Group Medical Insurance Plans

(BMIP & MMBP)

1 February 2018

SUMMARY

Social Security Office
Rome Based Agencies

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Summary of the Medical Plans

There are two plans for eligible staff of the Food and Agriculture Organization of the United Nations (FAO), World Food Programme (WFP), International Fund for Agricultural Development (IFAD) and International Centre for the Study of the Preservation and Restoration of Cultural Property (ICCROM). (Hereafter referred to collectively as the Organization): or

(a) The Basic Medical Insurance Plan (BMIP) provides coverage for hospital, physician, prescribed medicines, dental, vision and hearing aid expenses and certain other medical expenses. Coverage under the BMIP is mandatory for the Staff Member and family for those stationed in Italy. Coverage under the BMIP is mandatory for the Staff Member and voluntary for family members of participants stationed outside Italy. For IFAD, WFP and ICCROM the Organization contributes 50% of the cost of the BMIP, with the staff member contributing the remainder. For FAO, contributions are based on the application of the below percentages to the net salary for eligible staff under the GS category, net salary plus post adjustment for Professional or Higher categories and full net pension or Final Average Remuneration for Retirees, regardless of the Entry on Duty date of the participant up to the maximum of the BMIP premiums reported below.

(b) The optional Major Medical Benefit Plan (MMBP) provides coverage of certain expenses not reimbursed under the BMIP. The Staff Member bears the entire cost of the MMBP.

The medical insurance plans are insured through a contract between FAO and the Underwriter Allianz Worldwide Care SA, headquartered in Paris, while Allianz Worldwide Care Services Limited – Belgium Branch is the Administrator of the Insurance Plan.

Who can participate in the medical plan?

The following are eligible to participate in the scheme:

- Staff Members appointed for one year or more, or who have completed one year of continuous service.
- Staff Members who hold a continuing appointment.
- Staff Members seconded to another organization of the United Nations family and who opt to continue participation in the plans.
- The spouse (whether dependent or not) or other person recognized by the Organization for the purposes of granting benefits and entitlements.
- Children, up to the end of the calendar year in which they reach their 18th birthday.
- Children, over the age of 18 and up to the end of the month in which they reach their 26th birthday, who are not gainfully employed, and for whom the Staff Member (or a survivor) provides main and continuing support.
- Children, if permanently physically or mentally incapacitated, without limit of age.
- Secondary dependants for whom the Staff Member receives a secondary dependants' allowance and those already in the Plan (e.g. a parent).
- Eligible pensioners and family members.

Participants stationed in Italy

Participation in the BMIP is ***mandatory*** for both the Staff Member and all eligible family member(s) unless the Staff Member provides documentary evidence that his/her family member(s) is (are) covered by the Italian National Health Scheme (NHS), or by any other suitable medical insurance plan in the country of origin or residence. In such cases, Staff Members will not be allowed to enrol those exempted family members unless documentary evidence is provided showing that the coverage upon which exemption from coverage was granted, had ceased. In such cases, enrolment should be effective immediately on the date the other coverage ended.

Who can participate in the medical plan? *(Continued)*

Participants stationed outside Italy
Participation in the BMIP is ***mandatory*** for the Staff Member and ***optional*** for eligible family members. Staff Members will be able to enrol their eligible family members provided they hold a fixed-term appointment or upon conversion from short-term to fixed-term or upon extension of a fixed-term appointment for six (6) months or more. Staff Members holding a continuing appointment will be able to enrol their family members at any time. Staff Members will not be allowed to withdraw any family members before three (3) years from the date of enrolment. Staff Members who decide to withdraw any family member from the plan will not be allowed to re-enrol the same before three (3) years from the date of withdrawal. The Organization may waive the three-year limit mentioned above when changing duty station, upon written request.

Enrolment of staff members in MMBP is not compulsory. Staff members will not be allowed to withdraw themselves or their family members before three (3) years from the date of enrolment. Staff members who withdraw themselves or their family members will not be allowed to enrol the same before three (3) years from the date of withdrawal. The Organization may waive the three-year limit mentioned above when changing duty station, upon written request.

When does Coverage cease?

(a) Coverage of the Staff Member and family members shall cease at the end of the month during which the staff member is separated from service unless Group after Service Medical Coverage is applicable. Coverage of family members shall also cease for:

- a spouse, upon divorce from the staff member. however, children between 18 and 26 years of age who no longer fulfil the conditions set forth in the Staff Manual Section para 343.3.231(c) . Children who exceed the age of 26 or are not eligible for continuation of coverage under BMIP plan, may apply for an Individual Health Insurance coverage for periods ranging from 4 to 36 months;
- secondary dependants at the end of the month in which payment of the dependency allowance ceases (except as allowed in Manual Section);
- children on entering military service (who may, however, be re-enrolled immediately after military service, provided they then meet the criteria for enrolment); and
- when the master insurance policy terminates.

(b) Group After-Service Medical Coverage on a premium-paying basis shall cease if:

- the after-service participant (former Staff Member or family member) ceases to pay the contribution to the plan(s);
- the after-service participant (former Staff Member or family member) voluntarily withdraws themselves or a family member from the plan(s); provided, however, that if a former staff member withdraws, his family members shall be withdrawn automatically For voluntary withdrawals, a six month advance notice period is required
- a dependent spouse divorces;
- a deceased staff member's surviving spouse remarries;
- a dependent child no longer qualifies for coverage under the terms of the relevant medical plan or when the necessary documentation has not been submitted;
- the periodic disability benefit awarded to a former staff member is terminated;
- a former staff member who had elected a deferred pension benefit from the UNJSPF takes a withdrawal settlement; and
- the former staff member submits altered of fraudulent medical claims

When I leave, can I continue the medical insurance plans (BMIP/MMBP*)?

a) Staff members and family members, who were covered by BMIP at the time of separation, are entitled to Group After Service Medical Coverage (ASMC) if they meet the following criteria.

(i) Staff members aged **55 years or over** participating in BMIP at the time of separation, and who have participated in BMIP for at least 10 years and will receive a pension benefit, are entitled to the Group After Service Medical Coverage, together with their eligible dependants who have participated in the plan for at least 10-years. With respect to family members, the following exceptions apply:

- For staff members whose last appointment started prior to 1 January 1986, family members shall be exempted from meeting the 10-year requirement, provided that they were enrolled within 30 days from the date on which they became dependants and were not subsequently withdrawn from BMIP;
- Staff members, entitled for After Service Medical Coverage and, will be eligible to apply for After Service Medical Coverage for their family members, who were enrolled in BMIP at the time of separation, but were **not** meeting the 10-year requirement of in-service participation. The coverage is subject to the payment of a **full premium** (participant's and Organization's share) for coverage of the family members. Payment of the full premium will continue until the 10-year requirement is met. Thereafter, participation would be subsidized by the Organization.
- The Organization pays the entire BMIP premium for disabled children of pensioners/survivors, provided that the former staff member is over 55 and receives a pension benefit from the UNJSPF.

(ii) Staff members aged between **50 to 55** are entitled to the After Service Medical Coverage participation in BMIP on a **full premium** paying basis (participant's and Organization's share) if they meet the following conditions:

- they elected for a deferred pension from the UNJSPF
- they have participated for at least 20 years in the BMIP

After participants reach the age of 55, participation would be subsidized by the Organization. However, the staff member continues to pay a full premium for family members who have less than 10 years of participation in BMIP.

The ASMC provides the same benefits, provided to staff members and their eligible family members.

*** MMBP** coverage is optional for all staff members and their family members wherever located. To be eligible for MMBP in the Group After Service Medical Coverage, staff members and their family members must be enrolled in MMBP at the time of separation.

When I leave, can I continue the medical insurance plans? *(continued)*

b) Staff members and their family members, covered by BMIP/MMBP at the time of separation, **who are not entitled to Group After Service Medical Coverage (ASMC)**, are entitled, if they wish, to **extend their participation in the BMIP/MMBP** for three months, on a full-premium paying basis (participant's and Organization's share). The full-premium will be deducted from separating staff member's terminal emoluments. Staff members, wishing to continue the three-month medical coverage, should submit a request to their Human Resources Officer one month prior to their date of separation. After the three months, separating staff members may not enrol in any other plans extended or arranged by the Organization.

c) Staff members and their family members, covered under BMIP/MMBP at the time of separation, **who have not availed themselves to the three-months extension of coverage described in point (b) above,** may apply for an **Individual Health Insurance** coverage through a direct contract with Allianz Worldwide Care. Details of such coverage could be requested from Allianz Worldwide Care. Interested staff members should complete the appropriate application form and submitted to their HR Officer. The coverage provided and premium rates for this medical scheme are different from the one available under BMIP (contact the Social Security Branch or Allianz Worldwide Care for further details).

For more details on eligibility and interim provisions, the appropriate divisional HR Officer or FAO Manual Section 343 Part VI should be consulted.

BMIP and MMBP premiums in Euro and Dollars

A. ICCROM, IFAD and WFP

For ICCROM, IFAD and WFP participants, the amount of the monthly premiums* varies according to the number of dependants enrolled in each of the plans as follows:

Participants	Eur Premium		Dollar Premium	
	BMIP	MMBP	BMIP	MMBP
Staff member only	116.18	14.87	143.49	17.37
Staff member + 1 family member	232.34	29.50	286.98	34.75
Staff member + 2 family members	292.90	36.85	361.77	43.42
Staff member + 3 family members	353.46	44.21	436.59	52.09
Staff member + 4 or more family members	414.02	51.58	511.39	60.76

* **Effective 1 January 2018**

The above rates represent the participant's monthly contribution to the plan(s), with the Organization paying an equal amount to the BMIP plan. Where the monthly contribution to BMIP represents more than 5% of the Staff Member's gross salary, he/she will be charged an amount equal to 5% of gross salary and the Organization's share increased by the difference.

Similarly, in the case of pensioners, the BMIP contribution cannot exceed the individual retiree's BMIP cap. The BMIP cap is the greater of: 4% of the "full" pension or 4% of 46% of the monthly Final Average Remuneration (a simulated 25-year pension)

In cases where the retiree's BMIP contribution is capped, the Organization's share is increased by the difference between the retiree's contribution and the premium rate applicable.

*Except in cases of enrolment of unsubsidized family members.

The MMBP premium is fully paid by the participant.

The above premium rates are valid until 31 December 2015, they will be reviewed at the conclusion of the calendar year. When rates change, active staff and pensioners are informed by Administrative Circulars/Circular Letters. For further details concerning the exact premium amounts, please consult HR-services@fao.org or FAO Manual Sections 343 Part IV Appendix A (MMBP) and 343 Part III Appendix B (BMIP).

B. FAO

As of 1 January 2018 monthly for FAO Participants, contributions (both Euro and USD schemes) will be based on the application of the below percentages to the net salary for eligible staff under the GS category, net salary plus post adjustment for Professional or Higher categories and full net pension or Final Average Remuneration for Retirees, regardless of the Entry on Duty date of the participant up to the maximum of the BMIP premiums reported below.

BMIP New Premium Percentage Applicable as of 1 January 2018
EURO/USD SCHEME

BMIP Type	**Percentage**
Single	1.81%
Staff Member + 1 Dependants	3.62%
Staff Member + 2 Dependants	4.56%
Staff Member + 3 Dependants	5.50%
Staff Member + 4 Dependants	6.44%

The above percentage rates are capped at the below maximum amounts:

Participants	**BMIP euro scheme (HQ Staff and Retirees in Euro Zone)**	**BMIP USD scheme (Staff in the Field and Retirees)**
Staff Member only	232.35	286.98
Staff Member + 1 Dependant	464.68	573.96
Staff Member + 2 Dependants	585.80	723.54
Staff Member + 3 Dependants	706.81	873.18
Staff Member + 4 or more dependants	828.05	1022.79

What are the benefits?

BMIP benefits are reimbursed at 80% of the Reasonable and Customary expenses incurred. The MMBP covers 80% of the difference between the accepted charges and the amount reimbursed under the BMIP. The reimbursement only takes place after the accumulated level of non-reimbursement under BMIP reaches the threshold of USD 360 and EUR 260 per participant for the USD and Euro scheme per year.

Treatment		BMIP	MMBP
Maximum benefit/participant/year		USD 1 000. 000 (EUR 1.040. 000)	USD 200,000 (EUR 172,000)
Doctors' fees for services at consulting room, home or in hospital, including fees of surgical team		80%	80% 1/
Prescribed Medicine		80%	80%
Prescribed out-patient hospital services such as laboratory tests, x-rays, drugs and medicines, appliances such as artificial limbs, crutches		80%	80%
Professional ambulance service, including short distance air ambulance, for urgent evacuation which must be prescribed by a physician and is covered only in the absence of adequate ground transportation. Definition of Urgent Evacuation: evacuation under medical surveillance and used to transport the insured participant from the place where he or she is injured by an accident or stricken by disease to the nearest hospital where adequate treatment can be given.		80%	80%
Convalescence in sanatoria, institutional care for persons, including the aged, with permanent ailment when prescribed by a physician (only medical expenses)		80%	80%
Breast cancer screenings (physician exam, mammography, and if needed sonography and needle biopsy with cytology) through the FAO Medical Service, for women of 50 and over (every 2-3 years)		100%	N/A
Other breast screenings for a specific medical reason		80%	80%
Orthopaedic appliances such as: 1) Artificial part of the body (e.g. limbs, eyes) 2) Appliance needed as an extension of the body to be able to approach a normal functioning (e.g. crutches, wheelchair, but excluding adaptations to cars and home as well as physio equipment) 3) Orthopaedic shoes (i.e. tailor made shoes purchases at a specialized facility upon prescription by a physician) are limited to 2 pairs per participant per calendar year. Arch supports (orthotics) are to be medically justified and are limited to 4 pairs per participant per year. Prior approval by the Claim Processor's medical adviser is suggested.		80%	80%
Colorectal Cancer Screening Programme (for men, women and their dependents beginning at age 50 and at 10-year intervals for those with an average risk) through the FAO Medical Service.		100%	NA
Other Colorectal Cancer Screening Programme for a specific medical reason.		80%	80%
Hospital daily room and board charges effective 1 January 2008 2/	In Italy	Maximum daily charge EUR 600 100% first EUR 300 80% remaining EUR 300	N/A

Treatment		BMIP	MMBP
	In Europe, outside of Italy	Maximum daily charge USD 1,200.00 100% first USD 600 80% remaining USD 600	N/A
	In the USA: New York, Maryland, Virginia and the District of Columbia (Washington, D.C.)	Maximum daily charge USD 2,400 100% first USD 1,200 80% remaining USD 1,200	N/A
	In the rest of USA and in Canada	Maximum daily charge USD 1,900 100% first USD 950 80% remaining USD 950	N/A
	Rest of the World	Maximum daily charge USD 700 100% first USD 250 80% next USD 450	N/A
General nursing service, use of operating and recovery room and equipment, laboratory examinations, x-ray examinations, drugs and medicine for use in the hospital with an overnight stay.		100%	N/A
Hospital/clinic charges for use of operating and recovery room and equipment, laboratory examinations, x-ray examinations, drugs and medicine for use in the hospital without an overnight say.		80%	80%
Hospice Benefit covers home health aid or nursing at home for the terminally ill, subject to the following lifetime maximums: Italy Euro 7.862, Europe USD 7,560, US/Can USD 12,960, Other USD 7,560		100%	N/A
Dental treatment such as: routine oral examinations, scaling/cleaning, x-rays, fillings, crowns and bridgework, dental surgery. Maxillo-facial and osseous surgery is paid under BMIP and MMBP not subject to dental ceiling.		80% up to a maximum of USD 700 year per patient (EUR 728) 3/ 4/	N/A
Orthodontia treatment for children where treatment started before age 16. Orthodontia for TMJ Dysfunction is covered without age limitation.			N/A
Psychotherapy including psychoanalysis when the treatment is prescribed by a doctor on medical grounds and given by a duly recognized specialist, limited to a maximum of 50 out-patient treatment visits from January through June, and 50 visits from July through December. First visit to a psychiatrist in each 6 month period is reimbursed at 80% (plus MMBP) and not subject to semi-annual ceiling.		50% up to USD 800 3/ (EUR 832) for January to June and separately for July-Dec. (Approx. USD 1 600/year) (EUR 1 664) 80%	N/A 80%
Optical treatment (lenses with corrective diopter/grading and frames)		80% up USD 200 3/ (EUR 180) year	N/A
Hearing aids		80% up to USD 1 000 3/ 5/ EUR 1 040)/ year	N/A
Physiotherapy including treatment of localized degenerative spinal disorders. (Reminder: include the physician prescription for physiotherapy when submitting claim).		80% up to USD 600 2/ (EUR 624) year	N/A
In vitro Fertilization coverage up to maximum 3 treatments per successful pregnancy, i.e. a pregnancy lasting for at least 26 weeks. Up to the age of 45		80%	80%

Treatment	BMIP	MMBP
Coverage for non-medical Sterilization and Vasectomy.	80%	80%
Physiotherapy – The above limit does not apply to treatment required in case of post-operative rehabilitation, after a traumatic accident, or because of a congenital condition, or for a serious degenerative and/or life-threatening illness. In these cases, prior approval by the Claim Processor's medical adviser is suggested. Definition of degenerative and/or life-threatening illness: one which impairs the normal function of bodily systems, for example but not limited to rheumatoid arthritis, neurological disorders (e.g. Multiple Sclerosis (MS), paralysis after stroke (post cerebral infart/hemorrhage), spinal injuries (e.g. paraplegia) and muscoviscidosis.	80% sustained by detailed medical report	80%
Immunizations (both adults and dependent children) – Injections prescribed by a physician and given by a qualified person, and preventive inoculation and vaccination prescribed by a physician.	80%	80%
Treatments for alcohol and drug abuse (based on a treatment plan when admission, to a specialized facility, prescribed by a physician and followed by the approval from the Insurer medical consultant for maximum 30 days. The approved period can be extended.	80%	80%

Notes to benefits description:

1/ For example, the MMBP will pay 80% of the 20% not paid under the BMIP after the USD 360 (EUR 260) deductible amount has been incurred. This results in an additional 16% payment of reasonable and customary expenses, for a total of 96%.

2/ When the hospital charges an all-inclusive rate comprehensive of doctors' fees, for the purpose of calculating reimbursements, 80% of the cost will be considered as hospital/clinic charges (40% room and board / 40% other hospital expenses) and 20% will be considered as doctors' fees. If no doctors' fees are included in the all-inclusive rate, 50% of the charges will be considered as room and board and 50% as other hospital expenses.

3/ The ceiling applies on a calendar year basis. Prorate portions of the ceiling apply to persons becoming insured during the year. For example, if the person joins FAO on 1April, the maximum is nine-twelfths (9/12) of the yearly maximum allowance.

4/ Dental treatment – The unspent balance from the two (2) immediately preceding calendar years is to be added to the dental maximum.

5/ Hearing aids – The unspent balance from the immediately preceding calendar year is to be added to the hearing aid maximum.

Attention:

- ***Expenses in Italy – For the most common surgical procedures, as well as for deliveries and room rates in hospitals and clinics, the expenses eligible for reimbursement cannot exceed the plan ceilings, which change periodically. To avoid unpleasant surprises and to be sure that medical expenses are reasonable and thus eligible for reimbursement, participants are urged to submit the Hospital Estimate Form two to three weeks prior to treatment.***
- ***The Claim Processor may request additional medical information, even of a confidential nature, relative to the reimbursement of a claim, in line with the contractual agreement between the Organization and the Claims Administrator. Failure to provide the requested information may result in the claim not being reimbursed.***

What is the Travel Medical Cost Containment Programme?

The purpose of the travel provision is to provide the concerned insured member with a financial benefit in case a more cost-efficient alternative for a planned in-patient treatment / day-surgery is opted for.

This financial benefit will be granted once the following prerequisites are met:

- the concerned treatment must be a planned in-patient treatment or day-surgery;
- the travel provision can be granted worldwide, thus in principle in all countries
- obtaining prior approval from Allianz Worldwide Care (AWC) for this travel benefit prior to the planned in-patient treatment or day surgery is mandatory; and,
- no benefit will be granted in case of home leave or travel for which a DSA (daily subsistence allowance) is provided by the Organization.

Travel provision

The travel provision is applicable if costs in the country of travel are at least 20% cheaper than the reasonable and customary costs in the country where you are based in.
The reimbursement will be up to 20% of the savings, with no limit.
Only covers for flight and expenses related to your travel are payable upon presentations of receipts.

- Pre-authorization is required to avail of this benefit.

Please provide Allianz Worldwide Care with a detailed cost estimate for the planned in-patient treatment or day-surgery you are envisaging to undergo. AWC will then compare this cost estimate with the agreed in-network tariffs in Rome for the concerned treatment. The minimal saving between the cost estimate outside Italy and the agreed in-network tariff in your duty station should be at least EUR 1 000. The benefit granted will be based on 20% on the obtained saving. The travel provision is applicable if costs in the country of travel are at least 20% cheaper than the reasonable and customary costs in the country where you are based in.
The reimbursement will be up to 20% of the savings, with no limit.
Only covers for flight and expenses related to your travel are payable upon presentations of receipts.

Once Allianz Worldwide Care obtains the bills from the provider related to the concerned planned in-patient treatment or day-surgery, the travel benefit will be paid out to the insured member.

How does the out-of-pocket Maximum Provision work?

For insured persons enrolled in the MMBP, the plan will pay 100% of out-of-pocket reasonable and customary medical expenses not reimbursed under the MMBP as further specified below:

(a) The amounts to be reimbursed for each person will be those out-of-pocket charges which exceed 4% of the yearly net base salary or 4% of the yearly full pension benefit as applicable on 1 January of any year. The minimum threshold is USD 1 000 (or EUR 1 040).

(b) The amount to be reimbursed for each family insured under the plan will be 8% of the yearly net base salary or 8% of the yearly full pension benefit on 1 January of any year. The minimum threshold for family is USD 2 000 (or EUR 2 080).

(c) Out-of-pocket expenses for those insured persons not enrolled in the MMBP cannot be used to meet the 4% out-of-pocket limit.

(d) Medical expenses not reimbursed under MMBP because of the deductible of USD 360 (or EUR 260) are excluded from the calculation of the 4% out-of-pocket limit.

(e) Eligibility for reimbursements will be established and payments made, after the completion of the year of coverage during which expenses were reimbursed.

What is the Hospice Benefit?

When someone is seriously ill and near death, there is a tendency to hospitalize or institutionalize the patient when the family can no longer care for him/her at home. The Hospice Benefit facilitates continued home care of such terminally ill patients. The Hospice Benefit reimburses custodial care expenses of a home health aid or nurse under the BMIP and MMBP. Since the objective is to reduce hospital expenses, the benefit varies by geographic area as specified in the table of benefits. If the regular plan provisions normally cover the treatment, then the Hospice Benefit is not affected. Since family members sometimes help to care for their relative at home at no cost, the plan does not provide any reimbursement for charges by a direct relative (e.g. mother, father, brother, sister) who provides such services for the patient. The Hospice Benefit is payable when the patient is terminally ill.

What does the plan reimburse for expenses related to HIV and AIDS?

The BMIP and MMBP provide the same reimbursement for the diagnosis and treatment of HIV and AIDS as it provides for any other illness. For example, the BMIP provides for 80% reimbursement of necessary diagnostic blood tests, x-rays and other laboratory procedures to diagnose HIV, and related physician's fees. The BMIP also reimburses 80% of the cost of prescribed medicines to treat HIV. Further, the BMIP provides for hospitalizations for the treatment of AIDS and related illness. The MMBP provides 80% reimbursement of those covered charges, which are not reimbursed under the BMIP. In addition, the MMBP provides for 100% reimbursement of out-of-pocket reasonable and customary medical expenses not reimbursed by the plan when the total of such expenses exceeds 4% of the participant's salary or pension.

Further information about these conditions is available in the booklet entitled: AIDS and HIV Infection: Information for UN Employees and Their Families. This is also available at the websites listed below. (Please note that these are large files and will require several minutes of loading time depending on your connection and computer.)

English:
http://www.unaids.org/en/default.asp
French:
http://www.unaids.org/publications/documents/sectors/workplace/JC306-UN-Staff-F_Revision.pdf
Spanish:
http://www.unaids.org/publications/documents/sectors/workplace/JC307-UN-Staff-S-Full_Revision.pdf
Chinese:
http://www.unaids.org/publications/documents/sectors/workplace/HIV-staff-tr.doc

The UN website also has up-to-date information on these illnesses at http://unaids.org/.

Procedure for applying for a Guarantee of Payment

Complete the form "Hospital Estimate Form" that can be found on the Allianz Worldwide Care website www.my.allianzworldwidecare.com dedicated to FAO and forward to Allianz Worldwide Care's Medical Claims Centre or in the FAO intranet under Medical Insurance, Medical forms. You can send the Hospital Estimate Form to Allianz Worldwide Care by email, fax or post

- by e-mail: RBA.Medical@allianzworldwidecare.com
- by fax: +32 2 210 6591
- Post: Medical Services Department, Allianz Worldwide Care Services, 15 Joyce Way, Park West Business Campus, Nangor Road, Dublin 12, Ireland

Supporting documentation should be provided as follows:

- date of hospital admission and anticipated length of stay, or for out-patient care, date and duration of treatment;

- evidence that down-payment or full settlement upon discharge is required;
- location of treating facility;
- diagnosis;
- type of operation or treatment(s);
- details of costs of hospitalization and/or physicians' fees; and
- complete details of banking instructions.

What are the exclusions?

- Illnesses or injuries incurred as a result of the performance of official duties on behalf of the Organization, since these are typically covered under the Organization's Compensation Plan.

- Routine health examinations and preventive medicines (except Preventive Cancer Screening Tests as per table of benefits).

- Charges which are not reasonable and customary. The upper limit reasonable and customary charge for surgical procedures will be the 90th percentile (i.e., the 9th highest charge out of 10 cases starting from the lowest). However, for all procedures with a minimum of fifteen (15) observations (i.e. claims) plus all maternity deliveries submitted during the preceding 18 months, the limit is the 80th percentile. The limit is established by reference to the information already recorded in the Claims Processor's data bank, fee schedules used by other insurance companies and information obtained locally from known hospitals and clinics.

- Cost of rejuvenation cures, spa cures, and cures in "nature clinics" and "health farms".

- Cosmetic treatment and surgery are not covered unless it is required for a congenital anomaly or to restore or correct a part of the body which has been altered as a result of accidental injury, disease or surgery which occurred while the patient was covered by the plan.

- In time of war to persons who are mobilized or who volunteer for military service.

- The results of wounds or injuries resulting from motor-vehicle racing and dangerous competitions in respect of which betting are allowed; normal sports competitions are covered.

- Voluntary or intentional actions, for example attempted suicide and voluntary mutilation, it being however understood that the consequences of an attempt to save human life are covered.

- The direct or indirect result of ionising radiations or contamination by radioactivity from any nuclear fuel or from any nuclear waste from the combustion of nuclear fuel or the radioactive toxic explosive or other hazardous properties of any explosive nuclear assembly or nuclear component.

- Expenses incurred for travel or transportation are excluded, except for professional ambulance service, when prescribed by a physician and/or necessary, from the place where the accident or disease took place to the nearest hospital where adequate treatment can be provided.

- Non-prescription items, hygienic and cosmetic products, dietary products, artificial milk, syringes and personal comfort items such as radio, TV, etc.

- Reversal of voluntary sterilization.

- Infertility benefits for women who are beyond the normal child bearing age.
- The consequences of participation by insured persons, in violation of applicable laws, in insurrections or riots; the consequences of brawls, except in cases of self-defence or in which no active part was taken.
- Custodial Care where hospital or clinic admissions and medical treatments which are not medically recognized. Custodial care is a non-medical care that may be more appropriately handled in an outpatient

setting. Care can be provided by skilled professionals, or non-skilled professional, or by family members. Whether custodial care treatments are prescribed by a physician the related expenses are excluded by the policy. Some examples of custodial care are: assistance with walking, transferring in/out bed or chair, transportation, vital sign charting, help with self-administration of medication, bathing, feeding, grooming and dressing,

How to submit a claim

(a) Claims should be submitted with the least possible delay, and not more than two years after the date the expenses were incurred. Claim forms can be obtained from FAO Intranet or from Allianz Worldwide Care directly.

In case of hospitalization, the hospitals can send their invoices for in-patient treatment directly to Allianz for settlement according to the contract provisions. In order to guarantee the smooth operation of the direct billing system, please see to it that no advance or partial payments are effected to the hospital. (However, for Rome hospitals, which have conventions with Allianz, partial payments can be made by the patient to the hospital upon discharge; upon receipt of the bills afterwards, Allianz makes a final settlement). Staff Members should settle the uncovered portion without delay.

(b) Make sure that all claims are forwarded with supporting documentation: in particular the diagnosis (under seal, if desired), the detailed original and receipted bills, and the prescriptions. All receipts should comply with local legislative requirements or regulations. For participants living in Italy, claims without “fattura” (settled bill), “ricevuta fiscale” (receipt), or “scontrino fiscale” (cash register receipt for medicines) will be subject to close scrutiny. In case of reimbursement from another source, all original payment slips (with details of amounts reimbursed) made out by the other Claim Processor should be attached to the claim form along with copies of the bills and other necessary documents.

(c) Should original bills and/or other documents (e.g. for tax purposes), be needed by the participant, a request should be made upon submission of a claim. Regrettably Allianz Worldwide Care cannot return original bills, or make copies of bills submitted at a later date. Copies should be made of those bills, which may be required for tax and other purposes.

Please send your claims to:

Claims Department Allianz Worldwide Care Services, 15 Joyce Way, Park West Business Campus, Nangor Road, Dublin 12, Ireland

or

Deposit in special boxes located near the entrances of FAO and WFP

Claims can also be submitted by:

Email: RBA.claims@allianzworldwidecare.com
Fax: +32 2 210 6591
Smartphone app: MyHealth app.

How are reimbursements made and in which currency?

There are three ways in which reimbursements are made:

(a) Based on the currency of premium payment, reimbursement is made by direct deposit into your bank account;
(b) At request of the participant, payment is made in the currency of the expenses; or
(c) A direct payment to the hospital.
(d) The reimbursement is effected via electronic transfer to their bank for direct deposit on the condition that the participant provides Allianz Worldwide Care with the complete banking instructions (i.e. name and address of the beneficiary and the bank, full account number in the exact lay-out required by the bank, and where possible, the bank identification code), or by cheque which can be sent to the individual.

(e) The staff member or the retiree may request at the time of presenting a claim that it be reimbursed in the currency of the claim and not in the currency in which premiums are paid. This option is available only if all the expenses presented for reimbursement are in the same currency. Reimbursement will be made by transfer. The complete banking instructions are essential in case of transfer, the following bank information must be provided on the claim form: full account number, name of account holder, name of bank, IBAN code (International Bank Account Number) for cross border payment within the European Union or BIC code (Bank Identification Code); either SWIFT or ABA code.

(f) In the event of a hospital overnight stay, the staff member or the retiree may request that Allianz Worldwide Care make a direct payment to the hospital. .

General practices on currencies

- Expenses incurred in currencies other than the one in which reimbursement is made, will be converted to the currency of reimbursement.

- The conversion of other currencies into EUR will be done through the USD dollar, based on the Reuters rates of exchange prevailing on the date of service.

- For those who pay their premiums in USD dollars, their expenses will be converted from the actual expenses into USD dollars at the exchange rates prevailing on the date of service.

- In the event of a hospitalization, the rates of exchange will be based on the date the hospital bill is processed by Allianz Worldwide Care.

(The UN operational rate of exchange is determined monthly. The following website shows these rates: http://www.un.org/Depts/treasury/.)

How can I contact Allianz?

Allianz Worldwide Care can be contacted directly as shown below:

Allianz Representatives at FAO HQs

Lisa Macaluso D305 ext (06 570) 56593

Valeria Cara D307 ext (06 570) 55788

From HQs dial 4402 to be directed to the Toll Free Helpline

Helpline

Toll free number* 00800 1398 3812

(*) Toll free number available in 17 countries (AT, CH, CY, DE, DK, ES, FI, FR, GB, HU, IE, IT, LU, NL, NO, PT, TH)

Toll free BE: 0800 81639

Toll free SE: 020 109177

Toll free US: 001 844 4609520

Universal Telephone number: 0032 2 210 6601

Fax: 0032 2 210 6591

Email: RBA.Helpline@allianzworldwidecare.com

Postal Address: Allianz Worldwide Care Services, 15 Joyce Way, Park West Business Campus, Nangor Road, Dublin 12, Ireland.

questions of a medical nature, medical necessity and fee levels, participants can consult the Medical Advisor who has full authority to make decisions on the above issues.
You can schedule an appointment with the Medical Advisor at the following email address:
RBA.medical@fao.org

Allianz's Advisors are available as follows:

@ FAO: From Monday to Friday 8.30 – 12.30

@ WFP: Every Thursday afternoon 14.00 – 17.00

@ IFAD: every second Wednesday 14.00 – 17.00

Who can I contact in Social Security for questions about the medical insurance plans?

Most questions about enrolling in the BMIP and MMBP can be answered by your Personnel Officer. Questions about the status or explanations about a claim payment should be addressed directly to Allianz Worldwide Care. To provide extra support to staff, Social Security has established an e-mail address Medical-Insurance@fao.org. The Social Security fax number is +39 06 570 54329. In addition, please contact the following staff depending on the subject:

Subject	Staff Member	Telephone
Medical Coverage	Ms Olvido Escudero Moguer D344 Ms Elena Di Lorenzo D344 Medical-insurance@fao.org	+3906-570 53381 +3906-570 55172
After-Service Medical Coverage	Ms Barbara Ippoliti After-Service-Medical-Insurance@fao.org	06-570 55777
Three month extension of BMIP/MMBP upon separation Or Individual Health Insurance	**HR-Services@fao.org** **SSC-Bangkok-HRServicing@fao.org** **RLC-HR-Services@fao.org** **or** **RBA.helpline@allianzworldwidecare.com**	**Budapest** **Bangkok** **Santiago**
Medical Advances	RBA.Medical@allianzworldwidecare.com	+800 13983812
General Information	Ms Olvido Escudero Moguer Ms Barbara Ippoliti Ms Elena Di Lorenzo	06-570 53381 06-570 55777 06-570 55172

N.B. ***This booklet is an informal summary of the FAO medical insurance plans and is not to be used in the determination of the entitlements or the interpretation of the contract provisions. No information contained in this booklet, or omitted from it, can be taken to replace or alter the terms of the contract itself. The insurance contract, as summarized in Manual Section 343 and relevant Administrative Circulars, provides the official description of the medical insurance plans.***

Social Security, OHRS
Revised February 2018