plan Year: January 1 to December 31.

Prior authorization: The process of collecting information prior to all non-emergency **hospital** inpatient admissions and prior to the performance of selected ambulatory or **outpatient** procedures and services. The process permits advance eligibility verification, determination of coverage, and communication with the **physician** and/or **member**. It also allows the **Insurance Administrator** to coordinate the patient's transition from the inpatient setting to the next level of care (discharge planning), or to register patients for specialized programs such as case management, or the prenatal program for **members** in **MIP coverage option** C. There are two components to **prior authorization**: notification and coverage determination. Notification is the process of gathering basic information about proposed services before the service is rendered. Coverage determination requires provision of information regarding the clinical condition and treatment or services proposed for the member. Coverage decisions are based on nationally recognized criteria.

Prescription Drug Out-of-Pocket Maximum: A separate calendar year limit for **out-of-pocket expenses** on prescription drug purchases at **in-network** pharmacies. This is a limit separate from the **out-of-pocket maximum** for medical expenses. When out-of-pocket expenses for covered prescription drugs meet this limit for a participant or family, covered prescription drugs are reimbursed at 100% for the balance of the calendar year for that participant or family.

Preventive Care: Items or services rendered to prevent disease or its recurrence, which include:

- Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force;
- Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the Covered Person involved.
- For infants, children, and adolescents, evidence-informed **preventive care** and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and

- For women, evidence-informed **preventive care** and screening provided for in the comprehensive guidelines supported by the U.S. Department of Health and Human Services Health Resources and Service Administration.
- Preventive care as prescribed by formally recognized national medical authorities in national health care policies and programs of countries outside the United States in which participants are residents.

All in-network **preventive care** services are first dollar benefits, meaning that no **deductible**, **co-payment**, or **coinsurance** will be applied, irrespective of anything herein to the contrary. Medical management techniques that are prescribed as part of a duly recognized preventive care item are covered under the MIP.

Prior Coverage: any plan of group medical coverage sponsored by the **World Bank Group** that is replaced by coverage under part or all of a new plan sponsored by the **World Bank Group**.

Qualifying Service: The term "Qualifying Service" means the total period of pensionable service in one or more of the appointment types to which this Rule applies.

RMIP: The **World Bank Group Retiree Medical Insurance Plan** as effective January 1, 2017.

Skilled Nursing: A service or services that meet all of the following requirements: (i) the services require medical or paramedical training; (ii) the services are rendered by an **R.N.** or **L.P.N.** within the scope of his or her license; and (iii) the services are not custodial.

Urgent Care Facility: In the U.S., a facility designed to deal with conditions requiring prompt attention but not posing an immediate, serious, or life-threatening risk.

Usual and Customary Charges: For **in-network providers**, the fee that the provider has agreed to accept for the services or supplies furnished. For **out-of-network providers**, this is the charge made by providers for the services or supplies furnished within the same 3-digit zip code area or general area of service. For services rendered outside the U.S., the **Insurance Administrator** will use the usual and customary charge for the area of service, if known to the **Insurance Administrator**. Otherwise, the **Insurance Administrator** will use the charges made by most providers for that service in New York City (zip code 100xx). In determining a similar or comparable service, the **Insurance Administrator** may take into account the complexity of the service, the skill and specialty of the provider or the range of services supplied by a facility.

13 GENERAL PROVISIONS

13.01 No Guarantee of Employment

No person shall have any rights under the **MIP**, except as, and only to the extent, expressly provided for in the **MIP**. Neither the establishment nor amendment of the **MIP**, the payment of benefits, nor any action of the **World Bank Group** shall be held or construed to confer upon any person any right to be continued as a staff member of the **World Bank Group** or upon dismissal, any right or interest in any benefit other than as herein provided.

13.02 Assignment of Benefits

Except as may otherwise be required by applicable law, or as otherwise specifically provided in the **MIP**, no amount payable at any time under the **MIP** shall be subject in any manner to alienation by anticipation, sale, transfer, assignment, bankruptcy, pledge, attachment, charge or encumbrance of any kind, or in any manner be subject to the debts or liabilities of any person. Any attempt to so alienate or subject any such amount, whether currently or thereafter payable, shall be void. Notwithstanding the foregoing, any **member** may request and authorize the **Insurance Administrator** to pay benefits directly to a health care provider furnishing services or supplies covered under the **MIP**, and any such payment, if made, shall constitute a complete discharge of the liability of the **MIP** therefore.

13.03 Medical Care Decisions and Treatment

Certain of the benefits under the **MIP** provide for the payment of specified health care expenses. All decisions regarding health care are solely the responsibility of each **member** in consultation with the health care providers selected. The **MIP** contains rules for determining the percentage of allowable health care expenses that will be reimbursed, and whether particular treatments or health care expenses are eligible for reimbursement. Any decision with respect to the level of health care reimbursements, or the coverage of a particular health care expense, may be disputed by the **member** in accordance with the **MIP**'s claim procedures. Each **member** may use any source of care for health treatment and health coverage as selected, and neither the **MIP** nor the **World Bank Group** will have any obligation for the cost or legal liability for the outcome of such care, or as a result of a decision by a **member** not to seek or obtain such care, other than the liability of the **MIP** for the payments of benefits as outlined herein.

13.04 No Waiver of Terms

No term, condition or provision of the **MIP** shall be deemed waived, and there shall be no estoppel against the enforcement of any provision of the **MIP**, except by written agreement of the party charged with such waiver or estoppel. No such written waiver shall be deemed a continuing waiver unless specifically stated therein, and each such waiver shall operate only as to the specific term or condition waived and shall not constitute a waiver of such term or condition for the future or as to any act other than that specifically waived.

13.05 Limitation of Rights

Nothing appearing in or done pursuant to the **MIP** shall be held or construed to give any person any legal or equitable right against the **World Bank Group** or the **Insurance Administrator**, or any person connected therewith, except as expressly provided herein or as provided by applicable law, or to give any person any legal or equitable right to any assets of the **MIP**.

13.06 Severability

If any provision of the **MIP** is held invalid or unenforceable, its invalidity or unenforceability shall not affect any other provision of the **MIP**, and the **MIP** shall be construed and enforced as if such provision had not been included herein.

13.07 Use of Captions

The section and subsection numbers and captions used throughout the **MIP** have been inserted solely as a matter of convenience and in no way define or limit the scope or intent of any provision of the **MIP**.

13.08 No Oral Modifications

The terms of the **MIP** cannot be modified except by means of a written amendment duly authorized and adopted by the **World Bank Group**. Any attempted oral modification is not binding on the **World Bank Group**.

13.09 Tax Consequences

The **World Bank Group** does not represent or guarantee that any particular federal or state income, payroll, personal property, Social Security or other tax consequences will result from participation in this **MIP**. A **member** should consult with professional tax advisors to determine the tax consequences of participation.

IN WITNESS WHEREOF, this **MIP** is hereby adopted as of this 4th day of March, 2019.

By: 

Director, Human Resources
Employment Policy, Compensations and Systems

APPENDIX A DENTAL COVERAGE

To the extent deemed advisable by the **World Bank Group**, this Appendix A shall constitute a separate plan providing for the provision of dental benefits. To the extent necessary, other provisions of the **MIP** are deemed incorporated by reference in this Appendix A.

A.01 Dental Coverage Maximum

The maximum benefit payable for a **member** during a calendar year is shown in the current **benefit summaries** for each option, available online at http://mip for staff and at www.worldbank.org/humanresources for eligible family members. The calendar year maximum applies to all dental expenses except periodontal surgery (implant surgery, oral surgery, gingivectomy, gingivoplasty, alveoplasty, vestibuloplasty, osseous surgery) and orthodontia.

A separate lifetime maximum benefit applies for orthodontia services. This limit applies to all benefits payable for orthodontia while a **member** is insured under the **MIP**, whether the coverage was continuous or interrupted.

A.02 Covered Expenses

Covered expenses are limited to the **usual and customary charges** made by a dentist for **medically necessary** dental services provided to a **MIP member**. Covered expenses are listed under the **MIP**. A charge for any dental care, treatment, service or supply is considered to be incurred on the date the applicable care, treatment, service or supply is received. All benefits or services must begin before **MIP** coverage ends, and be installed or completed within three months following the end of a **member's** eligibility. Dental services provided in a **hospital**, at home, or in an extended care facility are limited to professional fees only, and are covered if the patient meets **medical necessity** criteria as determined by the **Insurance Administrator**.

A.02.01 Preventive and Diagnostic Services

Covered preventive and diagnostic services include the following:

- *Routine oral exams*: Up to two exams every calendar year per **member** including diagnosis, x-rays.
- *P*rophylaxis (routine dental cleaning) up to four times per year.
- *Space maintainers*: Fixed or removable space maintainers for missing primary teeth.
- *Fluoride treatment*: Topical application of sodium or stannous fluoride, up to two applications every calendar year.
- *Tooth sealants*: The application of fissure sealants on unfilled permanent molars.
- *Diagnostic exploratory services*.

A.02.02 X-ray and Basic Restorative Dental Services

Covered x-ray and restorative services include:

- *Anesthesia*: General and local anesthesia (including nitrous oxide) and palliative medication (e.g., tranquilizers) administered in connection with covered dental services.
- Emergency palliative treatment.
- *Endodontics*: Root canal therapy.

- *Fillings*: Including gold and composite (tooth-colored) materials.
- Injection of antibiotic drugs.
- *Oral exams*: Additional cleanings or exams (beyond two per calendar year) if **medically necessary** as determined by the **Insurance Administrator**.
- *Oral surgery*: Incision or excision procedures of the gum and tissues of the mouth when performed in connection with the extraction of the teeth or the fitting of dentures. These include but are not limited to: (i) splinting, and (ii) simple and surgical extractions including those in connection with orthodontic treatment.
- *Periodontics*: Treatment of periodontal and other diseases of the gums and tissues of the mouth, except as listed under Major Restorative Services (Section A.02.03), including but not limited to root planing and scaling, periodontal maintenance and gingival curettage.
- *Prescription drugs*: Prescription drugs administered by a dentist in a dentist's office.
- *X-rays*: X-rays other than those in connection with routine oral exams.

A.02.03 Major Restorative Dental Services

Major restorative dental services include:

- *Bridges and dentures*: The initial installation of dentures or fixed bridgework.
- *Implant devices*: Posts and crowns (non-surgical expenses), inclusive of regenerative techniques.
- *Restorations*: Inlays and crowns
- *Repair work*: Repair and re-cementing of crowns, inlays and fixed bridgework, and repair and relining of dentures.
- *Replacement work*: Replacement of existing dentures or fixed bridgework subject to limits described in Section A.03.02 and Section A.03.04. The replacement will not be covered if due to loss or theft of the denture or fixed bridgework. The replacement of bridges or dentures is **not** covered in the **first year** of the **member's** coverage.

Temporary bridges and restorations are not covered for any **member** as these are considered inclusive to the final restoration and should not be billed separately.

A.02.04 Special Periodontal Surgical Dental Expenses

Covered special periodontal surgical dental expenses include:

- *Anesthesia*: in association with oral surgery.
- *Other oral surgery*: if not covered under other **MIP** provisions.
- *Special periodontal surgical procedures*: gingivectomy, gingivoplasty, alveoplasty, vestibuloplasty, osseous surgery, and implant surgery.

A.02.05 Orthodontia Dental Expenses

Covered expenses include orthodontic treatment and appliances.

A.03 Dental Expenses Not Covered

A.03.01 First Year of Coverage

In the first year during which a **member** is covered by the **MIP**, the **MIP** does not cover:

- Replacement of existing fixed or removable bridgework.
- Replacement of full or partial dentures.
- Implants (surgical services, implants and crowns).

A.03.02 Crowns and Bridges

Crown and Bridge replacements are covered, limited to two items for the same tooth (or teeth) within a 10-year period, subject to the conditions of Section A.02.03.

A.03.03 Cosmetic Dentistry

Charges in connection with dental services primarily for the purpose of improving appearance are not covered, such as:

- Alteration or extraction and replacement of sound teeth;
- Services performed for cosmetic reasons, such as veneers, are not covered under this plan.
- Any treatment of the teeth to remove or lessen discoloration except to remove or lessen discoloration caused by an accidental injury to a natural tooth. Treatment to remove or lessen discoloration must commence within 90 days of the date of the accident.
- Replacement of congenitally missing teeth; or all appliances and restorations for the purpose of splinting teeth, except A-splinting and provision splinting in connection with periodontal treatment.

A.03.04 Dentures

Dentures are covered, limited to two within a 10-year period, subject to the conditions of Section A.02.03.

A.03.05 Expenses Incurred While Not Eligible for Coverage

The **MIP** does not cover charges incurred before a **member's MIP** coverage begins or after a **member's MIP** coverage ends, unless specifically provided in this document.

A.03.06 Space Maintainers

The **MIP** does not cover expenses for space maintainers other than those for missing primary teeth.

A.03.07 Not Covered Expenses

The **MIP** does not cover any dental services that are not **covered expenses** as determined by the **Insurance Administrator**.

A.03.08 Services Not Performed by a Dentist

The **MIP** does not cover dental services performed, furnished or ordered other than by a licensed dentist or by a licensed dental hygienist working under the supervision of a licensed dentist.

A.03.09 Services Otherwise Covered

Dental coverage excludes dental services that are **covered expenses** under any other part of the **MIP** (e.g., oral surgery, which is a medical expense).

A.03.10 Temporary Restoration of Dentures, Crowns, or Bridges

The **MIP** does not cover temporary restoration such as partial dentures, crowns or bridges, as these are considered inclusive to the final restoration and should not be billed separately.

APPENDIX B VISION COVERAGE

To the extent deemed advisable by the **World Bank Group**, this Appendix B shall constitute a separate plan providing for the provision of vision benefits (hereinafter referred to as "Vision Benefit"). To the extent necessary, other provisions of the **MIP** are deemed incorporated by reference in this Appendix B.

B.01 Covered Expenses

Covered expenses are limited to the **usual and customary charges** made for **medically necessary** vision services provided to a **MIP member**. The **MIP** determines what expenses are covered.

Covered services include the following:

- One routine eye exam, including refraction, per calendar year per **member** (copay required in-network, reimbursement applies outside of network). In addition to the eye exam referenced in this Section B.01, screenings (where appropriate) for cataracts and/or diseases of the eye are covered as a preventive care benefit under the **MIP**.
- Reimbursement of eyeglasses or contact lenses, up to a flat dollar (USD) amount, specified in the **benefit summaries,** each Plan Year per **member** for prescription contact lenses and prescription eyeglass lenses and frames.
    - The Plan-Year period is the calendar year.
    - If the member does not use the benefits over a Plan-Year period, the flat dollar amount benefit does not "rollover" or accumulate to the next Plan Year period.
    - Plan members may use multiple transactions during the calendar year in order to utilize the entire eyeglass or contact lens benefit.

  This limit does not apply to the first pair of glasses or contact lenses following cataract surgery. The first pair of glasses or contact lenses following cataract surgery is covered at the otherwise applicable **in-network** or **out-of-network** coverage level.

B.02 Vision Expenses Not Covered

B.02.01 Eye Tests

The **Vision Benefit** does not cover other eye tests, except for the annual routine eye exam provided for in Section B.01.

B.02.02 Surgery to Treat Myopia

Neither the **MIP** nor the Vision Benefit provide coverage for radial keratomy or similar surgery to treat myopia (including laser surgery).

B.02.03 Charges for Fitting Contact Lenses

Vision Benefit coverage for the fitting of contact lenses is as follows:

Item	In-Network Benefit	Non-Network Benefit
Standard Contact Lens Fitting	Member cost of up to $40	Not covered

Premium Contact Lens Fitting	10% off retail price	Not covered

B.02.04 Expenses Incurred While Not Eligible for Coverage

The **MIP** does not cover charges incurred before a **member's MIP** coverage begins or after a **member's MIP** coverage ends, unless specifically provided in this document.

B.02.05 Not Covered Expenses

The **Vision Benefit** does not cover any vision services that are not **covered expenses** as determined by the **Insurance Administrator**.

B.02.06 Services Not Performed by an Optometrist or an Ophthalmologist

The **MIP and Vision Benefit** do not cover vision services performed, furnished or ordered other than by a licensed optometrist or ophthalmologist. As such, services provided by an optician are not covered. However, production and fitting of the actual frames and lenses is covered.

B.02.07 Services Otherwise Covered

The Vision Benefit excludes vision services that are **covered expenses** under any other part of the **MIP** (e.g., the diagnosis, treatment and monitoring of an eye disease, illness or injury, which is covered as a medical expense).

ANNEX BENEFIT SUMMARIES

Active Staff MIP Comparison Benefit Grid

Effective January 1, 2018	U.S. Network Benefits	Out-of-Network Benefits ALL OPTIONS
A plan year is a calendar year, January 1 through December 31		
Deductible (per person)	$300 per plan year (Option A) $650 per plan year (Option B) $350 per plan year (Option C)	
Deductible (per family)	$600 per plan year (Option A) $1,300 per plan year (Option B) $700 per plan year (Option C)	
US Medical Network - Options A and B	Aetna Open Choice PPO	
US Medical Network - Option C	Aetna Managed Choice POS	
Option C: Registration of a Primary Care Physician (PCP) with Aetna is required for each covered family member and referrals from the PCP are required for network care. Self-referral only for annual routine eye, mental health services, and routine Ob/GYN.		
Medical Out-of-pocket limits (Office visit co-payments and dental services do not accrue toward the out of pocket limits)		
Medical out-of-pocket limits per person	$2,500 per plan year (Option A) $2,500 per plan year (Option B) $3,000 per plan year (Option C)	
Medical out-of-pocket limits per family	$5,000 per plan year (Option A) $5,000 per plan year (Option B) $6,000 per plan year (Option C)	
Office visits		
Office visits for Illness or Specialist	100% after $15 co-pay (Option A) 100% after $20 co-pay (Option B) 100% after $15 co-pay (Option C)	80% after deductible
Routine annual physicals and defined preventive services*, including one annual Ob/GYN (well woman) exam	100%	
Laboratory and X-rays		
All services; (unless covered under defined preventive services above)	90% no deductible (Option A) 90% after deductible (Option B) 100% if referred by PCP (Option C)	80% after deductible
Emergency room related		
Emergency Room	90% no deductible (Option A) 90% after deductible (Option B) 100% after $50 co-pay (Option C) *80% after deductible if non-emergency use*	
Ambulance Services	90% no deductible (Option A) 90% after deductible (Option B) 100% (Option C)	
Inpatient		
Hospital costs including anesthesia	90% no deductible (Option A) 90% after deductible (Option B) 100% if referred by PCP (Option C)	80% after deductible
Surgery (physician)		
Hospice		

Active Staff MIP Comparison Benefit Grid

Outpatient		
Hospice Surgery (physician) Facility charges, including anesthesia	90% no deductible (Option A) 90% after deductible (Option B) 100% if referred by PCP (Option C)	80% after deductible
Chemotherapy and Radiation Therapy		
Chemotherapy and Radiation Therapy: *Does not include oral or injectable medications purchased through pharmacy benefit*	100%, no deductible In-office/facility administration only	
Maternity		
Obstetrics: Single fee/delivery charge including Office visits	90% no deductible (Option A) 90% after deductible (Option B) 100% (Option C) Routine prenatal office visits covered at 100%, no deductible (Options A, B and C)	80% after deductible
Obstetrics: Routine prenatal office visits billed separately from single fee	100% (Options A, B and C)	
Infertility	90% no deductible (Option A) 90% after deductible (Option B) 100% if referred by PCP (Option C)	
Infertility Lifetime Limits – All Options	Contact Insurance Administrator for benefits	
Mental Health and Substance Abuse		
Inpatient hospitalization for mental health or substance abuse Outpatient facility, including day treatment programs	90% no deductible (Option A) 90% after deductible (Option B) 100% (Option C)	80% after deductible
Office visit *No PCP referral required under Option C*	100% after $15 co-pay (Option A) 100% after $20 co-pay (Option B) 100% after $15 co-pay (Option C)	
Nursing and Home Health Care		
Skilled Nursing Facility (e.g., Rehabilitation Center): *Limited to 60 days per plan year per condition* Convalescent Care *Maximum 60 days per condition per plan year* Visiting Nurse: *Limited to 120 visits per plan year per condition* Private Duty Nursing – *Contact Insurance Administrator for authorization*	90% no deductible (Option A) 90% after deductible (Option B) 100% if referred by PCP (Option C)	80% after deductible

Active Staff MIP Comparison Benefit Grid

Short Term Rehabilitation		
Physical, occupational or speech therapy. *Restorative after illness or accident. 60 visits PT, OT, ST combined per condition per plan year. Visits over 60 review for medical necessity*	100% after $15 co-pay (Option A) 100% after $20 co-pay (Option B) 100% after $15 co-pay (Option C) *Option C: PCP Referral required*	80% after deductible
Physical, occupational or speech therap *For diagnosis of Developmental Delay, a maximum of 60 visits PT, OT, ST, combined, per year, per child.*		
Chiropractor (30 visit limit per year)		
Acupuncture (30 visit limit per year)		
Durable Medical Equipment		
Durable Medical Equipment: Rentals *Purchases only if approved by Insurance Administrator*	90% no deductible (Option A) 90% after deductible (Option B) 100% if referred by PCP (Option C)	80% after deductible
Vision Care		
Routine eye exams (one per plan year) including refraction *No PCP referral required for Option C*	$20 co-pay	$20 reimbursement
Frames, lenses, contacts	$350 Allowance for frame, lens, lens options and contact lenses. - 20% off balance over $350 for frame, lens and lens options - 15% off balance over $350 for conventional contact lenses, plus, balance over $350 for disposable contact lenses, - 5% off balance over $350 for medically necessary contact lenses Members also receive a 40% discount off additional complete pair eyeglass purchases	Up to $250 reimbursement per person, every year
Hearing Aids		
Hearing Aids	Up to $4,000 per person, every five plan years.	

*Defined preventive care services will be provided at 100% when an In Network physician or facility is used and a referral is received for those in Option C. Defined preventive services are determined by gender and age and recommendations may change from time to time. Always check the most recent recommendations provided separately from this general overview and discuss them with your doctor.

Active Staff MIP Comparison Benefit Grid

Pharmacy Benefits (ALL OPTIONS)	US Networks	Out-of-Network
Annual Deductible	$0	
Annual Out-of-Pocket Maximum	Actives: Per Person: $1000 Per Family: $2000	
Automatic Substitution of Generic-Equivalent Drugs for Patent-Expired Brand Drugs	Yes	
Dispense As Written (DAW) Rule: If prescriber writes "DAW" on Rx, or if member asks pharmacist to dispense brand drug when generic equivalent is available, then member pays difference between brand and generic drug equivalent prices + brand cost share. Additional cost does not apply to out-of-pocket maximum.	Yes	
Retail Network – up to 30-day supply per fill		
Maximum Days Supply	30	Drugs purchased outside the US are covered under your medical plan at 80% after medical deductible.
Generic Coinsurance/Copay	10%; Max.: $25	
Preferred Brand Coinsurance/Copay	25%; Max.: $70	
Non-Preferred Brand Coinsurance/Copay	40%; Max.: $120	
Retail Network for Maintenance and Mandatory Mail Order		
Maximum Days' Supply	90 After 2-fill at Retail	Drugs purchased outside the US are covered under your medical plan at 80% after medical deductible.
Generic Coinsurance/Copay	10 %; Max.: $60	
Preferred Brand Coinsurance/Copay	25%; Max.: $175	
Non-Preferred Brand Coinsurance/Copay	40%; Max.: $300	

Active Staff MIP Comparison Benefit Grid

Specialty/Biotech Drugs		
Maximum Retail Fills Before Required Use of PBM's Specialty Pharmacy	1	Drugs purchased outside the US are covered under your medical plan at 80% after medical deductible.
Maximum Days' Supply	30 – 90 days based on PBM Specialty Pharmacy's clinical oversight.	
Generic Copay/Coinsurance	5%; Max.: $50 (30 days) 5%; Max.: $75 (90 days)	
Preferred Brand Copay/Coinsurance	25%; Max.: $100 (30 days) 25%; Max.: $150 (90 days)	
Non- Preferred Brand	40%; Max.: $150 (30 days) 40%; Max.: $225 (90 days)	
Other Plan Design Features		
Preferred Brand Diabetic Supplies	0% coinsurance on diabetic supplies based on prescription from treating doctor; limit 1 blood-sugar meter per 12 months	Drugs purchased outside the US are covered under your medical plan at 80% after medical deductible.
Infertility Treatment (includes oral and injectable drugs)	$10,000 per Lifetime - (Pharmacy plan only)	
Smoking-Cessation Products	Lifetime limit not permitted under ACA; OTC products require prescription	
Clinical/Utilization Management Programs		
Prior Authorizations	Yes	
Step Therapy	Yes— Expand to other non-Specialty and Specialty drug classes	

Active Staff MIP Comparison Benefit Grid

Dental (All Options)	In-network	All other
General		
US Dental Network	Cigna Dental PPO	Not applicable
Deductibles		
Deductible (per person)	$250	
Deductible (per family)	$500	
Maximum Coverage (All Options)		
Dental Expenses per person	$3,200 per plan year	
Periodontal-Surgical expenses	No limit	
Orthodontia Lifetime Limit	$2,400 per insured	
Preventative Care		
Two routine oral exams per year including cleaning	100% no deductible	80% no deductible
Diagnostic X-rays, fluoride treatment, sealants		
Minor Restorative, including additional cleanings		
Periodontics, endodontics, fillings, extractions	80% after deductible	
Major Restorative		
Crowns, inlays, bridges, dentures, implant devices	80% after deductible	
Special Periodontics and Oral Surgery		
Gingivectomy, gingioplasty, alveoplasty, vestibuloplasty, osseous surgery, implant surgery, oral surgery	90% after deductible	80% after deductible
Orthodontics		
Orthodontics	80% after deductible	

Active Staff MIP Option A Summary

Effective January 1, 2018	U.S. Network Aetna Open Choice PPO	Out-of-Network
General		
A plan year is a calendar year, January 1 through December 31		
Medical Deductible (per person)	$300 per plan year	
Medical Deductible (per family)	$600 per plan year	
Medical Out-of-pocket limits (Office visit co-payments and dental services do not accrue toward the out of pocket limits)		
Medical out-of-pocket limits per person	$2,500 per plan year	
Medical out-of-pocket limits per family	$5,000 per plan year	
Office visits		
Office visits for Illness or Specialist	100% after $15 co-pay	80% after deductible
Routine annual physicals and defined preventive services*	100%	
Ob/GYN (well woman) exam – one per plan year*	100%	
Laboratory and X-rays		
All services; (unless covered under defined preventive services above)	90%	80% after deductible
Emergency room related		
Emergency Room	90% 80% after deductible if non-emergency use	
Ambulance Services	90%	
Inpatient		
Hospital costs including anesthesia	90%	80% after deductible
Surgery (physician)		
Hospice		
Outpatient		
Hospital costs including anesthesia	90%	80% after deductible
Surgery (physician)		
Hospice		
Chemotherapy and Radiation Therapy		
Chemotherapy and Radiation Therapy: Does not include oral or injectable medications purchased through pharmacy benefit	100%, no deductible In-office/facility administration only	
Maternity		
Obstetrics: Single fee/delivery charge incl. Office visits	90% Routine prenatal office visits covered at 100%	80% after deductible
Obstetrics: Routine prenatal office visits billed separately from single fee	100%	
Infertility	90%	
Infertility Lifetime Limits: Contact Insurance Administrator for details		
Mental Health and Substance Abuse		
Inpatient hospitalization for mental health or substance abuse	90%	80% after deductible
Outpatient facility, including day treatment programs		
Office visits	100% after $15 co-pay	

Active Staff MIP Option A Summary

Nursing and Home Health Care		
Skilled Nursing Facility – (e.g., Rehabilitation Center) *Maximum 60 days per condition per plan year*	90%	80% after deductible
Convalescent Care *Maximum 60 days per condition per plan year*		
Visiting Nurse – *Maximum 120 days per condition per plan*		
Private Duty Nursing – *Contact Insurance Administrator for authorization*		
Short Term Rehabilitation		
Physical, occupational or speech therapy – *Restorative service after illness or accident. 60 visits PT, OT, ST combined per condition per plan year. Visits over 60 review for medical necessity.*	100% after $15 copay	80% after deductible
Physical, occupational or speech therapy – *For diagnosis of Development Delay a maximum 60 visits PT, OT, ST combined, per year, per child*		
Chiropractor (30 visit limit per year)		
Acupuncture (30 visit limit per year)		
Durable Medical Equipment		
Durable Medical Equipment: Rentals *Purchases only if approved by Insurance Administrator*	90%	80% after deductible
Vision Care (EyeMed Insight Network)		
Routine eye exams, one per plan year, including refraction.	100% after $20 co-pay	$20 reimbursement
Frames, lenses, contacts (Allowance is available for multiple time use until the dollar amount is exhausted.)	$350 Allowance for frame, lens, lens options and contact lenses. - 20% off balance over $350 for frame, lens and lens options - 15% off balance over $350 for conventional contact lenses, plus, balance over $350 for disposable contact lenses, - 5% off balance over $350 for medically necessary contact lenses Members also receive a 40% discount off additional complete pair eyeglass purchases	Up to $250 reimbursement per person, every year
Hearing Aids		
Hearing Aids	Maximum reimbursement $4,000 per person, every five plan years	

*Defined preventive care services will be provided at 100% when an In-Network physician or facility is used (and a referral is received for those in Option C). Defined preventive services are determined by gender and age and recommendations may change from time to time. Always check the most recent recommendations with your Insurance Administrator and discuss them with your doctor.

Pharmacy Benefits	US Networks	Out-of-Network
Annual Deductible	$0	
Annual Out-of-Pocket Maximum	Actives: Per Person: $1000 Per Family: $2000	
Automatic Substitution of Generic-Equivalent Drugs for Patent-Expired Brand Drugs	Yes	
Dispense As Written (DAW) Rule: If prescriber writes "DAW" on Rx, or if member asks pharmacist to dispense brand drug when generic equivalent is available, then member pays difference between brand and generic drug equivalent prices + brand cost share. Additional cost does not apply to out-of-pocket maximum.	Yes	
Retail Network – up to 30-day supply per fill		
Maximum Days Supply	30	Drugs purchased outside the US are covered under your medical plan at 80% after medical deductible.
Generic Coinsurance/Copay	10%; Max.: $25	
Preferred Brand Coinsurance/Copay	25%; Max.: $70	
Non- Preferred Brand Coinsurance/Copay	40%; Max.: $120	
Retail Network for Maintenance and Mandatory Mail Order		
Maximum Days' Supply	90 After 2-fill at Retail	Drugs purchased outside the US are covered under your medical plan at 80% after medical deductible.
Generic Coinsurance/Copay	10 %; Max.: $60	
Preferred Brand Coinsurance/Copay	25%; Max.: $175	
Non- Preferred Brand Coinsurance/Copay	40%; Max.: $300	

Active Staff MIP Option A Summary

Specialty/Biotech Drugs		
Maximum Retail Fills Before Required Use of PBM's Specialty Pharmacy	1	Drugs purchased outside the US are covered under your medical plan at 80% after medical deductible.
Maximum Days' Supply	30 – 90 days based on PBM Specialty Pharmacy's clinical oversight.	
Generic Copay/Coinsurance	5%; Max.: $50 (30 days) 5%; Max.: $75 (90 days)	
Preferred Brand Copay/Coinsurance	25%; Max.: $100 (30 days) 25%; Max.: $150 (90 days)	
Non- Preferred Brand	40%; Max.: $150 (30 days) 40%; Max.: $225 (90 days)	
Other Plan Design Features		
Preferred Brand Diabetic Supplies	0% coinsurance on diabetic supplies based on prescription from treating doctor; limit 1 blood-sugar meter per 12 months	Drugs purchased outside the US are covered under your medical plan at 80% after medical deductible.
Infertility Treatment (includes oral and injectable drugs)	$10,000 per Lifetime - (Pharmacy plan only)	
Smoking-Cessation Products	Lifetime limit not permitted under ACA; OTC products require prescription	
Clinical/Utilization Management Programs		
Prior Authorizations	Yes	
Step Therapy	Yes— Expand to other non-Specialty and Specialty drug classes	

Active Staff MIP Option A Summary

	Cigna Dental PPO

Network	Total Cigna DPPO		Out-of-Network	
Calendar Year Maximum (Class I, II & III expenses)	$3,200		$3,200	
Annual Deductible Individual Family	 $250 $500		 $250 $500	
Reimbursement Levels	Based on Reduced Contracted Fees		80th percentile of Reasonable & Customary Allowances	
Benefits	Plan Pays	You Pay	Plan Pays	You Pay
Class I: Preventive & Diagnostic Oral Exams Routine - 2 per calendar year Routine Cleanings - 2 per calendar year Routine X-rays - Bitewings Non-Routine X-Rays - Full mouth: 1 every 36 consecutive months; Panorex: 1 every 36 consecutive months Fluoride Application - 1 per calendar year Sealants - Limited to posterior tooth. 1 treatment per tooth every three years Space Maintainers - Limited to non-orthodontic treatment	100% No Deductible	No Charge No Deductible	80% No Deductible	20% No Deductible
Class II: Basic Restorative Fillings Root Canal Therapy / Endodontics Emergency Care to Relieve Pain Root Planing and Scaling - Various limitations depending on the service Splinting Oral Surgery – Simple Extractions Anesthesia	80% After Deductible	20% After Deductible	80% After Deductible	20% After Deductible
Class III: Major Restorative Crowns – Replacement every 5 years Dentures – Replacement every 5 years Bridges – Replacement every 5 years Inlays / Onlays – Replacement every 5 years Prosthesis Over Implant - 1 per every 5 years if unserviceable and cannot be repaired. Benefits are based on the amount payable for non- precious metals. Repairs to Dentures, Bridges, Crowns and Inlays - Reviewed if more than once Stainless Steel/Resin Crowns Transepithelial Cytologic / Brush Biopsies Relines, Rebases and Adjustments – Covered if more than 6 months after installation	80% After Deductible	20% After Deductible	80% After Deductible	20% After Deductible
Class IV: Orthodontia Lifetime Maximum Study Models or Diagnostic Casts - Payable only when in conjunction with orthodontic workup	80% After Deductible $2,400	20% After Deductible	80% After Deductible $2,400	20% After Deductible

Class VI: Periodontal Gingivectomy Gingivioplasty Alveoplasty Vestibuloplasty Osseous Surgery Separate $250 Calendar Year Deductible to cross accumulate between classes VI, VII, IX	90% After Deductible	10% After Deductible	80% After Deductible	20% After Deductible
Class VII: Oral Surgery Surgical Extractions of Impacted Teeth Separate $250 Calendar Year Deductible to cross accumulate between classes VI, VII, IX No Annual or Lifetime Maximums apply	90% After Deductible	10% After Deductible	80% After Deductible	20% After Deductible
Class IX: Surgical Implants Separate $250 Calendar Year Deductible to cross accumulate between classes VI, VII, IX No Annual or Lifetime Maximums apply	90% After Deductible	10% After Deductible	80% After Deductible	20% After Deductible

Active Staff MIP Option B Summary

Effective January 1, 2017	U.S. Network Aetna Open Choice PPO	Out-of-Network
General		
A plan year is a calendar year, January 1 through December 31		
Medical Deductible (per person)	$650 per plan year	
Medical Deductible (per family)	$1300 per plan year	
Medical Out-of-pocket limits (Office visit co-payments and dental services do not accrue toward the out of pocket limits)		
Medical out-of-pocket limits per person	$2,500 per plan year	
Medical out-of-pocket limits per family	$5,000 per plan year	
Office visits		
Office visits for Illness or Specialist	100% after $20 co-pay	80% after deductible
Routine annual physicals and defined preventive services*	100%	
Ob/GYN (well woman) exam – one per plan year *	100%	
Laboratory and X-rays		
All services; (unless covered under defined preventive services above)	90% after deductible	80% after deductible
Emergency room related		
Emergency Room	90% after deductible 80% after deductible if non-emergency use	
Ambulance Services	90% after deductible	
Inpatient		
Hospital costs including anesthesia	90% after deductible	80% after deductible
Surgery (physician)		
Hospice		
Outpatient		
Hospital costs including anesthesia	90% after deductible	80% after deductible
Surgery (physician)		
Hospice		
Chemotherapy and Radiation Therapy		
Chemotherapy and Radiation Therapy: Does not include oral or injectable medications purchased through pharmacy benefit	100%, no deductible In-office/facility administration only	
Maternity		
Obstetrics: Single fee/delivery charge incl. Office visits	90% after deductible Routine prenatal office visits covered at 100%, no deductible	80% after deductible
Obstetrics: Routine prenatal office visits billed separately from single fee	100%, no deductible	
Infertility	90% after deductible	
Infertility Lifetime Limits: Contact Insurance Administrator for details		
Mental Health and Substance Abuse		
Inpatient hospitalization for mental health or substance abuse	90% after deductible	80% after deductible
Outpatient facility, including day treatment programs		
Office visits	100% after $20 co-pay	

Active Staff MIP Option B Summary

Nursing and Home Health Care		
Skilled Nursing Facility – (e.g., Rehabilitation Center) *Maximum 60 days per condition per plan year*	90% after deductible	80% after deductible
Convalescent Care *Maximum 60 days per condition per plan year*		
Visiting Nurse – *Maximum 120 days per condition per plan*		
Private Duty Nursing – *Contact Insurance Administrator for authorization*		
Short Term Rehabilitation		
Physical, occupational or speech therapy – *Restorative service after illness or accident. 60 visits PT, OT, ST combined per condition per plan year. Visits over 60 review for medical necessity.*	100% after $20 copay	80% after deductible
Physical, occupational or speech therapy – *For diagnosis of Development Delay a maximum 60 visits PT, OT, ST combined, per year, per child*		
Chiropractor (30 visit limit per year)		
Acupuncture (30 visit limit per year)		
Durable Medical Equipment		
Durable Medical Equipment: Rentals *Purchases only if approved by Insurance Administrator*	90% after deductible	80% after deductible
Vision Care (EyeMed Insight Network)		
Routine eye exams, one per plan year, including refraction.	100% after $20 co-pay	$20 reimbursement
Frames, lenses, contacts (Allowance is available for multiple time use until the dollar amount is exhausted.)	$350 Allowance for frame, lens, lens options and contact lenses. - 20% off balance over $350 for frame, lens and lens options - 15% off balance over $350 for conventional contact lenses, plus, balance over $350 for disposable contact lenses, - 5% off balance over $350 for medically necessary contact lenses Members also receive a 40% discount off additional complete pair eyeglass purchases	Up to $250 reimbursement per person, every year
Hearing Aids		
Hearing Aids	Maximum reimbursement $4,000 per person, every five plan years	

*Defined preventive care services will be provided at 100% when an In-Network physician or facility is used (and a referral is received for those in Option C). Defined preventive services are determined by gender and age and recommendations may change from time to time. Always check the most recent recommendations with your Insurance Administrator and discuss them with your doctor.

Active Staff MIP Option B Summary

Pharmacy Benefits	US Networks	Out-of-Network
Annual Deductible	$0	
Annual Out-of-Pocket Maximum	Actives: Per Person: $1000 Per Family: $2000	
Automatic Substitution of Generic-Equivalent Drugs for Patent-Expired Brand Drugs	Yes	
Dispense As Written (DAW) Rule: If prescriber writes "DAW" on Rx, or if member asks pharmacist to dispense brand drug when generic equivalent is available, then member pays difference between brand and generic drug equivalent prices + brand cost share. Additional cost does not apply to out-of-pocket maximum.	Yes	
Retail Network – up to 30-day supply per fill		
Maximum Days Supply	30	Drugs purchased outside the US are covered under your medical plan at 80% after medical deductible.
Generic Coinsurance/Copay	10%; Max.: $25	
Preferred Brand Coinsurance/Copay	25%; Max.: $70	
Non- Preferred Brand Coinsurance/Copay	40%; Max.: $120	
Retail Network for Maintenance and Mandatory Mail Order		
Maximum Days' Supply	90 After 2-fill at Retail	Drugs purchased outside the US are covered under your medical plan at 80% after medical deductible.
Generic Coinsurance/Copay	10 %; Max.: $60	
Preferred Brand Coinsurance/Copay	25%; Max.: $175	
Non- Preferred Brand Coinsurance/Copay	40%; Max.: $300	

Active Staff MIP Option B Summary

Specialty/Biotech Drugs		
Maximum Retail Fills Before Required Use of PBM's Specialty Pharmacy	1	Drugs purchased outside the US are covered under your medical plan at 80% after medical deductible.
Maximum Days' Supply	30 – 90 days based on PBM Specialty Pharmacy's clinical oversight.	
Generic Copay/Coinsurance	5%; Max.: $50 (30 days) 5%; Max.: $75 (90 days)	
Preferred Brand Copay/Coinsurance	25%; Max.: $100 (30 days) 25%; Max.: $150 (90 days)	
Non- Preferred Brand	40%; Max.: $150 (30 days) 40%; Max.: $225 (90 days)	
Other Plan Design Features		
Preferred Brand Diabetic Supplies	0% coinsurance on diabetic supplies based on prescription from treating doctor; limit 1 blood-sugar meter per 12 months	Drugs purchased outside the US are covered under your medical plan at 80% after medical deductible.
Infertility Treatment (includes oral and injectable drugs)	$10,000 per Lifetime - (Pharmacy plan only)	
Smoking-Cessation Products	Lifetime limit not permitted under ACA; OTC products require prescription	
Clinical/Utilization Management Programs		
Prior Authorizations	Yes	
Step Therapy	Yes— Expand to other non-Specialty and Specialty drug classes	

Active Staff MIP Option B Summary

	Cigna Dental PPO			
Network	Total Cigna DPPO		Out-of-Network	
Calendar Year Maximum (Class I, II & III expenses)	$3,200		$3,200	
Annual Deductible Individual Family	 $250 $500		 $250 $500	
Reimbursement Levels	Based on Reduced Contracted Fees		80th percentile of Reasonable & Customary Allowances	
Benefits	Plan Pays	You Pay	Plan Pays	You
Class I: Preventive & Diagnostic Oral Exams Routine - 2 per calendar year Routine Cleanings - 2 per calendar year Routine X-rays - Bitewings Non-Routine X-Rays - Full mouth: 1 every 36 consecutive months; Panorex: 1 every 36 consecutive months Fluoride Application - 1 per calendar year Sealants - Limited to posterior tooth. 1 treatment per tooth every three years Space Maintainers - Limited to non-orthodontic treatment	100% No Deductible	No Charge No Deductible	80% No Deductible	20% No Deductible
Class II: Basic Restorative Fillings Root Canal Therapy / Endodontics Emergency Care to Relieve Pain Root Planing and Scaling - Various limitations depending on the service Splinting Oral Surgery – Simple Extractions	80% After Deductible	20% After Deductible	80% After Deductible	20% After Deductible
Class III: Major Restorative Crowns – Replacement every 5 years Dentures – Replacement every 5 years Bridges – Replacement every 5 years Inlays / Onlays – Replacement every 5 years Prosthesis Over Implant - 1 per every 5 years if unserviceable and cannot be repaired. Benefits are based on the amount payable for non-precious metals. Repairs to Dentures, Bridges, Crowns and Inlays - Reviewed if more than once Stainless Steel/Resin Crowns Transepithelial Cytologic / Brush Biopsies Relines, Rebases and Adjustments – Covered if more than 6 months after installation	80% After Deductible	20% After Deductible	80% After Deductible	20% After Deductible
Class IV: Orthodontia Lifetime Maximum Study Models or Diagnostic Casts - Payable only when in conjunction with orthodontic workup	80% After Deductible $2,400	20% After Deductible	80% After Deductible $2,400	20% After Deductible

Class VI: Periodontal Gingivectomy Gingivioplasty Alveoplasty Vestibuloplasty Osseous Surgery Separate $250 Calendar Year Deductible to cross accumulate between classes VI, VII, IX	90% After Deductible	10% After Deductible	80% After Deductible	20% After Deductible
Class VII: Oral Surgery Surgical Extractions of Impacted Teeth Separate $250 Calendar Year Deductible to cross accumulate between classes VI, VII, IX No Annual or Lifetime Maximums apply	90% After Deductible	10% After Deductible	80% After Deductible	20% After Deductible
Class IX: Surgical Implants Separate $250 Calendar Year Deductible to cross accumulate between classes VI, VII, IX No Annual or Lifetime Maximums apply	90% After Deductible	10% After Deductible	80% After Deductible	20% After Deductible

Active Staff MIP Option C Summary

Effective January 1, 2017	U.S. Network Aetna Managed Choice POS	Out-of-Network
General		
A plan year is a calendar year, January 1 through December 31		
Medical Deductible (per person)	$350 per plan year	
Medical Deductible (per family)	$700 per plan year	
Medical Out-of-pocket limits (Office visit co-payments and dental services do not accrue toward the out of pocket limits)		
Medical out-of-pocket limits per person	$3,000 per plan year	
Medical out-of-pocket limits per family	$6,000 per plan year	
Office visits		
Office visits for Illness or Specialist	100% after $15 co-pay	80% after deductible
Option C: Registration of a Primary Care Physician (PCP) with Aetna is required for each covered family member and referrals from the PCP are required for network care. Self-referral only for annual routine eye, mental health services, and routine Ob/GYN.		
Routine annual physicals and defined preventive services* provided by your PCP or referred Specialist	100%	
Ob/GYN (well woman) exam – one per plan year* *No PCP referral required*	100%	
Laboratory and X-rays		
All services; (unless covered under defined preventive services above)	100% when referred by PCP	80% after deductible
Emergency room related		
Emergency Room	100% after $50 co-pay 80% after deductible if non-emergency use	
Ambulance Services	100%	
Inpatient		
Hospital costs including anesthesia	100% when referred by PCP	80% after deductible
Surgery (physician)		
Hospice		
Outpatient		
Hospital/facility costs including anesthesia	100% when referred by PCP	80% after deductible
Surgery (physician)		
Hospice		
Chemotherapy and Radiation Therapy		
Chemotherapy and Radiation Therapy: Does not include oral or injectable medications purchased through pharmacy benefit	100%, no deductible In-office/facility administration only	
Maternity		
Obstetrics: Single fee/delivery charge incl. Office visits	100%	80% after deductible
Obstetrics: Routine prenatal office visits billed separately from single fee	100%	
Infertility	100% when referred by PCP	
Infertility Lifetime Limits: Contact Insurance Administrator for details		

Active Staff MIP Option C Summary

Mental Health and Substance Abuse		
Inpatient hospitalization for mental health or substance abuse	100% when referred by PCP	80% after deductible
Outpatient facility, including day treatment programs		
Office visits – *No PCP referral required*	100% after $15 co-pay	
Nursing and Home Health Care		
Skilled Nursing Facility – (e.g., Rehabilitation Center) *Maximum 60 days per condition per plan year*	100% when referred by PCP	80% after deductible
Convalescent Care *Maximum 60 days per condition per plan year*		
Visiting Nurse – *Maximum 120 days per condition per plan*		
Private Duty Nursing – *Contact Insurance Administrator for authorization*		
Short Term Rehabilitation		
Physical, occupational or speech therapy – *Restorative service after illness or accident. 60 visits PT, OT, ST combined per condition per plan year. Visits over 60 review for medical necessity.*	100% after $15 office co-pay when referred by PCP	80% after deductible
Physical, occupational or speech therapy – *For diagnosis of Development Delay a maximum 60 visits PT, OT, ST combined, per year, per child*		
Chiropractor (30 visit limit per year)		
Acupuncture (30 visit limit per year)		
Durable Medical Equipment		
Durable Medical Equipment: Rentals *Purchases only if approved by Insurance Administrator*	100% when referred by PCP	80% after deductible
Vision Care (EyeMed Insight Network)		
Routine eye exams, one per plan year, including refraction. *No PCP referral required*	100% after $20 co-pay	$20 reimbursement
Frames, lenses, contacts (Allowance is available for multiple time use until the dollar amount is exhausted.)	$350 Allowance for frame, lens, lens options and contact lenses. - 20% off balance over $350 for frame, lens and lens options - 15% off balance over $350 for conventional contact lenses, plus, balance over $350 for disposable contact lenses, - 5% off balance over $350 for medically necessary contact lenses Members also receive a 40% discount off additional complete pair eyeglass purchases	Up to $250 reimbursement per person, every year

Hearing Aids	
Hearing Aids	Maximum reimbursement $4,000 per person, every five plan years

*Defined preventive care services will be provided at 100% when an In-Network physician or facility is used (and a referral is received for those in Option C). Defined preventive services are determined by gender and age and recommendations may change from time to time. Always check the most recent recommendations with your Insurance Administrator and discuss them with your doctor.

Active Staff MIP Option C Summary

Pharmacy Benefits	US Networks	Out-of-Network
Annual Deductible	$0	
Annual Out-of-Pocket Maximum	Actives: Per Person: $1000 Per Family: $2000	
Automatic Substitution of Generic-Equivalent Drugs for Patent-Expired Brand Drugs	Yes	
Dispense As Written (DAW) Rule: If prescriber writes "DAW" on Rx, or if member asks pharmacist to dispense brand drug when generic equivalent is available, then member pays difference between brand and generic drug equivalent prices + brand cost share. Additional cost does not apply to out-of-pocket maximum.	Yes	
Retail Network – up to 30-day supply per fill		
Maximum Days Supply	30	Drugs purchased outside the US are covered under your medical plan at 80% after medical deductible.
Generic Coinsurance/Copay	10%; Max.: $25	
Preferred Brand Coinsurance/Copay	25%; Max.: $70	
Non- Preferred Brand Coinsurance/Copay	40%; Max.: $120	
Retail Network for Maintenance and Mandatory Mail Order		
Maximum Days' Supply	90 After 2-fill at Retail	Drugs purchased outside the US are covered under your medical plan at 80% after medical deductible.
Generic Coinsurance/Copay	10 %; Max.: $60	
Preferred Brand Coinsurance/Copay	25%; Max.: $175	
Non- Preferred Brand Coinsurance/Copay	40%; Max.: $300	

Active Staff MIP Option C Summary

Specialty/Biotech Drugs		
Maximum Retail Fills Before Required Use of PBM's Specialty Pharmacy	1	Drugs purchased outside the US are covered under your medical plan at 80% after medical deductible.
Maximum Days' Supply	30 – 90 days based on PBM Specialty Pharmacy's clinical oversight.	
Generic Copay/Coinsurance	5%; Max.: $50 (30 days) 5%; Max.: $75 (90 days)	
Preferred Brand Copay/Coinsurance	25%; Max.: $100 (30 days) 25%; Max.: $150 (90 days)	
Non- Preferred Brand	40%; Max.: $150 (30 days) 40%; Max.: $225 (90 days)	
Other Plan Design Features		
Preferred Brand Diabetic Supplies	0% coinsurance on diabetic supplies based on prescription from treating doctor; limit 1 blood-sugar meter per 12 months	Drugs purchased outside the US are covered under your medical plan at 80% after medical deductible.
Infertility Treatment (includes oral and injectable drugs)	$10,000 per Lifetime - (Pharmacy plan only)	
Smoking-Cessation Products	Lifetime limit not permitted under ACA; OTC products require prescription	
Clinical/Utilization Management Programs		
Prior Authorizations	Yes	
Step Therapy	Yes— Expand to other non-Specialty and Specialty drug classes	

Active Staff MIP Option C Summary

	Cigna Dental PPO			
Network	Total Cigna DPPO		Out-of-Network	
Calendar Year Maximum (Class I, II & III expenses)	$3,200		$3,200	
Annual Deductible Individual Family	 $250 $500		 $250 $500	
Reimbursement Levels	Based on Reduced Contracted Fees		80th percentile of Reasonable & Customary Allowances	
Benefits	Plan Pays	You Pay	Plan Pays	You Pay
Class I: Preventive & Diagnostic Oral Exams Routine - 2 per calendar year Routine Cleanings - 2 per calendar year Routine X-rays - Bitewings Non-Routine X-Rays - Full mouth: 1 every 36 consecutive months; Panorex: 1 every 36 consecutive months Fluoride Application - 1 per calendar year Sealants - Limited to posterior tooth. 1 treatment per tooth every three years Space Maintainers - Limited to non-orthodontic treatment	100% No Deductible	No Charge No Deductible	80% No Deductible	20% No Deductible
Class II: Basic Restorative Fillings Root Canal Therapy / Endodontics Emergency Care to Relieve Pain Root Planing and Scaling - Various limitations depending on the service Splinting Oral Surgery – Simple Extractions Anesthesia	80% After Deductible	20% After Deductible	80% After Deductible	20% After Deductible
Class III: Major Restorative Crowns – Replacement every 5 years Dentures – Replacement every 5 years Bridges – Replacement every 5 years Inlays / Onlays – Replacement every 5 years Prosthesis Over Implant - 1 per every 5 years if unserviceable and cannot be repaired. Benefits are based on the amount payable for non-precious metals. Repairs to Dentures, Bridges, Crowns and Inlays - Reviewed if more than once Stainless Steel/Resin Crowns Transepithelial Cytologic / Brush Biopsies Relines, Rebases and Adjustments – Covered if more than 6 months after installation	80% After Deductible	20% After Deductible	80% After Deductible	20% After Deductible
Class IV: Orthodontia Lifetime Maximum Study Models or Diagnostic Casts - Payable only when in conjunction with orthodontic workup	80% After Deductible $2,400	20% After Deductible	80% After Deductible $2,400	20% After Deductible

Class VI: Periodontal Gingivectomy Gingivioplasty Alveoplasty Vestibuloplasty Osseous Surgery Separate $250 Calendar Year Deductible to cross accumulate between classes VI, VII, IX	90% After Deductible	10% After Deductible	80% After Deductible	20% After Deductible
Class VII: Oral Surgery Surgical Extractions of Impacted Teeth Separate $250 Calendar Year Deductible to cross accumulate between classes VI, VII, IX	90% After Deductible	10% After Deductible	80% After Deductible	20% After Deductible
Class IX: Surgical Implants Separate $250 Calendar Year Deductible to cross accumulate between classes VI, VII, IX No Annual or Lifetime Maximums apply	90% After Deductible	10% After Deductible	80% After Deductible	20% After Deductible

International Active Staff MIP AI Summary

Effective January 1, 2018	U.S. Network	Out-of-Network (Cigna)
General		
A plan year is a calendar year, January 1 through December 31		
Medical deductible (per person)	$300 per plan year	
Medical deductible (per family)	$600 per plan year	
Medical out-of-pocket limits (Office visit co-payments and dental services do not accrue toward the out-of-pocket limits)		
Medical out-of-pocket limits per person	$3,000 per plan year	
Medical out-of-pocket limits per family	$6,000 per plan year	
Office Visits		
Office visits for illness or specialist	100% after $15 co-pay	80% after deductible unless the visit is for Preventive Care services outlined in the Preventive Care Guide, then 100%
Routine annual physical and defined preventive services*	100%	
Laboratory and X-rays		
All services (unless covered under defined preventive services above)	90%	80% after deductible
Emergency Room Related		
Emergency room	90% 80% after deductible if non-emergency use	
Ambulance services	90%	
Inpatient		
Hospital costs including anesthesia	90%	80% after deductible
Surgery (physician)		
Hospice		
Outpatient		
Hospital costs including anesthesia	90%	80% after deductible
Surgery (physician)		
Hospice		
Chemotherapy and Radiation Therapy		
Chemotherapy and radiation therapy: does not include oral or injectable medications purchased through pharmacy benefit	100% no deductible In-office/facility administration only	
Maternity		
Obstetrics: Single fee/delivery charge including office visits	90% Routine prenatal office visits covered at 100%	80% after deductible
Obstetrics: Routine prenatal office visits billed separately from single fee	100%	
Infertility	90%	
Infertility lifetime limits: contact Insurance Administrator for details		
Mental Health and Substance Abuse		
Inpatient hospitalization for mental health or substance abuse	90%	80% after deductible
Outpatient facility, including day treatment programs		
Office visits	100% after $15 co-pay	

International Active Staff MIP AI Summary

Nursing and Home Health Care		
Skilled nursing facility (e.g., rehabilitation center) *maximum 60 days per condition per plan year*	90%	80% after deductible
Convalescent Care *Maximum 60 days per condition per plan year*		
Visiting nurse: *maximum 120 days per condition per plan year*		
Private duty nursing: *contact Insurance Administrator for authorization*		
Short-Term Rehabilitation		
Physical, occupational or speech therapy: *restorative service after illness or accident. 60 visits PT, OT, ST combined per condition per plan year. Visits over 60 review for medical necessity.*	100% after $15 office co-pay	80% after deductible
Physical, occupational or speech therapy: *for diagnosis of development delay a maximum 60 visits PT, OT, ST combined, per plan year, per child*		
Chiropractor (30 visit limit per plan year)		
Acupuncture (30 visit limit per plan year)		
Durable Medical Equipment		
Durable medical equipment: Rental *Purchases only if approved by Insurance Administrator*	90%	80% after deductible
Vision Care		
Routine eye exams, one per plan year, including refraction	100% after $15 co-pay	80% after deductible
Frames, lenses, contacts	Up to $250 reimbursement per person, each plan year	
Hearing Aids		
Hearing aids	Maximum reimbursement $4,000 per person, every five (5) plan years	

*Defined preventive care services will be provided at 100% when an In-Network Physician or facility is used. Defined preventive services are determined by gender and age and recommendations may change from time-to-time. Always check with the Insurance Administrator for the most recent recommendations provided separately from this general overview and discuss them with your doctor.

For U.S. prescription drug coverage, please refer to the pharmacy benefits section of the MIP Option A Summary for HQ Staff. All other purchases of prescription medications are covered under the medical plan and claims should be filed to Cigna.

For International Option participants, the U.S. pharmacy benefit manager will send a record of U.S. network pharmacy purchases to Cigna after the end of the plan year for reconciliation. International Option participants who met their medical out of pocket maximum and who also had U.S. pharmacy out of pocket expenses during the same plan year will receive reimbursement for the out of pocket U.S. pharmacy costs from Cigna after reconciliation.

International Active Staff MIP AI Summary

	Cigna Dental PPO			
Network	Total Cigna DPPO		Out-of-Network	
Calendar Year Maximum (Class I, II & III expenses)	$3,200		$3,200	
Annual Deductible Individual Family	 $250 $500		 $250 $500	
Reimbursement Levels	Based on Reduced Contracted Fees		80th percentile of Reasonable & Customary Allowances	
Benefits	Plan Pays	You Pay	Plan Pays	You
Class I: Preventive & Diagnostic Oral Exams Routine - 2 per calendar year Routine Cleanings - 2 per calendar year Routine X-rays - Bitewings Non-Routine X-Rays - Full mouth: 1 every 36 consecutive months; Panorex: 1 every 36 consecutive months Fluoride Application - 1 per calendar year Sealants - Limited to posterior tooth. 1 treatment per tooth every three years Space Maintainers - Limited to non-orthodontic treatment	100% No Deductible	No Charge No Deductible	80% No Deductible	20% No Deductible
Class II: Basic Restorative Fillings Root Canal Therapy / Endodontics Emergency Care to Relieve Pain Root Planing and Scaling - Various limitations depending on the service Splinting Oral Surgery – Simple Extractions Anesthesia	80% After Deductible	20% After Deductible	80% After Deductible	20% After Deductible
Class III: Major Restorative Crowns – Replacement every 5 years Dentures – Replacement every 5 years Bridges – Replacement every 5 years Inlays / Onlays – Replacement every 5 years Prosthesis Over Implant - 1 per every 5 years if unserviceable and cannot be repaired. Benefits are based on the amount payable for non-precious metals. Repairs to Dentures, Bridges, Crowns and Inlays - Reviewed if more than once Stainless Steel/Resin Crowns Transepithelial Cytologic / Brush Biopsies Relines, Rebases and Adjustments – Covered if more than 6 months after installation	80% After Deductible	20% After Deductible	80% After Deductible	20% After Deductible
Class IV: Orthodontia Lifetime Maximum Study Models or Diagnostic Casts - Payable only when in conjunction with orthodontic workup	80% After Deductible $2,400	20% After Deductible	80% After Deductible $2,400	20% After Deductible

Class VI: Periodontal Gingivectomy Gingivioplasty Alveoplasty Vestibuloplasty Osseous Surgery Separate $250 Calendar Year Deductible to cross accumulate between classes VI, VII, IX	90% After Deductible	10% After Deductible	80% After Deductible	20% After Deductible
Class VII: Oral Surgery Surgical Extractions of Impacted Teeth Separate $250 Calendar Year Deductible to cross accumulate between classes VI, VII, IX No Annual or Lifetime Maximums apply	90% After Deductible	10% After Deductible	80% After Deductible	20% After Deductible
Class IX: Surgical Implants Separate $250 Calendar Year Deductible to cross accumulate between classes VI, VII, IX No Annual or Lifetime Maximums apply	90% After Deductible	10% After Deductible	80% After Deductible	20% After Deductible

International Option Active Staff MIP BI Summary

Effective January 1, 2018	U.S. Network	Out-of-Network (Cigna)
General		
A plan year is a calendar year, January 1 through December 31		
Medical deductible (per person)	$650 per plan year	
Medical deductible (per family)	$1,300 per plan year	
Medical out-of-pocket limits (Office visit co-payments and dental services do not accrue toward the out-of-pocket limits)		
Medical out-of-pocket limits per person	$3,000 per plan year	
Medical out-of-pocket limits per family	$6,000 per plan year	
Office Visits		
Office visits for illness or specialist	100% after $20 co-pay	80% after deductible unless the visit is for Preventive Care services outlined in the Preventive Care Guide, then 100%
Routine annual physical and defined preventive services*	100%	
Laboratory and X-rays		
All services (unless covered under defined preventive services above)	90% after deductible	80% after deductible
Emergency Room Related		
Emergency room	90% after deductible 80% after deductible if non-emergency use	
Ambulance services	90% after deductible	
Inpatient		
Hospital costs including anesthesia	90% after deductible	80% after deductible
Surgery (physician)		
Hospice		
Outpatient		
Hospital costs including anesthesia	90% after deductible	80% after deductible
Surgery (physician)		
Hospice		
Chemotherapy and Radiation Therapy		
Chemotherapy and radiation therapy: does not include oral or injectable medications purchased through pharmacy benefit	100% no deductible In-office/facility administration only	
Maternity		
Obstetrics: Single fee/delivery charge including office visits	90% after deductible Routine prenatal office visits covered at 100%, no deductible	80% after deductible
Obstetrics: Routine prenatal office visits billed separately from single fee	100%	
Infertility	90% after deductible	
Infertility lifetime limits: contact Insurance Administrator for details		
Mental Health and Substance Abuse		
Inpatient hospitalization for mental health or substance abuse	90% after deductible	80% after deductible
Outpatient facility, including day treatment programs		
Office visits	100% after $20 co-pay	

Nursing and Home Health Care		
Skilled nursing facility (e.g., rehabilitation center) *maximum 60 days per condition per plan year*	90% after deductible	80% after deductible
Convalescent Care *Maximum 60 days per condition per plan year*		
Visiting nurse: *maximum 120 days per condition per plan year*		
Private duty nursing: *contact Insurance Administrator for authorization*		
Short-Term Rehabilitation		
Physical, occupational or speech therapy: *restorative service after illness or accident. 60 visits PT, OT, ST combined per condition per plan year. Visits over 60 review for medical necessity.*	100% after $20 office co-pay	80% after deductible
Physical, occupational or speech therapy: *for diagnosis of development delay a maximum 60 visits PT, OT, ST combined, per plan year, per child*		
Chiropractor (30 visit limit per plan year)		
Acupuncture (30 visit limit per plan year)		
Durable Medical Equipment		
Durable medical equipment: Rental *Purchases only if approved by Insurance Administrator*	90% after deductible	80% after deductible
Vision Care		
Routine eye exams, one per plan year, including refraction	100% after $20 co-pay	80% after deductible
Frames, lenses, contacts	Up to $250 reimbursement per person, each plan year	
Hearing Aids		
Hearing aids	Maximum reimbursement $4,000 per person, every five (5) plan years	

International Active Staff MIP BI Summary

*Defined preventive care services will be provided at 100% when an In-Network Physician or facility is used. Defined preventive services are determined by gender and age and recommendations may change from time-to-time. Always check with the Insurance Administrator for the most recent recommendations provided separately from this general overview and discuss them with your doctor.

For U.S. prescription drug coverage, please refer to the pharmacy benefits section of the MIP Option B Summary for HQ Staff. All other purchases of prescription medications are covered under the medical plan and claims should be filed to Cigna.

For International Option participants, the U.S. pharmacy benefit manager will send a record of U.S. network pharmacy purchases to Cigna after the end of the plan year for reconciliation. International Option participants who met their medical out of pocket maximum and who also had U.S. pharmacy out of pocket expenses during the same plan year will receive reimbursement for the out of pocket U.S. pharmacy costs from Cigna after reconciliation.

International Active Staff MIP BI Summary

	Cigna Dental PPO			
Network	Total Cigna DPPO		Out-of-Network	
Calendar Year Maximum (Class I, II & III expenses)	$3,200		$3,200	
Annual Deductible Individual Family	 $250 $500		 $250 $500	
Reimbursement Levels	Based on Reduced Contracted Fees		80th percentile of Reasonable & Customary Allowances	
Benefits	Plan Pays	You Pay	Plan Pays	You
Class I: Preventive & Diagnostic Oral Exams Routine - 2 per calendar year Routine Cleanings - 2 per calendar year Routine X-rays - Bitewings Non-Routine X-Rays - Full mouth: 1 every 36 consecutive months; Panorex: 1 every 36 consecutive months Fluoride Application - 1 per calendar year Sealants - Limited to posterior tooth. 1 treatment per tooth every three years Space Maintainers - Limited to non-orthodontic treatment	100% No Deductible	No Charge No Deductible	80% No Deductible	20% No Deductible
Class II: Basic Restorative Fillings Root Canal Therapy / Endodontics Emergency Care to Relieve Pain Root Planing and Scaling - Various limitations depending on the service Splinting Oral Surgery – Simple Extractions Anesthesia	80% After Deductible	20% After Deductible	80% After Deductible	20% After Deductible
Class III: Major Restorative Crowns – Replacement every 5 years Dentures – Replacement every 5 years Bridges – Replacement every 5 years Inlays / Onlays – Replacement every 5 years Prosthesis Over Implant - 1 per every 5 years if unserviceable and cannot be repaired. Benefits are based on the amount payable for non-precious metals. Repairs to Dentures, Bridges, Crowns and Inlays - Reviewed if more than once Stainless Steel/Resin Crowns	80% After Deductible	20% After Deductible	80% After Deductible	20% After Deductible
Class IV: Orthodontia Lifetime Maximum Study Models or Diagnostic Casts - Payable only when in conjunction with orthodontic workup	80% After Deductible $2,400	20% After Deductible	80% After Deductible $2,400	20% After Deductible

Class VI: Periodontal Gingivectomy Gingivioplasty Alveoplasty Vestibuloplasty Osseous Surgery Separate $250 Calendar Year Deductible to cross accumulate between classes VI, VII, IX	90% After Deductible	10% After Deductible	80% After Deductible	20% After Deductible
Class VII: Oral Surgery Surgical Extractions of Impacted Teeth Separate $250 Calendar Year Deductible to cross accumulate between classes VI, VII, IX	90% After Deductible	10% After Deductible	80% After Deductible	20% After Deductible
Class IX: Surgical Implants Separate $250 Calendar Year Deductible to cross accumulate between classes VI, VII, IX No Annual or Lifetime Maximums apply	90% After Deductible	10% After Deductible	80% After Deductible	20% After Deductible