

Medical Insurance Plan Summary Plan Description



PLEASE KEEP THIS DOCUMENT FOR EASY REFERENCE

It is your Summary Plan Description (SPD) of benefits under the World Bank Medical Insurance Plan. Printed versions are published every three years. Changes and updates may occur at anytime and will be posted only on the internal website for Staff (type MIP on the Intranet url to link to the Summary) and on the external website for Retirees and Families, (www.worldbank.org/humanresources).

How can you find the information you need about your medical, prescription, or dental benefits?

There are three ways to find the information you need.

1. Look at the Table of Contents for the Section descriptions. The page where the Section begins is listed.
2. Review the Topics Index in the back of this Summary. This list is alphabetical and includes the page number for the Topic.
3. If you do not find the Topic you are interested in, contact the appropriate Insurance Administrator below to discuss your concern.

- **Aetna Global Benefits**
 - Toll Free Phone 800-723-8897
 - Direct Phone 202-473-8666
 - Collect Calls 813-775-0190
 - Email mclaims@aetna.com
 - Fax 800-475-9751
- **PharmaCare for US in-network prescription drug purchases**
 - Toll Free Phone 800-947-3826
- **Vanbreda International**
 - Toll Free Phone 800-3-217-5798 from most countries
 - Direct Phone 32 (3) 217-5798
 - Email mcc200@vanbreda.com
 - Fax 32 (3) 236-7538
 - Website www.vanbreda-international.com
- **HSI (US network of physicians/hospitals for Vanbreda only)**
 - Toll Free Phone 800-962-6831
 - Website: www.us-hsi.com



TO PARTICIPANTS IN THE WORLD BANK GROUP MEDICAL INSURANCE PLAN:

This booklet is your Summary Plan Description for the World Bank Group Medical Insurance Plan (MIP) for active staff, retired staff, and dependent family members. This Summary provides an overview of covered benefits, exclusions, and instructions for using the MIP to your best advantage.

The MIP is a self insured plan that is funded by member contributions and the Bank.

The MIP contracts with three Insurance Administrators who have fiduciary responsibility for the plan benefits and make all claim decisions and handle appeals. The basis for most MIP claim decisions is medical necessity and determination of medical necessity is solely the responsibility of the insurance administrator. There is no internal grievance process for MIP claims.

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 receive confidential member information from the administrators, nor can the World Bank Group intervene on claim decisions. There is a claim appeal process in place for each insurance administrator outlined in this Summary.

For some benefits, such as acupuncture, the MIP limits coverage to a certain number of visits per year. Other benefits may be limited to a maximum dollar lifetime benefit, such as orthodontia. These visit and dollar limited benefits are not subject to medical necessity review or appeal. Once the limit is reached, the benefit ends for the defined period.

The World Bank Group subsidizes the MIP as part of our commitment to staff, retirees, and their families to help them meet their insurance needs. We hope you will find this Summary a useful document to understand the global and comprehensive package of coverage offered under the MIP.

December 2006

Table of Contents

<i>01 Introduction</i>	<i>1</i>
01.01 This Document	2
01.02 Scope of This Document	2
01.03 MIP Plan Year	2
01.04 Coverage Changes	2
01.05 International Option	2
01.06 Tips for MIP Participants	3
01.07 Rights and Responsibilities	3
01.07.1 Your Rights and Responsibilities	3
01.07.2 How the MIP Works	4
01.07.3 In-Network Providers	4
01.07.4 How to Find In-Network Providers	5
01.07.5 Out-of-Network Providers	5
01.07.6 Your Identification Cards	6
01.08 Online Tools	7
01.09 Referrals	7
01.10 Patient Confidentiality	7
01.11 Sponsored Plan	7
<i>02 Summary of Benefits</i>	<i>8</i>
02.01 Introduction	8
02.02 Benefit Summaries	8
02.02.1 Deductibles and Limits	8
02.02.2 Medical Out-of-Pocket Maximum	9
02.02.3 Prescription Drug Out-of-Pocket Maximum and Brand-Name Deductible	9
02.02.4 Coordination with Active Staff Deductibles and Out-of-Pocket Maximums	10
02.02.5 Lifetime Maximum Benefit	10
02.03 Pre-certification of Hospitalization	10
02.04 Patient Management	11
<i>03 Covered Expenses and Reimbursement</i>	<i>12</i>
03.01 Introduction	12
03.02 How Does the MIP Pay Benefits?	12
03.02.1 In-Network Medical Benefits in the U.S. (except Pharmacy)	13
03.02.2 In-Network Dental Benefits in the U.S.	13
03.02.3 In-Network Benefits in the U.S. (Pharmacy)	13
03.02.4 Direct Billing Providers Outside the U.S.	13
03.02.5 Out-of-Network Benefits	13
<i>04 Emergency Medical Care</i>	<i>14</i>
<i>05 Medical Benefits</i>	<i>15</i>
05.01 Acupuncture Care	15

05.02	Ambulance Service _____	15
05.03	Chiropractic Care _____	15
05.04	Durable Medical Equipment and Medical Supplies _____	15
05.04.1	Durable Medical Equipment _____	15
05.04.2	Medical Supplies _____	15
05.04.3	Emergency Room Care _____	16
05.05	Hearing Care _____	16
05.06	Home Health Care _____	16
05.07	Hospice Care _____	16
05.07.1	Hospice Facility Expenses _____	17
05.07.2	Other Hospice Care Agency Expenses _____	17
05.07.3	Medical or Social Services Under a Physician’s Direction _____	17
05.08	Hospital Services _____	18
05.09	Immunizations _____	18
05.10	Infertility Services _____	18
05.11	Inpatient Hospital, Extended Care and Skilled Nursing Facilities _____	19
05.11.1	Skilled Nursing Facility Services _____	19
05.11.2	Convalescent Facility Care _____	19
05.12	Laboratory Services and Supplies _____	20
05.12.1	Anesthesia and Oxygen _____	20
05.12.2	Chemotherapy and Radiation Therapy _____	20
05.12.3	Laboratory Services _____	20
05.13	Mammography _____	20
05.14	Maternity _____	20
05.15	Medical Supplies _____	20
05.16	Mental Health and Chemical Dependency _____	21
05.16.1	Office Visits _____	21
05.16.2	Psychiatric Day Treatment Programs _____	21
05.16.3	Inpatient Treatment for Chemical Dependency and Substance Abuse _____	21
05.16.4	Inpatient Treatment at Institutions Licensed as a Hospital or Medical Facility _____	21
05.17	Outpatient Hospital Services _____	21
05.18	Physician and Private Duty Nursing Services _____	21
05.19	Routine Physicals/Preventive Care _____	22
05.19.1	Routine Physical Exams _____	22
05.19.2	Well Baby Care _____	22
05.19.3	Routine Digital Rectal Exam and Prostate Antigen (PSA) Test _____	23
05.19.4	Pap Smear (Independent Test) _____	23
05.19.5	Routine Nursery Care _____	23
05.20	Prescription Drug Benefits _____	23
05.21	Short-Term Rehabilitation _____	23
05.21.1	Occupational Therapy _____	23
05.21.2	Physical Therapy _____	23
05.21.3	Speech Therapy _____	23
05.22	Surgery _____	23
05.22.1	Cosmetic Surgery _____	24
05.22.2	Second Surgical Opinion _____	24
05.22.3	Surgery on Mouth, Jaws, Teeth _____	24
05.22.4	Sterilization _____	25

05.22.5	Transplants	25
05.23	Transportation Charges	25
05.24	Vision Services	25
05.25	Intravenous Immunoglobulin (IVIG)	25
<i>06 MIP Coverage Exclusions and Limitations</i>		26
<i>07 Medical Expenses Not Covered</i>		28
07.01	Convalescent Facilities	28
07.02	Cosmetic Surgery or Products	28
07.03	Counseling	28
07.04	Custodial Services	28
07.05	Durable Medical Equipment	28
07.06	Educational or Vocational Training	29
07.07	Environmental Improvements	29
07.08	Equipment and Services	29
07.09	Expenses Incurred While Not Eligible for Coverage	29
07.10	Experimental or Investigative Care	29
07.11	Eyes	30
07.12	Funeral Arrangements	30
07.13	Home Health Care Services	30
07.14	Infertility	30
07.15	Legal Fees	30
07.16	Massage Therapy and Spa Treatments	31
07.17	Mental Health	31
07.18	Orthopedic Services and Devices	31
07.19	Personal Comfort Items	31
07.20	Postage and Documentation	31
07.21	Sexual Dysfunction	31
07.22	Speech Therapy	31
07.23	Sterilization Reversal	31
07.24	Telephone Including Fax and E-mail	31
07.25	Therapy and Rehabilitation	32
07.26	Transportation Charges	32
07.27	Transsexual Surgery	32
07.28	Volunteer Services	32
<i>08 Dental Coverage</i>		33
08.01	Introduction	33
08.02	Dental Coverage Maximum	33
08.03	Covered expenses	33
08.04	Preventive and Diagnostic Services	33
08.05	X-ray and Basic Restorative Dental Services	34
08.06	Major Restorative Dental Services*	34
08.07	Special Periodontal Surgical Dental Expenses	35
08.08	Orthodontia Dental Expenses	35

<i>09 Dental Expenses Not Covered</i>	<u>36</u>
09.01 First Year of Coverage	36
09.02 Bridges	36
09.03 Cosmetic Dentistry	36
09.04 Dentures	36
09.05 Expenses Incurred While Not Eligible for Coverage	36
09.06 Late Enrollees to the MIP	36
09.07 Space Maintainers	37
09.08 Not Covered expenses	37
09.09 Services Not Performed by a Dentist	37
09.10 Services Otherwise Covered	37
09.11 Temporary Restoration of Dentures, Crowns, or Bridges	37
<i>10 Prescription Drug Benefits</i>	<u>38</u>
10.01 Brand-Name Drugs Versus Generic Drugs	38
10.02 Network Pharmacies	38
10.02.1 Retail	38
10.02.2 Mail Order	39
10.02.3 Specialty Drugs	39
10.02.4 Formulary	39
10.03 Out-of-Network Pharmacies	39
10.04 Benefit Levels	40
10.05 Covered Drugs	40
10.06 Prior Authorization	41
10.06.1 General Information	41
10.06.2 Infertility Drugs	41
10.06.3 All Other Drugs	41
10.07 Dispensing Limit	42
10.07.1 Dispensing Limit Except For Members in MIP Continuation	42
10.07.2 Dispensing Limit For Members in MIP Continuation	42
10.08 If You Disagree with a PharmaCare Prescription Drug Claim Decision	42
<i>11 Prescription Drug Expenses Not Covered</i>	<u>44</u>
<i>12 Aetna National Medical Excellence Program</i>	<u>46</u>
<i>13 Option C - Point of Service (Aetna only)</i>	<u>48</u>
13.01 Introduction	48
13.02 Self Referral	48
13.03 Choosing a PCP in Option C	49
13.04 Referrals	49
13.05 Emergency Care and Option C	50
13.06 Moms-to-Babies Maternity Management Program	50
<i>14 Eligibility and Enrollment</i>	<u>51</u>
14.01 MIP Eligibility	51

14.01.1	Active Staff (General)	51
14.01.2	Active Staff (Extended Term Appointments)	51
14.01.3	Retirees	51
14.01.4	Deferral	51
14.02	Retiree Plan 1	52
14.03	Retiree Plan 1 Buy up	52
14.04	Retiree Plan 2	52
14.05	Coverage for your Dependents	53
14.05.1	Spouses, Partners and Children	53
14.05.2	Parents and Parent-in-laws	54
14.06	When Both Spouses/Domestic Partners Are Eligible	54
14.07	Surviving Dependent Eligibility	54
14.07.1	General Provision	54
14.07.2	Death in Active Service of Staff Member Participating in the Staff Retirement Plan	54
14.07.3	Death in Active Service of Staff Member Not Participating in the Staff Retirement Plan	54
14.07.4	Death of a Retiree Participating in the Retiree MIP	55
14.07.5	Death of a Deferred Retiree Not Participating in the Retiree MIP	55
14.08	If Your Child Is Handicapped	55
14.09	When MIP Coverage Begins	56
14.09.1	Active Staff	56
14.09.2	Retirees	56
14.09.3	Sponsored Plan	56
14.10	Changing Coverage: Life Events and Annual Change Season	57
14.11	Late Enrollment	57
14.12	When Coverage Ends	58
14.12.1	All Cases Except Long-Term Disability	58
14.12.2	Long-Term Disability	58
14.13	MIP Continuation	58
14.14	Continuing Coverage If Disabled When Group Coverage Ends	60
14.15	Conversion to an Individual Plan With Aetna or Vanbreda	60
14.16	When Conversion Is Allowed	60
14.17	When Conversion Is Not Allowed	60
14.18	Applying for a Conversion Policy	61
14.19	After Conversion Begins	61
15	<i>Coordination of Coverage</i>	62
15.01	What “Other Plans” Means	62
15.02	National Health Plans for Retirees	62
15.03	Coordination Methods: “Coordination” or “Exclusion”	63
15.03.1	Coordination	63
15.03.2	Exclusion	63
15.04	Medicare Savings (Retiree Plan 1 Only)	63
15.05	Coordination Rules For Plans Other Than Medicare	64
15.06	Coordination and Prescription Drug Benefits	65
15.07	Medicare Direct for Part B Claims	65
15.08	How Prior Coverage Affects Your Benefits	65

15.09 Medicare Part D _____	65
16 Claims, Payments and Appeals _____	66
16.01 Keeping Records of Expenses _____	66
16.02 Filing Claims _____	66
16.03 Payment of Benefits _____	66
16.04 Domestic Disputes and Estrangement _____	67
16.04.1 Aetna _____	67
16.04.2 Vanbreda _____	67
16.05 Explanation of Benefits _____	67
16.06 Time to Process an MIP Claim _____	68
16.07 Predetermination of Benefits _____	68
16.08 Claim Payment Options _____	68
16.08.1 Aetna _____	68
16.08.2 Vanbreda _____	68
16.09 Exchange Rates _____	68
16.10 Direct Deposit Program _____	69
16.10.1 Vanbreda (Active Staff and Retirees) _____	69
16.10.2 Aetna (Active Staff) _____	69
16.10.3 Aetna (Retirees) _____	69
16.11 Medicare Direct (Aetna only) _____	69
16.12 Physical Exams _____	70
16.13 Adjustment Rule _____	70
16.14 Misstatement of Fact _____	70
16.15 Right of Recovery and Subrogation _____	70
16.16 Recovery of Overpayment _____	70
16.17 Legal Action _____	71
16.18 If You Disagree With a Claim Decision _____	71
16.18.1 Claim Decisions _____	71
16.18.2 Appeals _____	72
16.18.3 If Additional Time Is Needed _____	72
16.18.4 Second Appeal _____	72
16.18.5 Urgent Appeals _____	73
16.18.6 Independent External Review _____	73
17 International Option _____	76
17.01 Who May Elect the International Option? _____	76
17.01.1 Active Staff MIP Participants _____	76
17.01.2 Retiree MIP Participants _____	76
17.01.3 Sponsored Plan Participants _____	76
17.01.4 Use of Both Insurance Administrators _____	77
17.02 How Do I Enroll if I Am Eligible? _____	77
17.03 Premiums _____	77
17.04 Plan Design Differences _____	77
17.04.1 Dental _____	77
17.04.2 Application of Out-of-Pocket Limit _____	77
17.05 Other Differences _____	78
17.05.1 Care Outside the U.S. _____	78

17.05.2	Care Within the U.S.	78
17.06	Dental Services	79
17.07	Pharmacy Services	79
17.08	PharmaCare Out-of-Pocket Maximum Coordination	79
17.09	Identification Cards	80
17.10	Direct Billing and Negotiated Fees	80
17.10.1	Direct Billing	80
17.10.2	Negotiated Fees	80
17.11.1	Customer Service	81
17.11.2	How to File a Claim	81
17.11.3	Translation of Claims	81
17.12	Claims Adjudication	81
17.12.1	Fiduciary Responsibility	81
17.12.2	Medical Necessity	82
17.13	Claims Reimbursement	82
17.13.1	Claim Processing Service Standard	82
17.13.2	Usual and Customary Charges	82
17.13.3	Payment Option: Electronic Funds Transfer Versus Paper Check	82
17.13.4	Currency of Reimbursement	83
17.13.5	Explanation of Benefits	83
17.13.6	Mailing Address	83
17.14	Disputed Claims and Appeals Process	83
17.15	Predetermination of Benefits	84
17.16	Eligibility Changes, Continuation and Conversion	84
17.17	Coordination Between Vanbreda and Aetna	84
17.18	National Medical Plans	84
17.19	Switching Between Aetna and Vanbreda	84
17.19.1	Retirees	84
17.19.2	Active Staff	85
18	<i>Aetna Programs</i>	86
18.01	Alternative Health Care Program	86
18.02	Vision One Discount Program	86
18.03	Fitness Program	86
18.04	Aetna Informed Health Line	87
18.05	Aetna Vital Savings Program	87
19	<i>Member Services and Online Services</i>	88
19.01	Member Services	88
19.01.1	Aetna Member Services	88
19.01.2	Vanbreda/Health Systems International	88
19.01.3	PharmaCare	88
19.02	Online Services	88
19.02.1	Aetna	89
19.02.2	Vanbreda	89
19.02.3	PharmaCare	90
20	<i>MIP Contact Information</i>	91

20.01	How to Contact Aetna _____	91
20.02	How to Contact PharmaCare _____	92
20.03	How to Contact Vanbreda _____	92
20.04	How to Contact the HR Service Center _____	93
20.05	How to Contact Pension Administration _____	93
21	<i>Benefit Summaries</i> _____	94
21.01	How Do I Determine Which Benefits Summary to Use? _____	94
21.01.1	Active Staff (Aetna) _____	94
21.01.2	Active Staff (Vanbreda) _____	94
21.01.3	Retirees (Aetna) _____	94
21.01.4	Retirees (Vanbreda) _____	94
21.02	Aetna Active Staff Medical and Pharmacy Benefit Summaries for Options A, B, C _____	95
21.03	Aetna Retiree Benefit Summaries for Plans 1 and 2 _____	101
21.04	Vanbreda Active Staff Medical and Pharmacy Benefit Summaries for Options A and B _____	105
21.05	Vanbreda Retiree Medical and Pharmacy Benefit Summaries for Plans 1 and 2 _____	111
21.06	Aetna Sponsored Plan Medical, Dental and Pharmacy Benefit Summary _____	117
22	<i>Glossary</i> _____	119
	<i>Topics Index</i> _____	128

01 Introduction

The Medical Insurance Plan (MIP) is one of the World Bank Group's most valuable benefits, providing worldwide comprehensive health, dental, and prescription drug insurance to eligible staff and retirees, and their eligible dependents. The MIP helps staff and retirees meet the financial impact of quality health care coverage for themselves and their eligible dependents.

The MIP does not cover all medical, dental and prescription drug services and purchases, even if performed or prescribed by physicians or dentists. Coverage extends only to "medically necessary" services as specified in this document. Recommendation by a doctor or dentist for a specific treatment or service does not, in itself, make that treatment "medically necessary."

The MIP is self-insured. This means that the World Bank Group and MIP members, and not an insurance company, fund the MIP and pay the claims for eligible health expenses of participants. Participants pay monthly contributions, coinsurance and co-pays, but most funding comes from the World Bank Group. Generally, the World Bank Group pays \$3 for every \$1 in premium paid by participants.

MIP benefits are designed by the World Bank Group and are subject to change. The World Bank Group has contractually provided fiduciary responsibility to three MIP Insurance Administrators to process MIP claims, Aetna, Inc. (hereafter **Aetna**, which includes the services of Aetna Global Benefits), Vanbreda International, (hereafter **Vanbreda**), and **PharmaCare**. These Insurance Administrators adjudicate claims according to the MIP plan design, and disburse World Bank Group 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 insured lives, not how many claims are processed, reduced or denied.

For most staff and retirees, **Aetna** provides administrative services to the MIP and processes all MIP claims as described in the Administrative Services Agreement (which includes this Summary Plan Description).

A similar agreement is in place with **Vanbreda**, a Belgian-based employee benefits consultant and administrator, for non U.S. addressed participants who are eligible to elect the MIP's International Option.

For U.S. prescription drug benefits, a third administrative contract exists with **PharmaCare**, a U.S. pharmacy benefits management company. PharmaCare administers in-network prescription drug benefits in the U.S. through retail or mail order purchases. Prescription drug claims are also self-insured and PharmaCare acts as the Bank Group's fiduciary agent and administrator. All MIP members, whether using Aetna or Vanbreda are issued a PharmaCare card for use in the United States.

Prescription drug purchases outside of the PharmaCare network may be presented to Aetna or Vanbreda for consideration under your out of network medical benefits.

01.01 This Document

This Summary Plan Description (SPD) replaces any other Certificates of Insurance previously issued for the MIP. It reflects benefits in effect from January 1, 2006. The World Bank Group reserves the right to change the benefits of the MIP and the eligibility for the MIP at any time. MIP participants will be notified of all changes made. To take full advantage of the MIP, you must know how the MIP works, and how to make it work for you. Reading this SPD is the first step toward understanding your health care benefits. Many important terms are defined in the Glossary (Section 22).

01.02 Scope of This Document

Medical, dental 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 SPD, contact your Insurance Administrator (see Contact Information in front of Summary and in Section 20).

01.03 MIP Plan Year

The MIP plan year is January 1 to December 31 for all participants.

01.04 Coverage Changes

The scope of coverage of the MIP has been generally stable over time. However, the World Bank Group does review coverage continually, and may amend aspects of the MIP in response to changes in medical norms, advances in research, and changes in health economics. Participants are informed of these changes through various means, predominantly via e-mail (for active staff) and regular mail (for retirees).

If you are reading a printed version of this SPD, you may not be reviewing the most current information. Printed versions are issued periodically. The Bank Group maintains the current version online on the Bank Group's Intranet (type mip in the url) and Internet (www.worldbank.org/humanresources, then Retiree Medical Insurance). When launched, this document can be printed in full, or you can search for a specific topic, and print only that information.

01.05 International Option

The International Option is available to MIP participants who reside outside the U.S. indefinitely or, for active staff, for an extended duration. Vanbreda, and not Aetna, administers medical and dental claims for International Option participants.

The International Option is described in detail in Section 17. Most of the content of this document applies to all MIP participants, and both Aetna and Vanbreda use this document to adjudicate claims. However, some programs and services apply to Aetna

participants only, and others apply to Vanbreda participants only. Such differences, if they occur, are identified in this document.

01.06 Tips for MIP Participants

- Keep this SPD where you can easily refer to it. We have provided a Summary to staff members at their Bank address and mailed a copy to the home addresses of both staff and retirees. We maintain the most current version online as described in Section 01.04.
- Share this SPD with all family members enrolled in the MIP.
- Keep your ID card(s) with you, and show it to all medical.
- Give an ID card to each covered adult family member.
- Health care emergencies are covered anytime, anywhere, Section 4 for emergency care guidelines.

01.07 Rights and Responsibilities

01.07.1 Your Rights and Responsibilities

As an MIP participant, you have the responsibility to:

- Be informed and aware about your health;
- Follow the directions and advice you and your doctors have agreed upon;
- Help your doctor make decisions about your health care;
- Tell your provider if you do not understand the treatment you receive, and ask if you do not understand how to care for your illness;
- Make sure you have the appropriate authorization or referrals for certain services as required by your MIP coverage;
- Learn how to file a claim and always identify your documents and correspondence with your name and UPI and the patients name, if different. Instruct your doctors to do the same.
- Pre-certify non-emergency hospitalization by contacting your Insurance Administrator;
- Confirm whether a provider is in- or out-of-network before you receive care;
- Understand that in-network providers are not employees of Aetna, PharmaCare or Vanbreda (or its U.S. network, Health Systems International);
- Show your ID card to providers before getting care, and never permit another individual to use your ID card;
- Pay the co-payments, coinsurance and deductibles required by the MIP;
- Repay any amounts owed to the MIP promptly to the Insurance Administrator (for example, in cases of claims processing errors or Subrogation);
- Call your Insurance Administrator's Member Services if you do not understand how to use your benefits;
- Follow the MIP's appeal procedures if you wish to dispute a claims decision;
- Give correct and complete information to your health care providers;

- Advise your Insurance Administrator about other medical insurance coverage you or your covered family members may have, once a year for all participants and as your non-MIP insurance coverage changes;
- Not be involved in dishonest activity directed to the MIP or any provider; and
- Notify the HR Service Center promptly of any changes in eligibility, address changes, enrollment in a National Health Plan, or other life event changes that could affect your MIP enrollment.

01.07.2 How the MIP Works

For services in the U.S., the MIP offers the cost savings of a comprehensive network of medical and dental providers who offer discounted fees for services, with the freedom and flexibility of a traditional indemnity medical plan. You have access to a network of participating providers throughout the U.S., including specialists and hospitals that meet strict requirements for quality and service. These providers are independent physicians and facilities that are monitored by your Insurance Administrator for quality of care, patient satisfaction, cost-effectiveness of treatment, office standards and on-going training.

01.07.3 In-Network Providers

When you use a participating or “in-network” provider, you maximize benefits available under the MIP. After making a co-payment, (a fixed dollar amount), for certain types of care, you have no further out-of-pocket expenses, up to the limits shown in the Benefit Summary chart which applies to your MIP coverage. For example, for in-network physician office visits, you only pay your office visit co-payment at the time of service, you do not have to meet a deductible, and no claim forms are required.

For other services, such as in-network hospital or laboratory expenses, you receive services at a pre-negotiated rate (and a discount). You are responsible for any coinsurance, and in some cases you must meet your deductible as well, depending on your MIP enrollment. For Aetna participants, the medical network is called “the Aetna Open Choice PPO” for all participants except those in Active Staff Option C (Option C participants use the “Aetna Managed Choice POS” network). The dental network is the “Aetna Dental PPO” for all Aetna participants.

The network for Vanbreda participants receiving medical care in the U.S. is called “Health Systems International.” There is no dental network for Vanbreda participants.

The MIP’s pharmacy network in the United States is PharmaCare for all MIP participants including those with Vanbreda. PharmaCare provides access to a large national pharmacy retail network in the U.S., including most large retail chain pharmacies. In addition, they provide mail order pharmacy service for most maintenance drugs through PharmaCare Direct. There is no pharmacy network outside the U.S.

01.07.4 How to Find In-Network Providers

The easiest way to find in-network providers is via the Internet. Aetna, Vanbreda (with Health Systems International), and PharmaCare maintain web sites that list participating doctors, hospitals, pharmacies, laboratories and other providers. Each has a search engine so you can limit your search by zip code, specialty, etc. Alternatively, you can contact the Insurance Administrators for assistance.

01.07.4.1 Aetna

DocFind, Aetna’s online tool, is available at www.aetna.com. When you use DocFind, you must enter Aetna Standard Plan for your specific MIP coverage, then select the network for your option.

- Active Staff Option A & B, Sponsored Parents and Retirees select *Open Choice PPO*.
- Active Staff in Option C select *Managed Choice POS*.
- All members select *Dental PPO* for in network dental providers.

01.07.4.2 Vanbreda

Vanbreda participants use the Health Systems International network (www.us-hsi.com) for medical services in the United States. Vanbreda also has its own network of providers outside the United States. The Vanbreda web site (www.vanbreda-international.com) is password-protected; login details are provided in the Contacts information in Section 20.

01.07.4.3 PharmaCare

Both Aetna and Vanbreda participants use the PharmaCare network for prescription drug purchases in the U.S. Most of the large retail pharmacy chains, as well as many independent pharmacies, are affiliated. To find the closest pharmacy, call PharmaCare or use the PharmaCare web site, www.pharmacare.com.

01.07.5 Out-of-Network Providers

You can access out-of-network doctors or facilities, although this may decrease your level of coverage under the MIP:

- You must satisfy an annual deductible before the MIP begins to pay benefits.
- Once you meet the deductible, you pay a portion of the Covered expenses you incur (your coinsurance share), up to the out-of-pocket maximum each year.
- If your provider charges more than the Usual and Customary (U & C) charge as determined by the Insurance Administrator, you must pay any expenses above the U & C Charge. That excess amount does not apply toward your deductible or out-of-pocket maximum. This amount would be shown on your Explanation of Benefits (EOB) as an “Amount Not Covered.”
- Out of network also includes most self referred services in Active Staff Option C.

All non-emergency hospitalization requires pre-certification from the Insurance Administrator. If you do not use an “in-network” hospital, you are responsible for obtaining the necessary pre-certification by calling your Insurance Administrator directly prior to or as close as possible to a hospitalization. The admitting physician may do the precertification on your behalf, but it is your responsibility to ensure the precertification was made.

01.07.6 Your Identification Cards

Approximately two weeks after the effective date of your MIP enrollment, you will receive identification cards. You receive new cards even if you have no break in coverage between Active Staff MIP and Retiree MIP.

Aetna and Vanbreda have different (and mutually exclusive) MIP identification cards. Participants who elect the International Option will receive a Vanbreda card. These participants are no longer enrolled with Aetna and should destroy their Aetna MIP cards upon receipt of their Vanbreda MIP cards. In addition, for “in-network” services within the U.S., Vanbreda participants also receive a Health Systems International ID card. This card can only be used in the U.S. at Health Systems International providers.

Both Aetna and Vanbreda participants use their PharmaCare card for any prescription drug purchases in the U.S. at PharmaCare-affiliated pharmacies.

You will not receive new PharmaCare cards if you switch from the Active Staff MIP to the Retiree MIP, or if you switch between Aetna and Vanbreda.

Depending on your Insurance Administrator, you use the cards as follows:

Service Type	Country	Insurance Administrator	
		Aetna	Vanbreda
Medical services (in-network)	U.S.		Health Systems International card
Medical services (non-network)	U.S.	Aetna	Vanbreda
Dental services (in-network)	U.S.	Aetna card	None: participant prepays and submits claim
Dental services (other)	Non-U.S.	None: participant prepays and submits claim	
Prescription drug purchases (PharmaCare pharmacies)	U.S.	PharmaCare card Member pays co-payment at point of purchase	
Prescription drug purchases (other pharmacies)	All	None: participant prepays and submits claim	

01.08 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. These online services are described in Section 19.02

01.09 Referrals

Referrals are not required by the MIP except for members enrolled in Active Staff Option C, as described in detail in Section 13.04. However, certain services may require either a prescription, a physician's order, or a referral (e.g., physical therapy, mammography).

01.10 Patient Confidentiality

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

While the World Bank Group is legally immune from related U.S. legislation including the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the Bank Group and its Insurance Administrators comply with or exceed HIPPA standards. In particular, Insurance Administrators are prohibited from sharing personal medical information on insured individuals with the World Bank Group. However, Insurance Administrators may provide the Bank Group with the financial aspect of claims if there is a need to investigate fraud or misconduct, or to recover funds disbursed for ineligible MIP members.

01.11 Sponsored Plan

The World Bank Group offers Sponsored Plan coverage for elderly parents or in-laws who reside in the household of active staff MIP participants in the U.S., and who meet the Sponsored Plan eligibility criteria as defined on the World Bank Group intranet web site. Many services described in this Summary Plan Description are not covered, including dental. Check the Sponsored Plan benefits grid for details on what is covered.

02 Summary of Benefits

02.01 Introduction

This section describes the Medical Insurance Plan (MIP), its coverage levels, deductibles and limits, and pre-certification of medical services.

02.02 Benefit Summaries

The Benefit Summaries in Section 21 highlight the MIP coverage and the corresponding coinsurance or co-payment amounts that apply to each benefit. There are separate charts for Domestic Administrator (Aetna) and International (Vanbreda) for Active Staff and Retiree plans. Benefits, as summarized in these charts, are subject to review and may change based on MIP experience and industry changes.

02.02.1 Deductibles and Limits

For most out-of-network care, and certain types of in-network care, you and your dependents 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.¹ Once Covered expenses of two or more family members reaches 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 Summary charts show individual and family deductible amounts and those services that require a copayment rather than a deductible.

If you or your dependent are confined in a hospital for an uninterrupted period which continues from one calendar year to another, the deductible, if any, will be considered satisfied with respect to Covered expenses which are incurred by you or your dependent 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.

¹ A single deductible applies to all covered children born of the same pregnancy who receive care for (i) an illness within 30 days after birth; (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 your 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.

The deductible requirement for any calendar year after the year in which such confinement began must be met from Covered expenses incurred after the end of such uninterrupted period of confinement.

02.02.2 Medical Out-of-Pocket Maximum

The MIP includes a limit on the amount of Covered expenses you must pay out of your own pocket each year. This is known as the “out-of-pocket maximum” or “stop-loss limit,” and it protects you against the cost of very high medical expenses by shifting all covered costs to the MIP after you have paid a certain amount in a given year. The out-of-pocket maximums for each option are shown in the Benefit Summary chart for the MIP coverage in which you are enrolled.

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. The out-of-pocket maximum includes the annual deductible, but does not include:
 - 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.
 - Charges that are Covered expenses but for which no benefit is payable because of dollar or usage limit on that benefit has been exceeded (e.g., the annual chiropractic visit limit).
 - Co-payments for office visits (e.g., \$15, \$20).
 - Coinsurance for office visits for treatment of mental health and substance abuse.
 - All dental expenses.
 - Co-payments for in-network prescription drug expenses.

02.02.3 Prescription Drug Out-of-Pocket Maximum and Brand-Name Deductible

02.02.3.1 Aetna

The MIP’s prescription drug benefits have a separate brand-name deductible and out-of-pocket maximum for annual prescription drug purchases at PharmaCare pharmacies. If you purchase prescription drugs outside the PharmaCare network, you may file these expenses as a medical claim, but it will be subject to your medical benefit only.

02.02.3.2 Vanbreda

Vanbreda participants do not have a separate prescription drug out-of-pocket maximum. However, non-network prescription drug claims are filed as medical claims, and are subject to the medical out-of-pocket maximum.

Vanbreda participants have access to the PharmaCare network for prescription drug purchases in the U.S. No claims are filed for such purchases, since the MIP benefit is applied at the point of purchase. After the end of each calendar year, PharmaCare and Vanbreda coordinate and reconcile to assure that Vanbreda participants do not exceed annual Vanbreda medical out-of-pocket limits.

02.02.4 Coordination with Active Staff Deductibles and Out-of-Pocket Maximums

In years where a participant has both Active Staff and Retiree MIP coverage, the Retiree MIP annual deductible and out-of-pocket maximum must be met regardless of whether the Active Staff MIP deductible or out-of-pocket maximum was previously met in the same calendar year. However, charges applied toward the Active Staff MIP deductible and out-of-pocket maximum for any calendar year also count toward meeting the Retiree MIP deductible and out-of-pocket maximum for the same year.

These provisions apply to both the medical out-of-pocket maximum and the prescription drug out-of-pocket maximum.

02.02.5 Lifetime Maximum Benefit

The MIP does not have a lifetime maximum benefit. This means no overall lifetime limit applies to the covered benefits in the MIP. 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., orthodontia and infertility). Such lifetime benefit limits are tracked by individual, and apply to all MIP coverage in any capacity. They are not reset upon appointment of a former dependent, or reappointment of a staff member, or upon a change in coverage (e.g., Active Staff MIP to Retiree MIP).

02.03 Pre-certification of Hospitalization

If you are admitted to a hospital, the referring doctor, the patient or a family member must call your Insurance Administrator to “pre-certify” the hospital stay. In the case of an emergency, this call must be made within 48 hours of the hospital admittance. If you are using an in-network doctor, the provider should make the phone call for you. This phone call will register the hospital stay and allow access to patient management services as appropriate.

All inpatient and many outpatient hospital admissions should be pre-certified. If you have queries about pre-certification, please contact your Insurance Administrator.

02.04 Patient Management

Patient Management is an important service to you and your covered family members so that large, catastrophic medical conditions are treated in the most effective manner from both a cost and patient care perspective. There is no additional cost for you or a family member to use Patient Management services, and there is no benefit penalty if you do not participate with Patient Management.

For services in the United States, you or a family member or your doctor should contact your Insurance Administrator. For Aetna members outside the United States, you or a family member or your doctor should contact Aetna Customer Service. If your case is appropriate for Patient Management, an individual case manager will be assigned to review the recommended course of treatment to make certain that it is medically necessary (and therefore reimbursable under the MIP) and that it is the most effective method to treat the condition. Your case manager will be a professional trained in management of expensive catastrophic illnesses (including inpatient mental health) or accidents.

If you have queries about pre-certification, please contact your Insurance Administrator.

03 Covered Expenses and Reimbursement

03.01 Introduction

The MIP does not cover all medical, dental and prescription drug services and purchases, even if performed or prescribed by a doctor or dentist. Covered expenses must be “medically necessary” for your specific medical condition as determined by your Insurance Administrator. Recommendation by a doctor or dentist for a specific treatment does not make that treatment covered and reimbursable under the MIP. The Insurance Administrator determines reimbursement for a claim in accordance with the terms of the MIP. Thus, not all of the medical, dental and pharmacy expenses you or your dependents incur are Covered expenses.

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 determines which expenses are limited or not covered by the MIP. The Benefit Summary charts contain applicable deductibles and coinsurance percentages. Your 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 your coverage starts or after it ends, even if the expenses were incurred because of an accident, injury or disease that occurred began or existed while your coverage was in effect. In specific situations, however, your coverage may be continued beyond the date it would normally end. If you are a late entrant to the MIP, some benefits are limited for a period of time.

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 to provide the services.² Only the pro-rata share of the expense will be considered as incurred on the date of the service.

03.02 How Does the MIP Pay Benefits?

After you pay any required office copayment or deductible, benefits are paid as a percentage of covered expenses as determined in the Benefit Summary chart. Benefits for services furnished by a participating provider are called “in-network” benefits, and those furnished by a non-participating provider are called “out-of-network” benefits. Benefits are determined by applying the benefit percentages shown in the Benefit Summary chart to covered expenses in excess of the deductible.

² E.g., a \$2,000 orthodontia bill would be reimbursed by the Insurance Administrator at \$100 per month for a typical service duration of 20 months.

For details on payment of claims, please Section 16.

03.02.1 In-Network Medical Benefits in the U.S. (except Pharmacy)

Generally, the MIP pays in-network benefits directly to the provider. You may pay certain up-front charges such as an office visit co-payment, but your provider should bill your Insurance Administrator directly and receive reimbursement directly for your claim. If you owe money to the provider following this process (e.g., your deductible, your coinsurance for the service, or for non covered services), the provider bills you, and you must pay.

03.02.2 In-Network Dental Benefits in the U.S.

In-network dental providers typically require a 20% co-insurance from the patient for the cost of the dental services at the time the services are received. The “office visit copayment” concept does not apply to dental office visits.

03.02.3 In-Network Benefits in the U.S. (Pharmacy)

Pharmacy in-network discounts are applied at the time of purchase in participating PharmaCare retail or mail-order pharmacies, as described in Section 10.

03.02.4 Direct Billing Providers Outside the U.S.

Both Aetna and Vanbreda have special billing arrangements with hospitals, clinics and other medical providers which have agreed to file claims directly to the Insurance Administrator for services provided to MIP participants. For more information, Section 16.10.

03.02.5 Out-of-Network Benefits

When you receive out-of-network medical or dental services, you or your provider must complete an MIP claim form. These forms are available on the Bank’s Intranet (MIP) or on the Internet (www.worldbank.org/humanresources, then Retiree MIP), or from your Insurance Administrator.

A standard claim form from your provider may also be used. If a provider does not file the claim form for you, you 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 Insurance Administrator will then reimburse MIP benefits to you directly. If you pay for a service in full, generally you should file the claim. If the provider files the claim on your behalf, you 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 must pay the provider (not you). If you also have paid the provider, then the provider would be paid twice and you would need to seek reimbursement from the provider.

04 Emergency Medical Care

The MIP covers care for a medical emergency, regardless of where you receive care. When you have a medical emergency, go to the nearest hospital emergency room or urgent care facility and show your ID card.

A medical emergency is a medical condition characterized by acute symptoms (including pain) that are severe enough that a prudent layperson with an average knowledge of health and medicine might think that without immediate medical attention, the condition would result in:

- Placing the health of the patient (or in the case of a pregnant woman, the unborn baby) in serious jeopardy;
- Serious impairment to bodily function; or
- Serious dysfunction of any bodily organ or part.

If you are away from home, and need emergency care, use the nearest hospital emergency room or urgent care facility. If your condition is an emergency condition, as defined above, and as confirmed by your Insurance Administrator, your MIP claim will be processed at the in-network level of benefits, regardless of where you receive treatment. However, if the emergency room care is provided by non-network physicians 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.

When possible, use an emergency room for emergencies only. If you use an emergency room for non-emergency care, benefits will be processed at a lower benefit and the deductible will apply, even at in-network facilities. Be sure to discuss after-hours (nights, weekends) care with your physician and what you should do if you or a family member becomes ill after the office is closed. For example, your doctor may offer an after-hours service or recommend an urgent care facility for medical events that are not life threatening. **Urgent care** is for conditions requiring prompt attention but not posing immediate, life threatening health risk.

05 Medical Benefits

The MIP covers the following medical services, subject to the provisions of Section 06, MIP Coverage Exclusions and Limitations, and all other provisions in this document:

05.01 Acupuncture Care

Charges made for acupuncture treatment, whether performed in or out of a hospital, are covered. The acupuncturist must be licensed and certified to perform such services. The maximum benefit is 30 treatments per calendar year per covered individual.

05.02 Ambulance Service

Section 05.23, Transportation Charges.

05.03 Chiropractic Care

Eligible expenses rendered by a licensed chiropractor are covered up to 30 visits per calendar year per covered individual.

05.04 Durable Medical Equipment and Medical Supplies

05.04.1 Durable Medical Equipment

The MIP covers charges made for the rental (or purchase, if a purchase is shown to be more cost effective) of durable medical equipment of a medical or surgical nature. This equipment is limited to that which is not useful without illness or injury, can stand repeated use, and is suitable for use in the home. Charges are also covered for the rental or purchase of the following durable medical equipment:

- Hospital beds.
- Wheelchairs, including batteries (initial and replacement), cushions and supports.
- Respirators and oxygen equipment (including portable hand-held oxygen tanks).
- Artificial limbs.
- Artificial eyes.

Purchases must be authorized by the Insurance Administrator in writing and must provide a cost-effective alternative to rental. The patient must also need long-term care and use of the item.

Section 07.08 and Section 07.16 lists exclusions to covered equipment.

05.04.2 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 (e.g., lupus, chemotherapy, radiation therapy, many types of alopecia but not androgenic alopecia, etc.);
- Splints; Crutches; Braces; and other medical and nursing supplies.

05.04.3 Emergency Room Care

The MIP covers treatment of emergency medical conditions in a hospital emergency room. If you visit a hospital emergency room for a non-emergency condition, the MIP will pay a reduced benefit as shown in the Benefit Summary charts. For the definition of an “emergency medical condition” and more information about receiving care in an emergency, Section 04.

05.05 Hearing Care

The MIP covers expenses for one audiometric exam per calendar year per covered individual. The exam must be performed by an otologist or physician certified for otolaryngology; or by an audiologist who (i) is either legally qualified in audiology or holds a certificate of Clinical Competence in Audiology from the American Speech and Hearing Association; and (ii) performs the exam at the written direction of a legally qualified otolaryngologist or otologist. The MIP covers the cost of hearing aids, up to \$2,000 per person, once every five plan years.

05.06 Home Health Care

The MIP covers 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 your home, for up to 120 visits per year per condition. 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 charges 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.
- Psychological and dietary counseling.

05.07 Hospice Care

The MIP covers Hospice Care benefits, provided the patient has been admitted to a hospice care program (inpatient, outpatient or in-home) and a physician has confirmed a life expectancy for the patient of six months or less.

All MIP participants using Aetna for Insurance Administration are required to coordinate hospice benefits with Aetna’s Patient Management group as soon as a physician recommends hospice care. MIP participants using Vanbreda for Insurance Administration must advise Vanbreda.

05.07.1 Hospice Facility Expenses

Covered charges include those made by a hospice care facility, hospital or convalescent facility on its own behalf for:

- Room and board, and other services and supplies provided to a person while he or she is a full-time inpatient for pain control or other acute and chronic symptom management; and
- Services and supplies provided on an outpatient basis.

The MIP's recognized charge for a room rate is limited to the semi-private room rate unless there is a medical need for confinement to a private room, such as contagion. If there are no semi-private rooms, the MIP uses 80% of the private room rate as the covered expense for the room rate. The MIP benefit would be applied to this reduced private room rate.

05.07.2 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 who resides in the insured patient's home.

05.07.3 Medical or Social Services Under a Physician's Direction

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 eight 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 six visits in the 3-month period prior to or the 12month 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 Hospital Services

See Section 05.11, Inpatient Hospital Services and Section 05.17, Outpatient Hospital Services.

05.09 Immunizations

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

The MIP covers immunizations for allergies and travel immunizations.

05.10 Infertility Services

Infertility services and drugs are not available to late entrants to the MIP for the first 12 months following MIP coverage.

The MIP covers the diagnosis and treatment of the underlying cause of infertility. Benefits are payable as 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 or her partner's voluntary sterilization or hysterectomy.

Prescription drug charges associated with artificial insemination treatment or ovulation induction courses beyond the limit of six courses of treatment are not covered. PharmaCare will provide infertility treatment prescription charges to Aetna and Vanbreda quarterly.

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

- In-vitro 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 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 has a \$50,000 lifetime limit for all professional services and prescription drugs under ART. When applying this lifetime limit, the Insurance Administrator will only take into account services rendered under the MIP while you and your dependents were enrolled in either the Active Staff MIP or the Retiree MIP. Once the limit is reached, prescription drug coverage for ART also ends. PharmaCare will provide infertility treatment prescription charges to Aetna and Vanbreda quarterly.

The MIP does not cover some aspects of infertility services (Section 07.14).

05.11 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 due to 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.

05.11.1 Skilled Nursing Facility Services

The MIP covers Skilled Nursing Facility charges provided the confinement is in lieu of a hospital confinement and the treatment provided is for skilled nursing services and not custodial care services. The maximum benefit per condition per calendar year is 60 days. These services need not immediately follow a hospitalization.

05.11.2 Convalescent Facility Care

Convalescent facility care must be provided to a patient who had been confined as an inpatient immediately prior to the convalescent care facility, and who is recovering from a disease or injury. Benefits are paid for up to 60 days per person per condition per calendar year.

The MIP covers charges made by a convalescent facility for the services and supplies listed below:

- Room and board, including charges for services (such as general nursing care) made in connection with room occupancy. The MIP does not recognize charges for room and board in a private room that exceeds the semi-private room rate, unless the patient has a contagious disease. If there are no semi-private rooms, the MIP uses 80% of the private room rate as the covered expense for the room rate. The MIP benefit is applied to this reduced private room rate.
- 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.
- Medical supplies.

05.12 Laboratory Services and Supplies

05.12.1 Anesthesia and Oxygen

The MIP covers charges made for anesthesia and oxygen and its administration.

05.12.2 Chemotherapy and Radiation Therapy

The MIP covers charges for chemotherapy and radiation therapy.

05.12.3 Laboratory Services

05.13 Mammography

The MIP covers charges incurred for mammography including screening and related physician's fees. Computer-Aided Detection (CAD) mammography is considered part of a routine or diagnostic mammogram. Charges for CAD may be paid out of pocket at the time of service but are reimbursed by the Insurance Administrator.

05.14 Maternity

The MIP covers charges by a licensed physician or nurse midwife, provided such procedure is due to pregnancy (including resulting childbirth, abortion or miscarriage) as long as you or your dependent becomes insured within 31 days of the date you would otherwise become eligible for insurance under the MIP. Coverage is also provided for voluntary abortion and sterilization.

Maternity expenses (including laboratory and other services) for late entrants who are pregnant at the time of MIP enrollment are not covered for that pregnancy (Section 14.11).

05.15 Medical Supplies

See Section 05.04

05.16 Mental Health and Chemical Dependency

Section 07.17 lists mental health charges not covered by the MIP.

05.16.1 Office Visits

The MIP covers up to 50 office visits per covered individual per calendar year, combined for mental/nervous conditions and chemical dependency treatment. Additional office visits may be approved by the Insurance Administrator in lieu of inpatient hospitalization for mental/nervous conditions.

05.16.2 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. These treatments are not subject to the annual behavioral health office visit maximum.

05.16.3 Inpatient Treatment for Chemical Dependency and Substance Abuse

Charges are covered for a licensed institution engaged primarily in treating alcoholism or drug addiction. Pre-certification of inpatient care by the Insurance Administrator is not required. There is a 90-day lifetime limit for inpatient coverage.

05.16.4 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 pre-certification. Additional days of inpatient care require pre-certification by 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.

05.17 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 emergency care clinic or ambulatory surgery center.
- Outpatient diagnostic x-ray and laboratory tests.
- All other outpatient services.

05.18 Physician 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.

05.19 Routine Physicals/Preventive Care

05.19.1 Routine Physical Exams

The MIP covers charges made by a physician for a routine physical exam given to you or a covered dependent. A routine physical exam comprises the office visit, x-rays, lab tests, and other tests given in connection with the exam. It also includes immunizations against infectious disease and materials for testing for tuberculosis. Associated laboratory tests, x-rays and immunizations may be billed separately from the office visit fees and if so, will be processed under their separate benefit levels. Exams given to diagnose, treat, or monitor a suspected or identified injury or disease are not considered a routine physical.

The physical exam must include at least a review and written record of the patient's complete medical history, a check of all body systems and a review and discussion of the results with the patient (or parent of a child).

The routine physical is covered up to once per calendar year for covered individuals age 3 and over, and as follows for younger dependents:

- Up to seven exams during the first year of the child's life (birth to 12 months).
- Up to four exams during the second year of the child's life (13 - 24 months).
- Up to two exams during the third year of the child's life (25 - 36 months).

In addition, the routine exam coverage for women includes one routine gynecological exam per calendar year, including a Pap smear (Section 05.19.4) and related lab fees.

Note - Routine physical exams cannot be given while the patient is confined to a hospital or other facility for medical care.

05.19.2 Well Baby Care

The MIP covers charges made by a physician for services performed or supervised by that physician for a child for the first 36 months of life. (Routine care for individuals aged 3 and older is described above in Section 05.19.1.) Such services consist of a physical examination, medical history, developmental assessment, anticipatory guidance, appropriate immunizations, and laboratory tests at the intervals listed above. The routine examination should include a total overall evaluation of health, including a check of hearing and vision. Such checks should be included in the overall office visit charge. Any covered member would be eligible for a separate hearing and vision diagnostic exam if an illness were suspected. Such diagnostic tests would be covered at the benefits rate for any other diagnostic test.

05.19.3 Routine Digital Rectal Exam and Prostate Antigen (PSA) Test

The MIP covers a routine digital rectal exam and/or a PSA test once per calendar year for members over age 40, and earlier if associated illness or symptoms are present.

05.19.4 Pap Smear (Independent Test)

The MIP covers one routine Pap smear test and related physician's fees per calendar year when performed independently of a routine medical or gynecological exam.

05.19.5 Routine Nursery Care

The MIP covers routine nursery care of a newborn child in a hospital before the mother is discharged, if the charges are in connection with a pregnancy covered by the MIP. Such charges are treated as part of the mother's pregnancy charges.

05.20 Prescription Drug Benefits

See Section 10.

05.21 Short-Term Rehabilitation

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.

For covered children, up to a maximum of 60 visits per year for Occupational, Physical, and Speech therapies combined will be allowed when the diagnosis is Developmental Delay or related to Developmental Delay.

05.21.1 Occupational Therapy

The MIP covers inpatient or outpatient charges made by a licensed occupational therapist.

05.21.2 Physical Therapy

The MIP covers charges made by a licensed or certified physiotherapist or physical therapist.

05.21.3 Speech Therapy

The MIP covers charges made by a licensed or certified speech therapist.

05.22 Surgery

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

05.22.1 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; 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 you or your dependent 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.

See Section 07.02

05.22.2 Second Surgical Opinion

The MIP covers charges for a second opinion on the medical necessity of a surgical procedure. These charges are covered at 100%, up to an annual limit of \$150. Expenses over this limit are covered at 80%, no deductible. 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 performed 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 cost limits.

The MIP will not cover the second or third opinion from a physician who provides it in practice with the physician who initially recommended the surgery or who rendered a prior opinion.

05.22.3 Surgery on Mouth, Jaws, Teeth

The MIP covers charges made for the following treatment on or to the teeth, mouth, jaws, jaw joints and supporting tissue, bones, muscles and nerves:

- Closed or open reduction of fractures or dislocations of the jaw or facial bones.
- Excision of bony cysts of the jaw, leukoplakia or malignant tissue.
- Freeing of muscle attachments, correction of harelip, cleft palate or protruding mandible.

- Other incision or excision procedures of the gums and tissues of the mouth when not performed in connection with the extraction of the teeth or the fitting of dentures, including but not limited to the excision of lesions, tumors and cysts and biopsies.
- The MIP also covers treatment of natural teeth injured in an accident that takes place while a participant is insured, provided (i) such treatment begins within 90 days after the accident, (ii) charges are incurred within one year from the date of the accident, and (iii) charges are not incurred for replacement of teeth other than the initial replacement of natural teeth.

The charges under Section 05.22.3 are reimbursed under the medical (and not the dental) provisions of the MIP.

05.22.4 Sterilization

The MIP covers voluntary sterilization for male (i.e., vasectomy) and female members, but not the reversal of such surgery.

05.22.5 Transplants

The MIP covers harvest costs incurred by patients relating to donation of organs or bone marrow for transplantation to an MIP participant. Donor costs related to infertility treatment are not covered expenses (Section 07.14).

05.23 Transportation Charges

The MIP covers professional ambulance services for the patient only. 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.

05.24 Vision Services

Charges for one routine eye exam, including refraction, per calendar year for you or your dependent are covered. An optometrist or ophthalmologist, and not an optician, must perform such an examination. Up to \$100 per calendar year per insured person for prescription contact lenses and prescription eyeglass lenses and frames is also covered. (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 after such surgery will be covered as hardware at the in or out of network benefit.)

05.25 Intravenous Immunoglobulin (IVIG)

Intravenous Immunoglobulin (IVIG) includes coverage for the treatment of Myasthenia Gravis if recommended by a qualified neurologist.

06 MIP Coverage Exclusions and Limitations

Coverage is not provided for charges for 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.

This section applies to medical, dental and pharmacy services. Covered expenses do not include charges for services and supplies that are not medically necessary as determined by the Insurance Administrator. For all benefit provisions, no coverage is provided for 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 patient has a compensable workers compensation claim.
- That you or your dependent would not legally pay if there were no insurance.
- That are 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 you or your dependent has medical insurance, unless otherwise prohibited by law.
- For non-emergency care furnished or paid for by an government or government agency except (a) if furnished or paid for by Medicaid, or a Veterans Administration Hospital or other military hospital for a veteran for a non-service disability or a Veterans Administration Hospital or other military hospital for inpatient services provided to a retiree of the armed services or to a dependent of an active member, retired member or deceased member of the armed service; or (b) where otherwise prohibited by law.
- For custodial care except as provided under Covered expenses of hospice care (Section 05.07).
- For services furnished by persons who are related to insured person in any way by blood or marriage.
- For services that exceed the Usual and Customary (U&C) 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 U&C 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 as not covered in an Aetna Coverage Policy Bulletin 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. Aetna Coverage Policy Bulletins are available on www.aetna.com.
- Services or benefits received when the patient has not met an MIP eligibility condition (e.g., bridge replacements or denture replacements are not covered in the first 12 months of MIP enrollment).

- 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 or not 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).

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 05.22.1, and Section 05.04.2.

07.03 Counseling

Mental health counseling coverage excludes:

- Religious counseling;
- Marital 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 05.07.3), the MIP does not cover custodial services including:

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

07.05 Durable Medical Equipment

In addition to those items listed in Section 07.08 below, 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 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.

07.07 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 Equipment and Services

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

- Bathroom safety equipment;
- Posture chair/recliner;
- 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;
- Breast pumps;
- Modifications to automobiles or other transportation devices;
- Van and stair lifts;
- Traction devices; and
- Intercoms or communications devices.

07.09 Expenses Incurred While Not Eligible for Coverage

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

07.10 Experimental or Investigative Care

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

07.11 Eyes

The MIP does not cover eye tests, except one annual routine eye exam. However, coverage is provided to diagnose, treat, or monitor an eye disease, illness or injury.

The MIP does not cover radial keratotomy or similar surgery to treat myopia (including laser surgery), any services performed by an optician, or charges for fitting of contact lenses except for non-disposable contact lenses prescribed due to cataract surgery.

07.12 Funeral Arrangements

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

07.13 Home Health Care Services

Home Health Care services do not cover charges for the services of someone who usually lives with you or is a relative by blood or marriage, nor for transportation charges of a service provider nor for a social worker provided through a Home Health Care agency.

07.14 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 an MIP member at both the time of the initially-scheduled transfer and the second attempt.

07.15 Legal Fees

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

07.16 Massage Therapy and Spa Treatments

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

07.17 Mental Health

The MIP does not cover school tuition or expenses, boot camps, wilderness programs, equine therapy programs, custodial expenses in halfway houses, and similar charges relating to mental health care. Also see 07.06.

07.18 Orthopedic Services and Devices

The MIP does not cover treatment of weak, strained or flat feet, instability or imbalance of the feet, 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. Charges for cutting, removal or other treatment of corns, calluses or toenails are not covered unless needed due to 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.

07.19 Personal Comfort Items

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

07.20 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.

07.21 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).

07.22 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 5.21.

07.23 Sterilization Reversal

The MIP does not cover charges for the reversal of male or female sterilization.

07.24 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.

07.25 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.

07.26 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 participants to or from medical, dental or pharmacy providers.

The MIP does not cover evacuation or repatriation charges.

07.27 Transsexual Surgery

The MIP does not cover transsexual surgery, sex change or transformation including any procedure, treatment or related service designed to alter a participant's physical characteristics from their biologically determined sex to those of another sex, regardless of any diagnosis of gender role or psychosexual orientation problems.

07.28 Volunteer Services

The MIP does not cover charges made by a volunteer in connection with services furnished to a participant while part of a Hospice Care program.

08 Dental Coverage

08.01 Introduction

Dental benefit coverage can be determined before you begin treatment. If the charges for the treatment are expected to be more than \$300, ask your dentist to describe the proposed treatment plan and charges on a dental claim form, and submit the form to the Insurance Administrator. Additional information such as x-rays and pretreatment plans may be required before the Insurance Administrator can make a predetermination. Within 15 days after receipt of the request, the Insurance Administrator will tell your dentist and you how much would be considered as Covered expenses and how much would be paid based on the submitted estimate. You (or your provider) must still submit a claim after actual services have been rendered.

08.02 Dental Coverage Maximum

The maximum benefit payable for a participant during a calendar year is shown in the Benefit Summary chart. 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. It applies to all benefits payable for orthodontia while a participant is insured under the MIP, whether the coverage was continuous or interrupted.

08.03 Covered expenses

Covered expenses are Usual and Customary Charges made by a dentist for necessary dental services provided to an MIP participant. The MIP determines what expenses are covered. 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 participant's eligibility. Dental services provided in a hospital, at home, or in an extended care facility are covered if the patient meets medical necessity criteria as determined by the Insurance Administrator.

08.04 Preventive and Diagnostic Services

Covered preventative and diagnostic services include the following:

- *Routine oral exams*: Up to two exams every calendar year per person including diagnosis, x-rays, and prophylaxis (routine dental cleaning).
- *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*.

08.05 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.
- 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 08.06), 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.

08.06 Major Restorative Dental Services*

*Some dental exclusions exist for late entrants to the MIP. Section 09.06.

Major restorative dental services include:

Bridges and dentures	The initial installation of dentures or fixed bridgework.
Implant devices:	Posts and crowns (non-surgical expenses).
Restorations:	Inlays and crowns (high noble metal rate is covered at the noble metal rate; no limit on gold fillings).
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 09.02 and Section 09.04. 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 members' coverage.

**NOTE - Temporary bridges and restorations are not covered (Section 09.01).

08.07 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, implant surgery.

08.08 Orthodontia Dental Expenses

Covered charges include orthodontic treatment and appliances.

09 Dental Expenses Not Covered

09.01 First Year of Coverage

In the first year during which a participant becomes an insured person, the MIP does not cover:

- Replacement of existing fixed or removable bridgework; or
- Replacement of full or partial dentures.

09.02 Bridges

Bridge replacements are covered, limited to two bridges within a 10-year period, subject to the conditions of Section 08.06.

09.03 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;
- Porcelain or other veneer crowns, facing on crowns, or pontics to replace molar teeth;
- 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.

09.04 Dentures

Dentures are covered, limited to two within a 10-year period, subject to the conditions of Section 08.06.

09.05 Expenses Incurred While Not Eligible for Coverage

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

09.06 Late Enrollees to the MIP

The following dental services for a late enrollee (Section 14.11) are not covered for the first 12 months following such late enrollment:

- Inlays;
- Crowns and gold fillings
- Full or partial dentures;

- Fixed or removable bridge work;
- Bridge or denture replacement;
- Re-cementing or repairing crowns or inlays;
- Periodontal services; and orthodontia.

09.07 Space Maintainers

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

09.08 Not Covered expenses

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

09.09 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.

09.10 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 Covered Expense.

09.11 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.

10 Prescription Drug Benefits

Prescription drug benefits are payable for covered drugs a participant obtains while insured. In the U.S., covered drugs may be obtained from a participating mail-order pharmacy, a participating preferred retail pharmacy or a nonparticipating retail pharmacy. There are no participating pharmacies outside the U.S.

10.01 Brand-Name Drugs Versus Generic Drugs

The MIP covers brand-name or generic drugs, but your MIP benefits are maximized if you choose to use a generic drug. In the United States, generic drugs are approved by the U.S. Food and Drug Administration, and are chemically and therapeutically equivalent to their brand-name drug counterparts. Generic drugs generally offer substantial savings when compared to the brand-name products since U.S. patent law protects the pricing of brand-name products. In the U.S., a drug patent is approved for 17 years. After the patent expires, many drug manufacturers try to alter a drug formulation to create a new patented drug, which has essentially the same therapeutic effect. Physicians and clinical pharmacists have found that many therapeutic drug classes offer significant opportunities to reduce drug costs to both the patient and the MIP simply by switching prescriptions to lower-cost brands or to generics.

A generic drug has the same active ingredient(s) as the brand name drug and the MIP encourages the use of generic versions when appropriate. Please discuss the clinical effectiveness of the generic with your physician. If your physician requires you to take a brand-name drug for which a generic is available, then your physician should write “dispense as written” or “brand necessary” on the prescription. Otherwise, your pharmacist may attempt to substitute the brand with a generic drug.

Comprehensive information on both brand-name and generic drugs can be found on the U.S. Food and Drug Administration website at www.fda.gov/cder/ogd/index.htm.

10.02 Network Pharmacies

10.02.1 Retail

The MIP’s in network prescription benefits are managed by a separate administrator, PharmaCare. The PharmaCare network has over 57,000 retail pharmacies in the U.S., including, CVS, Wal-Mart, Giant Pharmacy, Safeway Pharmacy, Costco, Target, Harris Teeter and many independent pharmacies (such as Foer’s and Preston’s). In addition, PharmaCare provides members with a mail order pharmacy, PharmaCare Direct, and a separate pharmacy for ‘Specialty Drugs’.

If you fill your prescriptions at an in-network pharmacy, and show your PharmaCare card, the negotiated discount and MIP coverage is applied at the point-of-purchase. No claim forms are required. You pay only your annual brand name deductible and

coinsurance, if any. You are also protected by an out-of-pocket expense limit (Section 10.04).

You must show your PharmaCare identification card to identify yourself as an MIP member in order to access the network discounts. If you purchase prescription drug at a network pharmacy, but you do not show your PharmaCare card, your purchase will be treated as out-of-network. You would be required to pay the full cost of the prescription at the time of purchase, and file a medical claim with your Insurance Administrator. Your MIP benefits will be reduced.

10.02.2 Mail Order

PharmaCare has a mail order facility, PharmaCare Direct, which provides many generic drugs and brand-name drugs at significantly reduced cost. PharmaCare Direct cannot ship to the World Bank Group offices or to mailing addresses outside the U.S. Not all prescriptions are suitable for this mail order service and must be purchased either through the retail pharmacies or through the Specialty Pharmacy service described in 10.02.3.

10.02.3 Specialty Drugs

Prescribed drugs classified as a "Specialty" drugs, will be dispensed through PharmaCare Specialty Pharmacy only. Specialty drugs are high cost biotech drugs, usually injectables, used to treat chronic conditions which can be dispensed only under close medical supervision. In addition to free shipment of these drugs to the patient's home or doctor's office, the PharmaCare Specialty Pharmacy provides refill reminders, nurses and care coordinators to answer questions about the drug/condition, ancillary supplies such as syringes, and other services. Examples of Specialty drugs include chemotherapy drugs, infertility drugs, human growth hormone drugs, drugs for multiple sclerosis, rheumatoid arthritis. To learn more, please visit www.pharmacare.com/Specialty or call PharmaCare.

10.02.4 Formulary

A formulary is a list of drugs determined by PharmaCare to be the most effective for the majority of patients and includes generic and brand name prescription drugs. The MIP utilizes a three-tiered formulary benefit for prescription drug purchases at in-network PharmaCare pharmacies in the US and mail order. Members retain free choice of prescription drugs, but members maximize savings by using generic and formulary brand-name drugs. Details are listed in the Benefit Summaries.

The effective date for formulary implementation was July 1, 2006 for Retiree and Sponsored Parent plans. The effective date of the formulary for Active Staff will be announced in 2007.

10.03 Out-of-Network Pharmacies

All pharmacies outside the U.S., and those pharmacies within the U.S. which are not affiliated with PharmaCare, are "out-of-network." If you purchase prescriptions from

an out-of-network pharmacy, you must pre-pay the entire cost, and then submit a medical claim to your Insurance Administrator for reimbursement. If you use a participating network pharmacy, but do not show your PharmaCare card, your purchase is considered “out-of-network.”

10.04 Benefit Levels

The amount of benefits payable depends on where the covered drugs are obtained. The Benefit Summary charts show the benefits payable by the MIP, the annual brand name deductible, and the out-of-pocket maximum for prescription drugs obtained at participating PharmaCare pharmacies in the U.S., and the annual medical deductible amount you must pay if the covered drug is obtained from an out-of-network pharmacy.

For Aetna participants, the benefit percentage during a calendar year may be increased to 100% for all pharmacy Covered expenses. This occurs when you or your dependent reaches the in-network prescription drug out-of-pocket maximum, which is calculated separately from the medical out-of-pocket maximum. Any deductible you have paid for prescription drugs is included. Any co-payments for in-network mail-order prescription drug purchases are not included in the out-of-pocket expense calculation.

For Vanbreda participants, no separate pharmacy out-of-pocket limit exists. If a Vanbreda participant has in-network purchases at PharmaCare pharmacies, PharmaCare and Vanbreda will reconcile out-of-pocket expenses annually to ensure that Vanbreda participants coordinate out-of-pocket expenses for in-network pharmacy purchases with medical out-of-pocket limits. (Section 17.08)

10.05 Covered Drugs

Covered drugs and vitamins are those that may be lawfully dispensed only on a doctor’s prescription. They must be medically necessary and prescribed for use by you or your insured dependents for treatment of an injury, illness or a pregnancy. They include but are not limited to:

- Prescribed smoking cessation products, with a six-month lifetime supply per patient;
- Injectable drugs including injectable insulin prescribed by a physician;
- Diabetic supplies (insulin syringes and needles, alcohol swabs, glucose blood and urine test strips, Ketone test strips and tablets, lancets and lancet devices);
- Prescribed contraceptive devices and medications;
- Prescribed progesterone including suppositories, caps and suspensions
- Infertility drugs;
- Nystatin oral powder;
- Immunization agents and biological sera;
- Prescribed prenatal vitamins;

- Vitamins available only by prescription for specific medical conditions and not as a dietary supplements;
- Viagra or pharmacological equivalent (up to six tablets per month).

Section 11 for information on excluded drugs.

10.06 Prior Authorization

10.06.1 General Information

PharmaCare and your Insurance Administrator are authorized to obtain any information deemed necessary to fill (PharmaCare) or reimburse (Insurance Administrator) a prescription. PharmaCare and your Insurance Administrator may review any prescription for medical necessity and compliance with the provisions of the MIP and established medical norms.

10.06.2 Infertility Drugs

Infertility drugs require preauthorization and are not covered if the patient has exceeded any lifetime limit for corresponding medical infertility services as specified in the Benefits Summaries.

Infertility treatment and drugs are not covered for late entrants to the MIP in their first 12 months of coverage.

10.06.3 All Other Drugs

Certain covered drugs require preauthorization prior to dispensing at a participating network pharmacy, or prior to reimbursement by your Insurance Administrator. Those drugs include, but are not limited to the following list:

- Accutane
- Actiq
- Avita for patients aged 26 and older
- Azelex for patients aged 26 and older
- Anoxerics available by prescription only such as Merida and Xenical
- Colony-stimulating drugs (e.g., Leukine, Neupogen, Neulasta)
- Desoxyn
- Dexedrine
- Growth hormones
- Infertility drugs
- Some injectable drugs (e.g., Synvisc)
- Interferon drugs
- Retin-A for patients aged 26 and older
- Rogaine
- Smoking cessation products
- Yocon

10.07 Dispensing Limit

10.07.1 Dispensing Limit Except For Members in MIP Continuation

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 PharmaCare. Requests for supplies of 181 days to 365 days must be approved between PharmaCare and the Bank Group. The supply cannot exceed 365 days.

All injectable products intended for self-injection covered through the pharmacy benefit will be limited to a 30-day supply. Examples of these injectable products include biologics for rheumatoid arthritis like Enbrel, Humira or Kineret, and biologics for multiple sclerosis like Betaseron, Copaxone or Avonex).³

10.07.2 Dispensing Limit For Members in MIP Continuation

The dispensing limit for all prescription drugs purchases by members in MIP Continuation is 30 days, irregardless of whether the purchase is made via a retail or a mail-order pharmacy.

10.08 If You Disagree with a PharmaCare Prescription Drug Claim Decision

When an MIP member attempts to fill a prescription in a network pharmacy, coverage under your MIP benefit may be denied:

- If the drug needs prior authorization (Section 10.06);
- If prior authorization is required and been denied by PharmaCare or your Insurance Administrator;
- If the prescribed drug is not covered by the MIP;
- If the dispensing limit is exceeded; or
- If the prescription is out of date (in the U.S. this normally means more than one year from the signature date of the prescribing dentist or physician).

Your PharmaCare pharmacist should be able to explain to you why a prescription was denied under your MIP benefit coverage. If you dispute this reason, or if you do not understand the reason for denial, you should first contact PharmaCare Member Service.

³ The term "biologics" applies to synthetic or recombinant versions of natural biologic substances, including proteins such as enzymes, soluble receptors, cytokines or antibodies, and nucleic acids such as DNA or RNA. Biologic drugs are much more complicated than conventional drugs and are injected.

If you do not agree with the explanation provided by PharmaCare, you may request an appeal of the denial. You may appeal in writing to PharmaCare, Attn: World Bank Account Manager, 695 George Washington Highway, Lincoln, RI 02865, USA. Your appeal should explain the reason why you feel the prescription should be filled. Your prescribing physician must:

- Provide medical information supporting your claim;
- Document any other treatments that were pursued; and
- Clearly demonstrate the need for the prescribed drug.

PharmaCare will conduct an internal review by qualified pharmacists, with a final decision by PharmaCare's Medical Reviewer. Your doctor or dentist will receive notification of PharmaCare's decision within 30 days of receipt of a complete, written appeal.

The appeal process is governed by the MIP contract and this SPD, and some drugs are simply not provided or reimbursed under the MIP, regardless of medical need.

11 Prescription Drug Expenses Not Covered

Prescription drug expenses not covered include:

- Over-the-counter products (including over-the-counter vitamins and nicotine products) other than diabetic supplies. 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, Section 05.04.2.
- Cosmetics and cosmetic drugs.
- Dietary supplements other than those administered enterally, 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 has not approved for general use, or for drugs labeled "Caution: Limited by Federal law to investigational use."
- 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 covered under the MIP.
- Charges that are incurred before the insured person's coverage under the MIP begins, or after the insured person's coverage under the MIP ends.
- Charges for prescribed nicotine products in excess of a six-month supply during a person's lifetime while insured under the MIP.
- 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.
- Any drug for which an insured person would not legally have to pay if there were no insurance for prescription drugs.
- Any drug or its administration for which a terminally ill patient is entitled to benefits under the MIP's Hospice Care coverage (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 require the Insurance Administrator or PharmaCare to determine medical necessity, the Insurance Administrator or PharmaCare requires evidence of an existing medical condition that meets the MIP criteria. Such documentation must be submitted by a physician, including the patient's name, date of birth, diagnosis, statement as to the medication, benefits of the prescribed medicine

and other medications which have proven to be ineffective in the patient'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 than the insured, e.g., a drug approved for children taken by an adult, unless specifically approved by PharmaCare or your Insurance Administrator.

12 Aetna National Medical Excellence Program

Aetna's National Medical Excellence (NME) program helps eligible MIP participants access covered treatment for solid organ transplants, bone marrow transplants and certain other rare or complicated conditions at participating facilities experienced in performing these services. NME is not available to Vanbreda participants. Patients must be referred to the NME Program, but an MIP member may be referred to the NME program from several units within Aetna such as Patient Management or Member Services.

For Active Staff MIP members enrolled in Option C, the primary care physician and/or treating specialist physician initiates NME participation.

For MIP members enrolled in all other options, the treating physician must call the NME unit at 877-212-8811 to initiate review and coverage.

The NME program has three components:

National Transplantation Program, designed to help arrange care for solid organ and bone marrow transplant patients.

National Special Case Program, developed to coordinate arrangements for treatment of complex conditions at tertiary care facilities across the U.S. when that care is not available within 50 miles of the participant's home.

Out-of-Country Care Program, designed for MIP participants who need emergency inpatient medical care while temporarily traveling outside the U.S. If you are admitted to a non-U.S. hospital for a medical emergency, this part of the program can assist you in ensuring that you receive the appropriate treatment. The out-of-country care management program evaluates the capability of the facility in which you are hospitalized and if that facility cannot effectively treat you, this program will co-ordinate transfer to the nearest facility able to treat the emergency condition.

For transplants and other specialized care that cannot be provided within the service area within the U.S., the NME program will coordinate covered services and will provide the following lodging and travel expenses if you must travel more than 50 miles:

- Transportation expenses you and a companion (if applicable) incur while traveling between your home and the program facility. Travel expenses incurred by more than one companion are not covered.
- Lodging expenses incurred while traveling between home and an NME facility or outpatient provider to receive covered services as an NME patient.
- Lodging expenses incurred by a companion accompanying a patient while the patient travels to an NME facility or outpatient provider to receive covered services.

- Lodging expenses of a companion when the companion's presence is required to enable a patient to receive services from an NME facility or provider on an inpatient or outpatient basis. Only the lodging expenses incurred by one companion are covered per night.

Benefits for travel and lodging expenses are subject to a maximum of \$10,000 per episode of care. Lodging expenses are subject to a \$50 per night maximum reimbursement for each person. Travel and lodging expenses must be approved in advance by Aetna and are not approved retroactively.

You become eligible for coverage of travel and lodging expenses on the day you become a participant in the NME program. Coverage ends on the earliest of:

- One year after the day a covered procedure was performed;
- The date you cease to receive any services from the NME provider in connection with the covered procedure; or
- The date your coverage terminates under the MIP.

Travel and lodging expenses do not include expenses that are covered under any other part of the MIP. These travel benefits are separate from and are coordinated with the MIP's other transportation benefits (Section 05.23).

The MIP covers only those services, supplies and treatments that are considered medically necessary as determined by Aetna for your medical condition. Experimental treatment (as determined by Aetna) is not covered by the MIP or the NME program, and is not facilitated by NME.

13 Option C – Point of Service (Aetna only)

13.01 Introduction

Active Staff Option C is Aetna’s “Managed Choice POS” product, a “point-of-service” plan under which each participant’s non-emergency room medical care is coordinated by an in-network Primary Care Physician or PCP. Option C and the Managed Choice POS network are not available to retirees or Vanbreda participants.

Under Option C, PCP office visits or office visits to in-network specialists referred by a PCP require a co-payment, but then most referred medical services such as hospital care and laboratory work, are reimbursed by the MIP at 100% with no deductible and no claims forms. If no in-network specialist exists, an out-of-network referral is treated as in-network.⁴ Self-referred services or use of non-network providers are both processed as “out-of-network” and are subject to an applicable deductible, and coinsurance.

Each PCP must be a participating physician in Aetna’s Managed Choice POS network, and you must select a PCP for each member of the family prior to accessing in-network benefits. PCPs are internal medicine specialists, general practitioners or family practitioners for adults, and pediatricians or family practitioners for children. (In rare cases, specialists can serve as a participant’s PCP. The best example is an oncologist for a cancer patient. All such exception requests must be pre-approved by Aetna.) You can select the same PCP for the family or each family member can have a different PCP.

If you coordinate medical care through your PCP, you maximize your MIP coverage and minimize your costs. Furthermore, there are no claims forms or deductibles.

Pregnant female participants in Option C may elect to participate in Aetna’s maternity management program (Section 13.06).

13.02 Self Referral

Except as outlined below, medical services under Option C are considered self-referred and “out-of-network” if not referred by a PCP. If the provider is “in-network” (i.e., a participating provider in Aetna’s Managed Choice POS network) then the participant still enjoys a discounted fee for the services per Aetna’s negotiation with network providers. However, the annual deductible applies, and the MIP coverage is generally 80% after deductible for these “self-referred” services.

⁴ Such out-of-network referrals must be authorized by Aetna Member Services, whose decision is based in part on the availability of in-network providers in the same specialty. Thus, a PCP referral to an out-of-network specialist does not automatically invoke treatment of out-of-network expenses at in-network levels of coverage. Contact Aetna Member Services for assistance.

Referral from a PCP is not required in certain situations, and the following expenses are reimbursed at the highest rates without deductible:

- Emergency room care;
- In-network OB/GYN services for female participants for office visits and “consult and treat” conditions only;
- In-network behavioral health providers for mental health and substance abuse services;
- In-network optometrists or ophthalmologists for routine eye exams; and dental services including oral surgery.

In cases of OB/GYN or ophthalmologist services, PCP referrals are required to maximize in-network benefits for follow-up care such as surgery.

13.03 Choosing a PCP in Option C

Each participant in Option C needs his or her own PCP. The PCP provides routine and preventative care, becomes familiar with the patient’s medical history, and works closely with the patient to help make medical decisions. Participants can see their PCP as often as needed, paying only the office visit co-payment. The cost for specialist services or other care (e.g., lab tests, radiology, etc.) referred by your PCP is either an office visit co-payment or 0% coinsurance.

A participant may switch PCPs at any time with no restriction on the number of changes or minimum time between changes.

Once PCPs are selected for each participant, you are required to register those selections by calling Aetna Member Services. Until Member Services records each individual’s PCP selection, all services are considered self-referred (except as described above in Section 13.02) and thus out-of-network. Family members who are U.S. residents but do not reside with the staff member (e.g., a child at university) can choose a PCP in another geographic service area.

Aetna carefully reviews the licensing, education and work history of its PCPs to ensure quality of care and service. PCPs must undergo re-certification by Aetna regularly.

13.04 Referrals

For specific conditions that require consultation, diagnosis or treatment by a specialist, your PCP will provide an in-network referral to 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.

13.05 Emergency Care and Option C

Active Staff Option C participants 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. Your PCP should coordinate follow-up care. Follow-up care with nonparticipating providers is only covered with a referral authorization from your PCP and pre-approval from Aetna. Whether you were treated inside or outside your Aetna Managed Choice POS service area, you must obtain a referral before any follow-up care can be covered. Suture removal, cast removal, x-rays and clinic and emergency room revisits are some examples of follow-up care.

13.06 Moms-to-Babies Maternity Management Program

The Moms-to-Babies Maternity Management program (MMM) is a voluntary program and applies only to members enrolled in the Active Staff Option C. It provides maternity health care information and guides patients through pregnancy. The MMM program provides:

- Assistance in accessing prenatal care.
- Case management by registered nurses, who assist in arranging covered services, coordinate covered specialty care, review the program's features and answer general pregnancy-related questions.
- Smoke-free Moms-to-be™, a personalized stop-smoking program designed specifically for pregnant women.
- Focused, educational information, "For Dad or Partner."
- A comprehensive pregnancy handbook.

Under the MMM program, all care during a pregnancy is coordinated by the patient's in-network obstetrical care provider and Moms-to-Babies case managers, so there is no need to return to the patient's PCP for referrals relating to the pregnancy for the duration of the pregnancy. However, the obstetrician will need to request a referral from Aetna for any tests or other services performed outside of the office, and referrals from the PCP continue to be required for services unrelated to the pregnancy.

Another program feature, Pregnancy Risk Assessment, identifies women who may need more specialized prenatal and/or postnatal care due to medical history or present health status. If risk is identified, the program assists the patient and physician in coordinating any specialty care that may be medically necessary.

14 Eligibility and Enrollment

14.01 MIP Eligibility

14.01.1 Active Staff (General)

You are eligible for MIP coverage if you are classified as:

- The President.
- An Executive Director, an Alternate Executive Director, a Senior Advisor to an Executive Director, or an Advisor to Executive Director.
- A Regular (headquarters) appointment.
- An Open, Term, Extended Term Consultant or Extended Term Temporary staff member appointed to a Headquarters position.

Staff members in Country Offices on Open or Term appointments or Local Regular appointments are not eligible for the MIP but participate in the separate Medical Benefits Plan (MBP). The provisions of this SPD do not apply to MBP participants.

You are not eligible for MIP coverage if you hold a Short Term Consultant, Short Term Temporary, Contractor, Special Assignment or other appointment.

14.01.2 Active Staff (Extended Term Appointments)

Staff members on Extended Term Consultant or Extended Term Temporary appointments are eligible only for Option B.

14.01.3 Retirees

You are eligible if you are a retired staff member for whom Staff Rule 6.12 (Participation in the Medical Insurance Plan) of the Bank Group's Staff Manual applies. Your MIP option depends on your age and length of pensionable service under the Bank Group Staff Retirement Plan on your date of separation from the Bank Group as well as in which pension plan you participated while an active staff member.

Retirees in Country Offices from Open or Term appointments or Local Regular appointments are not eligible for the Retiree MIP but may participate (if eligible) in the separate Retiree Medical Benefits Plan (MBP). The provisions of this SPD do not apply to Retiree MBP participants.

14.01.4 Deferral

Staff who met the Retiree MIP eligibility criteria prior to their last day of active service may elect to defer the start of their Retiree MIP coverage. The deferral election must be made prior to the end of employment (Section 14.09.2).

14.02 Retiree Plan 1

You are eligible for the Retiree Plan 1 if you were a participant of the Staff Retirement Plan on or before April 14, 1998 and upon retirement from the Bank Group you are:

- age 62 or older; or
- age 55 but less than 62 with 10 or more years of pensionable service; or
- age 50 but less than 55 and your pensionable service when added to your age equals 75 or more.

If you meet any of these three conditions above, you are not eligible to elect Retiree Plan 2.

Staff members whose claim for long-term disability under Staff Rule 6.22, Disability Insurance Program, has been accepted are eligible for Retiree Plan 1 coverage at no cost during the disability period. Otherwise, Retiree Plan 1 coverage cannot start prior to age 50. When long-term disability ends, eligibility and premiums for Retiree MIP for the former staff member (or surviving spouse or partner) are based on pensionable service and the age of the former staff member on the date that long-term disability ends.

14.03 Retiree Plan 1 Buy up

You are eligible for either Retiree Plan 1 (at a higher contribution rate than if you were eligible under Section 14.02) or Retiree Plan 2 if you were a participant of the Staff Retirement Plan on April 14, 1998 and:

- age 50 or more; and
- have at least five years of pensionable service with the Bank Group; and
- your pensionable service on your last day of service, when added to your age, equals 60 or more; and
- you are not eligible for Retiree Plan 1 under the provisions of Section 14.02 above.

Retirees who elect to buy up to Retiree Plan 1 (or their surviving dependents) may revert to Retiree Plan 2 effective January 1 of any calendar year as long as the application for such a plan change is made prior to that January 1. Such a reversion decision is irrevocable and irreversible; any retiree (or survivor) who has reverted to Retiree Plan 2 cannot later re-enroll in Retiree Plan 1.

14.04 Retiree Plan 2

You are eligible for Retiree Plan 2 if you became a participant of the Staff Retirement Plan on or after April 15, 1998 and, upon your last day of active service (or long-term disability coverage) in the World Bank Group, you:

- have at least five years of pensionable service with the Bank Group; and

- your pensionable service on your last day of active service, when added to your age, equals 60 or more.

Retiree Plan 2 coverage cannot start prior to age 50.

14.05 Coverage for your Dependents

14.05.1 Spouses, Partners and Children

Spouses, registered domestic partners and dependent children of eligible active staff and retirees are also eligible for coverage. Eligibility of dependent children is governed by Staff Rule 6.02, Dependency (Tax Equivalency) Allowances, but is subject to other provisions (Section 14.08). Grandchildren are eligible only if they are dependents of your dependent child, and only for the duration the dependent child (the parent of the grandchild) remains eligible for MIP coverage as your dependent child.

In the case of natural children born to female members, the MIP covers the newborn child (or children in the case of multiple births) for the first 31 days of life even if the newborn child is not eligible for coverage (for example, in cases of MIP Continuation where no new dependents are allowed).

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. Per Staff Rule 6.02, the World Bank Group has restrictions on recognition of adoption, particularly the adoption of relatives such as nieces or nephews. The Bank Group also does not recognize adoption of older children. All adoptions are reviewed and approved by the HR Service Center. 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.

Each person who is your eligible dependent on the day you become eligible for the MIP is also eligible for MIP coverage on that day, but is not enrolled until you complete the enrollment process. Active staff members are covered automatically at entry on duty, but dependent coverage at entry on duty is not automatic and requires completion of an MIP enrollment form within 31 calendar days of entry on duty.

For active staff who join the World Bank Group, and for retirees who deferred coverage under Section 14.09, MIP coverage for a dependent who is confined to a hospital on the date his or her coverage is scheduled to begin is deferred until the hospital confinement ends.

Parents, siblings or other individuals are not eligible for coverage in the MIP. Unmarried parents residing in your household who meet the dependency and other eligibility criteria may be eligible for individual coverage in the Sponsored Plan (Section 14.05.2). Contact the HR Service Center for details.

14.05.2 Parents and Parent-in-laws

An unmarried parent or parent-in-law permanently residing with you in your household who meets the eligibility criteria for dependency may be eligible for coverage under the Sponsored Plan. All Sponsored Plan applicants must pass medical underwriting.

14.06 When Both Spouses/Domestic Partners Are Eligible

When both spouses or registered domestic partners are eligible for MIP coverage in their own right, either partner may choose to become insured as the insured or as the dependent. You may not be covered under the MIP both as an insured and a dependent. You or your spouse or registered domestic partner, and not both, may enroll children who are joint eligible dependents.

14.07 Surviving Dependent Eligibility

14.07.1 General Provision

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

14.07.2 Death in Active Service of Staff Member Participating in the Staff Retirement Plan

If an active staff member participating in the Staff Retirement Plan dies in service, his/her spouse, registered domestic partner and/or children may continue subsidized coverage under Retiree Plan 1 as long as they receive a surviving spouse pension or child's benefit from the Staff Retirement Plan.

If an active staff member participating in the Staff Retirement Plan dies in service and a surviving spouse or partner is not eligible to receive a survivor pension, the spouse or registered domestic partner and/or children may continue subsidized coverage under Retiree Plan 2. Premiums are collected monthly through a direct-billing arrangement with the Insurance Administrator. Premiums are based on pensionable service, with a minimum subsidy of 25%.

14.07.3 Death in Active Service of Staff Member Not Participating in the Staff Retirement Plan

If an active staff member not participating in the Staff Retirement Plan dies in service, the spouse or registered domestic partner and/or children may continue unsubsidized coverage under the same active staff MIP Option, for up to 36 months via MIP Continuation (see paragraph 14.13), as long as the staff member was a participant in the active staff MIP at the time of death. Dependents not covered at the time of death are ineligible.

14.07.4 Death of a Retiree Participating in the Retiree MIP

For surviving spouses or partners of retirees participating in the Retiree MIP, subsidized coverage continues under the Retiree MIP Plan in effect at the time of death automatically, as long as the surviving spouse or partner is eligible for a survivor pension.

For surviving spouses or partners of retirees participating in the Retiree MIP who are not eligible for a survivor pension, unsubsidized coverage is available for up to 36 months under the Retiree MIP Plan in effect at the time of death, via MIP Continuation (Section 14.13).

For surviving dependent children of retirees not otherwise covered under the survivor provisions of the surviving spouse or partner, and who are covered under the Retiree MIP, subsidized coverage continues until the earlier of child ending dependency eligibility or age 25. Monthly contributions may be billed directly by the Insurance Administrator.

14.07.5 Death of a Deferred Retiree Not Participating in the Retiree MIP

If the deceased individual had met Retiree MIP eligibility on the date of termination and elected to defer his or her Retiree MIP enrollment, a surviving spouse or partner and dependent children may enroll in the Retiree MIP at subsidized premiums as long as the spouse or partner is the same spouse or partner to whom the individual was married or partnered at the time of termination. Premiums are deducted from the survivor pension, if applicable. Otherwise, monthly contributions may be billed directly by the Insurance Administrator. Coverage cannot commence before the deceased individual would have been age 50 or older. Proof of medical insurance coverage for the three years prior to Retiree MIP enrollment is required.

If the deceased individual had met Retiree MIP eligibility on the date of termination and elected to defer his or her Retiree MIP enrollment, and had no spouse or partner on the date of termination, then any surviving spouse or partner is ineligible for Retiree MIP coverage.

14.08 If Your Child Is Handicapped

If you have a handicapped child, the child's coverage may be continued past the MIP's maximum age for dependents (age 25). Your 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 your dependent and before he or she reached the maximum age of 25.
- He or she depends mainly on you for support and maintenance.

You must provide the Insurance Administrator with proof of your child's handicap no later than 31 days after your child reaches age 25. 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 child's coverage ends on the earliest of the following:

- the date your MIP coverage ends;
- the date your child is no longer handicapped;
- the date you fail to provide medical evidence that the handicap continues;
- the date you fail to have any required exam performed; or
- the date your child's coverage ends for a reason other than reaching the age limit.

Coverage may continue past the age of 25 as long as the handicapped child does not have an individual conversion policy. An individual conversion policy is one that is purchased to convert from group to individual coverage (Section 14.15).

14.09 When MIP Coverage Begins

14.09.1 Active Staff

Coverage in the Active Staff MIP is effective from the first day of qualifying service, except that any eligible dependent who is confined to a hospital or other medical institution on that date becomes insured upon discharge from the hospital or other medical institution. You must apply for Active Staff MIP coverage within 31 days of initial eligibility. Otherwise, late enrollment applies (Section 14.11).

All active staff have automatic default enrollment in Option B/Individual coverage from commencement of qualifying service. Unless coverage (other than the default enrollment) is elected or waived within 31 days of qualifying service, the staff member will be enrolled in Option B Individual and responsible for payment of the corresponding premium for the Option B Individual coverage.

14.09.2 Retirees

If you were covered under the Active Staff MIP, that coverage ends on the last day of the month in which your service with the Bank Group ends. You must apply for Retiree MIP coverage (if you are eligible) on or before your last day of active service. If you elect immediate coverage under the Retiree MIP, it begins automatically from the first day of the following month. If you had deferred the start of your Retiree MIP coverage, your coverage begins on the first of the month following the date the Bank Group receives your request to begin coverage and confirms your proof of other medical insurance coverage during the prior three-year period.⁵ (The deferral option does not apply to those retirees who retired prior to April 15, 1998.)

14.09.3 Sponsored Plan

Coverage begins on the date of medical underwriting approval.

⁵ Proof of dental or prescription drug coverage is not required.

14.10 Changing Coverage: Life Events and Annual Change Season

After a life event, you may add a dependent to your coverage (e.g., Individual to Dual, Dual to Family, Family to Family Plus, etc.) without evidence of good health for your new dependent if the written enrollment application is received by the HR Service Center within 31 days of marriage⁶, initial eligibility of a registered domestic partnership, or within 31 days of the birth or adoption of the first or second child for a single parent. Coverage is effective as of the date of the marriage, partnership registration, birth or adoption. The MIP Option (A, B, or C) remains the same and cannot be changed at the time a new dependent is added. Staff and dependents who wish to start MIP coverage after 31 days from initial eligibility date must undergo late enrollment. Late enrollment is waived in certain situations, such as loss of coverage from a spouse's insurance plan due to a spouse's involuntary loss of employment, and is subject to the provisions of Section 14.11 below.

14.11 Late Enrollment

Late enrollment requires you to provide the Insurance Administrator with detailed medical information on each applicant. The Insurance Administrator then decides (based on general medical underwriting criteria) whether or not the individual should be insured and allowed entry into the MIP. Medical information is sent directly to the Insurance Administrator, and the decision is solely that of the Insurance Administrator. The Bank Group has no influence or control over late enrollment decisions, and cannot overrule the Insurance Administrator's decision. Currently Aetna reviews all late enrollment applications, even if the MIP participant is enrolled in the International Option.

If late enrollment to the MIP is approved, some restrictions apply:

- Certain dental benefits are not covered for the first year following late entry (Section 09.06).
- A pregnant applicant may be approved for late enrollment, but the pregnancy will not be covered (Section 05.14).
- Infertility treatment and drugs are not covered for the first year following late entry (Section 05.10).

⁶ 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. Except for Extended Term Consultant and Extended Term Temporary staff (who are only eligible for Option B), staff members enrolled in the MIP in active service may elect to switch their MIP Option to Option A, B or C during the annual change season. Staff members receive reminders of the change season via an email from the HR Service Center, normally during the month of December. Changes must be requested prior to the stated deadline each year. The effective date of the new option will be the following January 1.

Late enrollment is not applicable to the Retiree MIP. If a life event is not reported within 31 days, your new dependent(s) cannot enter the Retiree MIP even if they are healthy.

Coverage for eligible dependent children born or adopted after the first child (or stepchildren due to remarriage) is automatic under Family coverage, although you still must notify the HR Service Center in order for the child to be listed in the electronic eligibility files which our Insurance Administrators receive. Your dependents must be covered under the same Retiree MIP coverage (Retiree Plan 1 or Retiree Plan 2) as you.

14.12 When Coverage Ends

14.12.1 All Cases Except Long-Term Disability

MIP coverage ends at the earlier of the date of death, the last day of the month that you end of employment (Active Staff MIP participants only) or the last day of the month following your notice that you wish to withdraw from the MIP. Coverage can be terminated at the Bank Group's discretion in cases of fraud committed against the MIP, refusal to refund MIP overpayments in case of enrollment error, or if a participant does not pay his or her required contribution.

When your coverage ends, dependent coverage also ends except in the event of your death. If you die while you have covered dependents, Section 14.07 applies.

14.12.2 Long-Term Disability

For former staff members who entered the Bank Group's Long-Term Disability program, the following conditions apply when long-term disability ends:

- If a former staff member in Retiree Plan 1 on an approved long-term disability benefit ends disability and is not eligible for Retiree MIP coverage, then Retiree Plan coverage ends. The individual can apply for MIP Continuation (Section 14.13 below or conversion (Section 14.15).
- If the disability benefit ends after the individual becomes eligible for Retiree MIP coverage, then the individual may enroll in Retiree Plan 1 or Retiree Plan 2, depending on eligibility. Individuals ineligible for Retiree Plan 1 would transfer to Retiree Plan 2.

14.13 MIP Continuation

Except for fraud/misconduct cases, any MIP participant who loses eligibility (for example, if employment ends or a staff member or retiree divorces) may continue coverage for up to 36 months from the day coverage ends. Coverage generally ends the last day of the month during which the event occurred except in cases of marriage of dependent children, in which case MIP eligibility ends upon the date of marriage.

The participant 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 for active staff, and May 1 for retirees). Under MIP Continuation, all MIP provisions and benefits remain in effect, and MIP Continuation participants are subject to the same periodic plan design changes and premium adjustments as any other MIP member. MIP Continuation coverage is with the same administrator (Aetna or Vanbreda) that was in effect when group eligibility ends. Participants may reduce coverage (e.g., Family to Individual) at the time of MIP Continuation, but all participants must remain in same Active Staff Option or Retiree Plan with the same Insurance Administrator as existed during the group coverage. Currently, Aetna handles all billing even if MIP Continuation is with Vanbreda.

You must contact the HR Service Center to register an event that ends MIP eligibility for you or a covered dependent, or when you resign from active employment and do not immediately enroll in the Retiree MIP. If you end employment, you will receive an MIP Continuation application as part of the outplacement benefits counseling. If you divorce, an MIP Continuation application for your spouse will be sent to you, your ex-spouse, or your ex-spouse's attorney upon processing of the divorce after you have notified the HR Service Center. You are obligated to facilitate MIP Continuation for an ex-spouse by providing the appropriate forms in a timely manner. If your child ends dependency, you also must contact the HR Service Center. You will then receive an MIP Continuation application form for him or her.

The monthly cost of MIP Continuation coverage is included with the MIP Continuation form. 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 Aetna using the address on the form. If this deadline is missed, the MIP Continuation application is rejected without possibility of later submission.

Billing is monthly, directly between Aetna and the participant. The participant is responsible for informing Aetna of billing address changes. Participants can pay in advance for future coverage, but non-payment for any reason cancels MIP Continuation coverage without possibility of reinstatement. The Bank Group cannot and will not intervene in any billing dispute.

MIP Continuation applicants may reduce coverage (e.g., drop a dependent) but not add dependents. If a participant gains a new dependent through childbirth, marriage or registration of a domestic partnership during the MIP Continuation coverage, that individual cannot be added.⁷

⁷ Two exceptions exist. If a female participant 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. Also, MIP Continuation in Family coverage can add natural children born during the MIP Continuation period. In either case, the participant must notify Aetna of the childbirth.

14.14 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 you: You are not able to work at your usual occupation, and are not working for pay or profit at any occupation. If you are retired, this means you are unable to engage in most of the normal activities of a healthy person of the same age and gender.
- For a dependent: 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.

14.15 Conversion to an Individual Plan With Aetna or Vanbreda

The MIP’s conversion privilege allows you and your covered family members to apply for an individual policy insured by Aetna or Vanbreda if your MIP coverage ends regardless of your medical condition at that time. No medical exam is required, but you can only apply within 31 days of your group or MIP Continuation coverage ending. You pay the full cost of the conversion policy and this policy is completely independent from the MIP and has different costs, benefits, plan provisions and administration from the MIP. (For example, most conversion policies do not include dental coverage.) Its provisions are subject to change as determined by the Insurance Administrator. Premiums and plan benefits differ depending on where the insured lives. The conversion policy may cover any individual who had MIP coverage.

14.16 When Conversion Is Allowed

You and your covered dependents may convert when MIP coverage (including MIP Continuation) ends. You may convert to a personal policy when you retire. However, if you elect to enroll in the Retiree MIP, this conversion privilege will not be available to you again.

14.17 When Conversion Is Not Allowed

Conversion is not allowed if your coverage ends because medical coverage under the group contract has discontinued or you become eligible for any other medical coverage under this plan. The Insurance Administrator may elect to not issue a conversion policy if, on the date of conversion, the Insurance Administrator determined that an individual would be over-insured. This means that a conversion

policy would not be issued if a person is covered, eligible for, or has benefits available under any other group hospital or surgical expense insurance policy paid by themselves, or by an employer or any government-provided welfare plan or program.

Conversion is not available to those who commit fraud against the MIP.

14.18 Applying for a Conversion Policy

You or your covered family member must apply for the conversion policy within 31 days after your MIP coverage ends (including MIP Continuation if elected). The 31-day period starts on the date coverage actually ends, even if the person is still eligible for benefits because he or she is totally disabled (Section 14.16). If you or a covered family member wants to apply for a conversion policy in lieu of MIP Continuation, contact the HR Service Center. For those applying at the end of MIP Continuation with Aetna, the application will vary by your state of permanent residence, and information will be provided by the Insurance Administrator at the end of the MIP Continuation period or from Vanbreda for members enrolled in the International Option. The first premium will be due at the time of application. Aetna or Vanbreda determines the amount of the premium. The cost and benefits are subject to change. The conversion policy will take effect on the day after coverage ends under the MIP or MIP Continuation.

14.19 After Conversion Begins

Once a participant is enrolled in conversion coverage, he or she is no longer associated with the MIP. Their insurer or the broker is the issuer of the conversion coverage (Aetna or Vanbreda). Specific conversion policy provisions govern coverage levels and reimbursements.

15 Coordination of Coverage

Coverage under more than one health plan is not unusual. For example, you may have coverage under your spouse's health plan as well as the MIP. Or, if you are over age 65, you 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 you and your family members.

15.01 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 insurance.
- Any other type of coverage for persons in a group. This includes plans that are insured and those that are not.
- No-fault auto insurance required by law and provided on other than a group basis. Only the level of benefits required by the law will be counted.

There is no coordination with individual health plans.

15.02 National Health Plans for Retirees

Retiree MIP participants are obligated to join any national health plan for which they are eligible and for which they can participate on the same level as other nationals of their country of residence (e.g., Medicare in the U.S., which applies to U.S. citizens and U.S. permanent residents). You must report such enrollment of you and/or your spouse (or registered domestic partner) to the HR Service Center, as it will reduce the premium you pay for the Retiree MIP, if your enrollment is in a national health plan of the country of your pension address record. Premium reductions start the first day of the month following your notification to the HR Service Center or the effective date of the national health plan coverage, whichever comes later. Your Insurance Administrator will coordinate your MIP coverage with any national health plan coverage. Failure to enroll in a national health plan, when you are eligible to do so on the same terms as a resident or citizen of that country, may result in lower MIP benefits for you. Medicare participants using Aetna are encouraged to enroll in Medicare Direct (Section 16.11).

Premium reductions are available only if a national health plan matches the country of permanent residence of an MIP member. A resident of the U.S., for example, would be ineligible for an MIP premium reduction if he or she were enrolled in a Canadian provincial national health scheme, even if he or she were a Canadian citizen. In this example, the MIP discount would become effective only if the MIP member changed

his or her permanent residence to Canada. The World Bank Group may audit the participation of any insured individual in a national health plan.

15.03 Coordination Methods: “Coordination” or “Exclusion”

Under the coordination rules described in this section, the MIP will pay either:

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

Benefits may be reduced by either “coordination” (Retiree Plan 1) or “exclusion” (Retiree Plan 2).

15.03.1 Coordination

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. Therefore under the coordination method, it is possible for a member to receive 100% reimbursement for a covered MIP expense.

15.03.2 Exclusion

The “exclusion” method takes the amount of “allowable expenses” under the MIP incurred by the person for whom a claim for benefits is filed, minus any benefits payable by “other plan(s)” and applies the MIP coverage rules to the resulting balance. (Some plans may provide benefits in the form of services rather than cash payments. If this is the case, the cash value is used.) “Allowable expenses” are any medically necessary and reasonable health expense, part or all of which is covered under any of the plans involved.

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.

15.04 Medicare Savings (Retiree Plan 1 Only)

For members enrolled in Retiree Plan 1, when the MIP coordinates with Medicare, the MIP may experience savings as a result of such coordination method because the amount paid by the MIP, after Medicare, is less than what the MIP would have paid in the absence of Medicare. This benefit credit (called “Medicare Savings”) develops once your Medicare and MIP deductible have been satisfied. The total of such savings is maintained by the Insurance Administrator on an individual member basis for the calendar year and is used to refund some of your eligible MIP expenses (deductible, coinsurance, copayments) that you may have paid out of your pocket. Medicare Savings are calculated for claims within one calendar year and there is no carryover from year to year. As each claim is processed, the claims system automatically looks

for such savings to refund your out-of-pocket expenses and will automatically refund out-of-pocket expenses if savings are available. Co-payments or coinsurance for any prescription drug or dental expenses are not eligible for reimbursement from Medicare savings since Medicare does not cover such expenses. Charges used to satisfy the Medicare Part B deductible will be applied to the MIP in the order received by the Insurance Administrator. If two charges are received at the same time, the larger one will be applied first.

15.05 Coordination Rules For Plans Other Than Medicare

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. If you have queries about the order of coverage for you or your dependents, contact your 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 not as a dependent determines its benefits before the plan that covers the person as a dependent. If the person is eligible for Medicare and is not actively working, Medicare Secondary Payer rules apply.
- 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.

Except for children of divorced or separated parents, the plan of the parent whose birthday occurs earlier in the calendar year pays first. This means that if you were born in April and your spouse was born in October, your plan is considered primary and pays benefits first, even if your spouse is older than you are. 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.

15.06 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. Medicare Savings in Retiree Plan 1 (Section 15.04) will not apply to out-of-pocket prescription drug expenses.

15.07 Medicare Direct for Part B Claims

Please see Section 16.11.

15.08 How Prior Coverage Affects Your Benefits

Employers sometimes decide to select a new company to administer their health care plan, or to replace one plan of benefits with a different plan. When this happens, the employer's old plan (prior coverage) may affect your benefits under the new plan:

- The MIP will replace all privileges and benefits provided under any "prior coverage" (see definition below).
- Any benefits provided under prior coverage may reduce the MIP's benefits.

"Prior coverage" is defined as any plan of group health coverage sponsored by the World Bank Group that is replaced by coverage under part or all of the plan described in this document.

15.09 Medicare Part D

Retiree MIP participants should not enroll in Medicare Part D as the MIP provides a prescription plan in the U.S. through PharmaCare which has been certified by an independent auditor to be at least as good as or better than Medicare Part D. An annual letter of Creditable Coverage will be issued annually to all retiree members in the Retiree MIP as required by Medicare and copies will be stored on the retiree website, www.worldbank.org/humanresources.

16 Claims, Payments and Appeals

This section explains claims and benefit payment for members. Information in this section generally pertains to both Aetna and Vanbreda participants. However, Vanbreda participants should also review the relevant material in Section 17.

16.01 Keeping Records of Expenses

You must keep records of health expenses for yourself and all covered family members. These will be required when you file 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.

16.02 Filing Claims

A claim must include an original itemized receipt showing the patient's name, date of service, provider name, and diagnosis. It should show each service or supply provided with the associated fee. Vanbreda accepts faxed or scanned claims but the requirement to present all required documents remains.

If you use an in-network provider (including your PCP under Option C), he or she will file claims on your behalf. However, if you use an out-of-network provider (or, under Option C, you self-refer except as specified in Section 13.02), you (or your legally authorized representative) are responsible for filing your own claims if your provider does not do so on your behalf.

To file a claim, you must complete a claim form. MIP claim forms are available from your Insurance Administrator, from the Intranet (MIP) or from the Internet (www.worldbank.org/humanresources then "Pension and Benefits (including Retiree Life and Medical insurance)"). 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 incurred during 2006, you may file the corresponding claim up until December 31, 2007.

You should keep a copy of every claim you file. Summaries of Explanations of Benefits are not provided.

16.03 Payment of Benefits

All benefits are payable to the insured staff member or retiree, but the Insurance Administrator has the right to pay any health benefits directly to your doctor or other care provider. The Insurance Administrator will pay your provider automatically if you

have completed an “assignment of benefits” and the provider has submitted the claim on your behalf. If you submit the claim, and you have not assigned your benefits, the Insurance Administrator will reimburse the insured person for your claims and those of your dependents.

If you pay the provider directly, but the provider files the claim on your behalf and states incorrectly that you have agreed to an assignment of benefits, the Insurance Administrator is obliged to pay the provider. In that case, the provider would receive double payment, once from the MIP and once from you. You must then recover such overpayments from the provider.

16.04 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 dependent covered by the MIP without authorization by the staff member or retiree.

16.04.1 Aetna

Aetna conforms to U.S. standards for claims management. Benefits are reimbursed only to the insured member (i.e., staff member or retiree) and not directly to a dependent. Thus, in cases of pending divorce, domestic dispute or estrangement, Aetna cannot redirect claims reimbursements to a dependent who incurred the charges. In such cases, use of in-network providers is strongly encouraged, since these are typically handled via office visit co-payments without additional reimbursement of full expenses. Explanations of Benefits are sent to the insured member only.

16.04.2 Vanbreda

Vanbreda pays claims based on information provided on the claim form. Explanations of Benefits are sent to the insured member only.

16.05 Explanation of Benefits

When you or your in-network provider files a claim, you will receive an Explanation of Benefits (EOB) that shows information about the expenses incurred and how the claim was processed. If you have questions about the EOB or a claim, contact Member Services. EOBs are mailed to the MIP mailing address you have provided to the Bank Group. For active staff, this is the home address as provided in the HRKiosk (staff based outside the U.S. only may elect to use the Bank’s pouch system for their MIP mail). For retirees, the pension mailing address is used, which be changed only via a written request to Pension Administration (Section 19.05).

You should retain all EOBs since copies and annual summaries are not printed. However, both Aetna and Vanbreda have online tools to print EOBs (Section 19.02).

16.06 Time to Process an MIP Claim

Once a complete claim with all required supporting documentation is received, the Insurance Administrator will attempt to process it within the MIP's service standard: 90% of all complete claims must be processed within 14 calendar days. The Insurance Administrator will process the claim as soon as possible, but will not exceed 30 calendar days.

16.07 Predetermination of Benefits

You can request that the Insurance Administrator provide you with a predetermination of benefits by asking your doctor or dentist to complete an MIP claim form to document the diagnosis, and to describe the proposed treatment plan. Additional information such as x-rays, test results or patient notes may be required. The Insurance Administrator will review this predetermination request and will advise within 15 days of the expected benefits reimbursable under the MIP. You are encouraged to request a predetermination for services exceeding \$300.

16.08 Claim Payment Options

16.08.1 Aetna

Aetna reimburses claims by U.S. dollar checks unless members elect other options. U.S. residents and non-residents may elect to use their payroll (active staff) or pension (retirees) account⁸ for claim reimbursements by completing a Direct Deposit Form and returning it to the HR Service Center.

Non-U.S. residents have the additional option to set up a different deposit account and currency, but must contact Aetna to complete the appropriate forms (contact Aetna to obtain the form). Aetna does not charge a fee to wire funds, but other financial institutions may charge a fee to accept such funds. Such fees are not reimbursable by the MIP.

16.08.2 Vanbreda

Vanbreda participants specify reimbursement currency options on every claim form, and are thus not eligible for the Local Currency option.

16.09 Exchange Rates

Benefits paid by the MIP are in U.S. dollars. For services paid in non-U.S. dollar currencies and reimbursed in U.S. dollars, or for services paid in non-U.S. dollar currencies, the exchange rate used will be the rate in effect on the date of service.

⁸ In cases where a pension is paid to multiple accounts, any claim reimbursement will be paid to the primary account (generally, the account from which the Retiree MIP premium is deducted).

16.10 Direct Deposit Program

16.10.1 Vanbreda (Active Staff and Retirees)

Vanbreda participants may specify direct deposit account information on every claim form, and are thus not subject to Direct Deposit.

16.10.2 Aetna (Active Staff)

Active staff using Aetna may elect direct deposit to their payroll account. Reimbursements cannot be made to any other account. The election is made via the HRKiosk (<http://hrkiosk>). Aetna is notified within 30 calendar days of the election. Active staff who do not have their salary deposited to a U.S. bank account should refer to Section 16.08.1 for direct deposit information.

16.10.3 Aetna (Retirees)

Retirees using Aetna may elect to have benefits deposited directly to the account from which they receive their primary pension payment. The account must be a U.S. dollar-denominated bank account, and the bank must participate in the Automated Clearing House (ACH) System. You may obtain a Direct Deposit Request form from www.worldbank.org/humanresources (click on Forms, then Insurance, then Retiree MIP Direct Deposit), or from the HR Service Center.

To change the account where you receive your primary pension payment, contact Pension Administration. Aetna participants who do not have their primary pension payment deposited to a U.S. dollar bank account should refer to Section 15.08.1 for direct deposit information.

16.11 Medicare Direct (Aetna only)

Medicare Direct is an arrangement between Medicare and Aetna that allows Medicare to electronically file Medicare Part B (doctor's visits) claims to Aetna for consideration under the MIP. Enrollment is voluntary. Once a member enrolls, providers will file Part B claims to Medicare as the primary insurer. Medicare determines its claim reimbursement, and then forwards a Medicare Explanation of Benefits and payment information to Aetna electronically. This program shortens total claims processing times. Some Medicare carriers do not forward claims that Medicare denied or that fall under Medicare deductibles. These may be forwarded by the member to Aetna for MIP consideration.

Participation in Medicare Direct is free for MIP members. Enrollment is handled by Aetna. Contact Aetna Member Services to enroll. Once enrolled, members should notify their providers to avoid duplicate secondary filing of Medicare Part B claims.

Medicare Part A (hospital) claims that are not sent to Medicare then Aetna directly by a hospital are your responsibility to file first with Medicare and then with Aetna.

16.12 Physical Exams

The Insurance Administrator has the right to require a physical exam of any person for whom certification of benefits has been requested. The exam will be done at any reasonable time while a claim for benefits is pending or under review. The Insurance Administrator will choose a doctor or dentist to perform this exam, and will pay for it.

16.13 Adjustment Rule

If a member changes his or her insurance option, or moves from the Active Staff MIP to the Retiree MIP or vice versa, benefits for claims incurred after the effective date of the change will be paid according to the provisions for the new plan selected. In other words, 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 only applies to claims incurred on or after the effective date of the increase, not to claims incurred prior to that date.

16.14 Misstatement of Fact

If there is any misstatement of fact that affects your coverage under the MIP, the true facts will be used to determine the coverage that applies. If it is proven that you or your dependents have committed fraud on the MIP, then your MIP coverage will be terminated. Disciplinary action under Staff Rule 8.01, Disciplinary Measures may also apply.

16.15 Right of Recovery and Subrogation

The Insurance Administrator may recover benefits paid for expenses incurred by a covered person due to an injury or illness for which another person (called the “third party”) may be liable. In this case, the Insurance Administrator 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 Insurance Administrator also has the right to recover from the insured person amounts received by judgment, settlement or otherwise from the third party, his or her insurance carrier, or any other person or entity. The covered person must execute and deliver any documents required, and do whatever is necessary to secure the Insurance Administrator’s rights of recovery and will co-operate fully with the Insurance Administrator or their subcontractors in recovery attempts.

The Insurance Administrator may also recover refunds from providers for services already reimbursed by the MIP.

16.16 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 participant refuses to repay any owed amount to the Insurance Administration, the 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.

16.17 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.

16.18 If You Disagree With a Claim Decision

The Insurance Administrator has fiduciary responsibility to review and process claims in accordance with the MIP contract. 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 claim will be denied.

The World Bank Group is prohibited from reviewing medical claim information, and cannot and will not instruct the Insurance Administrator on specific claim reimbursements. The 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. If all or any part of your claim or other request is denied, you will receive a written notice from the Insurance Administrator through the Explanation of Benefits (EOB). The EOB will explain the reason for the denial and the procedure to follow to request a review of the decision.

16.18.1 Claim Decisions

There are many reasons why you may disagree with a claim decision. Firstly, you should review the relevant sections of this document that pertain to the medical, dental or pharmacy service including exclusions to coverage that may apply to your claim.

Secondly, your Explanation of Benefits should help you understand the reason for denial or reduced benefit. Read all notes carefully. For example, if your doctor charges more than the MIP maximum fee allowed (the Usual and Customary charge for the service rendered), the MIP will “cut back” or reduce the amount covered, and your Explanation of Benefits will show an “Amount Not Covered.” You are financially liable for this amount, and your provider will bill you accordingly.

Another source of claim dispute is the result of a service billing error, whereby a provider performs and charges for a complex service, but presents a bill for a simple service. (An incorrectly processed bill may produce the same result if the complex service is miscoded by Aetna as a simple service.) These errors can usually be diagnosed with a telephone call to Aetna Member Service, who will examine the bill and compare it to their claim decision. The claim will either be reprocessed by Aetna, or the bill must be revised by the provider and resubmitted to Aetna for processing.

16.18.2 Appeals

If your claim issue remains unresolved after the process described above in Section 16.18.1, the following process describes the formal appeal mechanism for Aetna (Vanbreda has a different method, described in Section 16.14):

- Review the reason for denial with Aetna by contacting Member Services .
- If the dispute remains, you must first send Aetna a written request for review. This must be sent as soon as possible but not later than 180 days following your receipt of the notice of denial. Be sure to include a copy of the EOB, your UPI and contact information, the patient name and reasons for requesting a review. You may submit comments, documents, records or other information relevant to the claim. Send your request to Member Services.
- You are responsible for the cost of compiling and mailing the information that you wish to be reviewed.
- Within five days after Aetna receives your request, you will receive an acknowledgement letter. This letter may ask you for additional information. If so, you must send the additional information to Aetna as soon as possible.
- Aetna will review your request. Under ordinary circumstances, you will receive a response within 30 days of Aetna's receipt of your appeal for pre-service claims or within 60 days for post-service claims. The response will be based on the information provided with the appeal and any information sent after that.

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.

16.18.3 If Additional Time Is Needed

If Aetna needs more time to resolve an appeal, you will receive a written notice which explains why more time is needed and setting a new date for a response. The additional time will not amount to more than 30 days, assuming that Aetna has complete information.

16.18.4 Second Appeal

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

For non-medical necessity reviews, an Aetna appeals analyst that was not involved in the first 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 Section 09, Dental Expenses Not Covered.

For medical necessity reviews, an Aetna medical review team that did not process the original claim will conduct the second internal review. This team is managed by a different Medical (or Dental) Director to ensure second review impartiality. If your second internal review is also unsuccessful and the original coverage denial is again upheld, you may be eligible to request an Independent External Review (Section 15.18.6).

16.18.5 Urgent Appeals

If your claim involves urgent care, an expedited appeal may be initiated by a telephone call to Member Services. You or your authorized representative may appeal urgent care denials either orally or in writing. All necessary information, including the appeal decision, will be communicated between you or your authorized representative and Aetna by telephone, fax or e-mail. You will be notified of the decision not later than 72 hours after the appeal is received. You will be notified of the decision by telephone, followed immediately by a written notice delivered by courier, e-mail, mail or fax.

16.18.6 Independent External Review

For claims denied as not medically necessary, you may request an Independent External Review (IER) if you or your care provider disagrees with Aetna's denial decision and the claims are for services in excess of \$500. An IER is a review by an independent physician or dentist who has expertise in the problem or question involved. An Independent External Review is voluntary and both the member and Aetna agree to be bound by the IER decision.

16.18.6.1 Non-Urgent Procedure

To request an IER, the following requirements must be met:

- You have exhausted the appeal process described in this section, and you have received a final denial;
- The final denial was based on the lack of medical necessity or the experimental or investigational nature of the proposed service or treatment; and
- The cost of the service or treatment involved for which you are responsible is more than \$500.

If you meet these requirements, you will receive written notice of your right to request an external review when a final decision on your internal appeal is made.

To request an external review, you (or someone acting on your behalf) must send an "Independent External Review Request Form" to Aetna (except in the case of an Expedited Independent External Review, Section 15.18.6.2), along with a copy of the letter denying coverage and any other information you want reviewed as part of your

request. You obtain the form from Member Services . You must send your written request for an IER to Aetna within 60 calendar days after you receive the final decision on your internal appeal. There is no fee to the MIP member for using the External Review process.

Aetna will contact the External Review organization which will conduct your external review. The External Review organization will then select an independent physician or dentist with appropriate expertise in the appropriate specialty to perform the external review. To make a decision, the external reviewer may consider any appropriate information that you provide with the Independent External Review Request Form and must follow the MIP provisions that govern benefits.

The External Review organization will generally notify you of the decision within 30 calendar days of Aetna's receipt of a properly completed "Independent External Review Request Form." The notice will state whether the prior determination was upheld or reversed, and explain the reasons for the determination. The decision of the external reviewer will be binding on the MIP and the member, unless Aetna or the MIP shows that the reviewer has a conflict of interest, bias or fraud. In such cases, you would be notified and the matter will be promptly resubmitted for consideration by a different reviewer.

16.18.6.2 In an Emergency or Urgent Situation

In an emergency which involves admission to or services from an acute care hospital, your doctor or the hospital may submit a written request for an Expedited Independent External Review if they believe that you face a serious injury or life-threatening situation. Aetna will respond to this request within 72 hours of receiving the request and any necessary information. In all other emergency or urgent situations, an expedited review may be requested by contacting Member Services.

If there is an urgent situation, your treating physician can request an expedited external review by submitting a separate "Request For Expedited Independent External Review" form (or by telephone with prompt written follow-up) that explains the clinical urgency of the situation. "Urgent" means that a delay (waiting the full 30 calendar day period) to receive a service or treatment would jeopardize the health of the patient. Expedited reviews will be decided within five calendar days of receipt of the request. You will be notified of the decision by telephone, followed immediately by a written notice delivered by courier, e-mail, mail or fax.

16.18.6.3 Costs

Aetna is responsible for the cost of sending information to the Independent External Review organization. Any professional fee for the Independent External Review will be paid by Aetna.

The World Bank Group will assist you with service issues relating to claims adjudication, should such issues arise. You may contact the HR Service Center, for

example, if the Insurance Administrator does not respond to your appeal within the specified time frame.

The World Bank Group cannot intervene on substantive claim issues, and is prohibited (due to medical confidentiality) from reviewing your claim. 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.

17 International Option

The World Bank Group offers an International Option for staff and retirees participating in the MIP and residing outside the United States. Vanbreda administers the International Option. This section describes in detail the International Option, its features, and its procedures.

17.01 Who May Elect the International Option?

17.01.1 Active Staff MIP Participants

The International Option is available to Active Staff MIP participants whose principle residence is not in the U.S., in the following circumstances, and subject to Section 16.01.3:

Extended assignment away from Headquarters under Staff Rule 6.17, Benefits on Change of Duty Station	Eligible
Appointment to "HQ Satellite" duty station (Paris, Tokyo, London, Brussels, Rome, etc.)	
External Service (with or without pay) for at least one full calendar year (January to December)	
Leave without pay for at least one full calendar year (January to December)	
Telecommuting assignment outside the U.S. of at least one full calendar year (January to December)	
Short term assignment as defined in Staff Rule 6.17	Not eligible

17.01.2 Retiree MIP Participants

The International Option is available only to those Retiree MIP participants with a non-U.S. pension mailing address subject to the provisions of Section 16.01.3 and Section 16.01.4 below.

17.01.3 Sponsored Plan Participants

The International Option is not available to any active staff member with an elderly parent or parent-in-law enrolled in the Sponsored Plan. (The Sponsored Plan is currently supported only by Aetna.) A retiree with an elderly parent or parent-in-law in the MIP Continuation program of the Sponsored Plan may elect the International Option. However, the Sponsored Plan participant would continue to be administered by Aetna.

17.01.4 Use of Both Insurance Administrators

The staff member or retiree and all dependents must use the same Insurance Administrator. This provision extends to surviving dependents covered under the Retiree MIP as individuals (e.g., orphaned children).

17.02 How Do I Enroll if I Am Eligible?

If you wish to elect the International Option, please contact the HR Service Center to confirm you are eligible and for information on the change season during which you may make this election. The change season usually takes place during December of each calendar year.

17.03 Premiums

Staff or retiree MIP contributions do not differ between Insurance Administrators.

17.04 Plan Design Differences

The International Option of the MIP is nearly identical in terms of the coverage of benefits provided to staff or retirees to the MIP administered by Aetna. For active staff, Option C is not available with Vanbreda. The minor plan design differences of the International Option are summarized below.

17.04.1 Dental

Under the International Option, which has no dental “preferred provider” network, routine dental care is covered at 100% with no deductible, and special periodontal and oral surgery services are covered at 90% after deductible⁹ (Section 16.06). Under Aetna, these higher benefits (from the normal 80% after deductible coverage) are only available via use of “in-network” Aetna Dental PPO dentists.

17.04.2 Application of Out-of-Pocket Limit

Under Aetna, there is a medical expense out-of-pocket limit (Section 02.02.2), and an in-network prescription drug out-of-pocket limit for brand-name drugs purchased in PharmaCare-affiliated pharmacies (Section 10.04). Under the International Option, there is only one medical out-of-pocket limit. The combined out-of-pocket limit for any participant is identical. Coordination of information by Aetna, Vanbreda and PharmaCare ensures consistent and identical application of the out-of-pocket maximum to all MIP participants, including International Option participants, regardless of where prescription drugs are purchased.

⁹ For Retiree Plan 2 only, the special periodontal and oral surgery benefit is 50% after deductible.

17.05 Other Differences

There are differences between the two administrators other than coverage levels which may be of particular interest to MIP participants who do not reside in the United States. These are described in detail below.

17.05.1 Care Outside the U.S.

Staff and retirees who elect the International Option and who receive care outside the U.S. are encouraged to use providers (usually hospitals and clinics) who have an agreement with Vanbreda. Participating hospitals, clinics and other providers which have an agreement with Vanbreda offer direct payment to MIP members. This means that such services do not require prepayment by the patient, and the providers bill Vanbreda directly first, and then bill the participant for any portion of the cost that is not covered by the MIP. Many direct payment affiliates also offer discounted fees. For more details, Section 16.10.

For more information on Vanbreda providers, see Vanbreda's web site, www.vanbreda-international.com, or contact their Contact Center.

17.05.2 Care Within the U.S.

Vanbreda is affiliated with a large U.S. "preferred provider organization" (PPO), Health Systems International. If International Option participants receive medical care in the U.S., use of Health Systems International providers offers significant advantages:

- A co-payment of \$15 (Active Staff Option A and Retiree Plan 1) or \$20 (Active Staff Option B and Retiree Plan 2) for all 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. Health Systems International providers and hospitals have agreed to charge Vanbreda patients reduced fees for their services.
- In addition to a large nationwide network of qualified physicians and hospitals, Health Systems International's network includes many other medical facilities and services, such as laboratories, radiology centers, dialysis centers, durable medical equipment providers, etc. By using one of these providers, you maximize your MIP benefits because your care will be less expensive than identical care from providers who are not affiliated with Health Systems International.
- Depending on your MIP Option or Retiree MIP Plan, you may receive a higher level of coverage when you use Health Systems International services. For example, in Retiree Plan 1, laboratory and x-ray fees are covered at 90% after deductible at a laboratory or radiology facility affiliated with Health Systems International, but 80% after deductible if you use non-affiliated "out-of-network" facilities.

- You can find Health Systems International providers on the Internet (www.us-hsi.com) or by contacting Vanbreda.

The MIP's U.S. PPO network for Aetna participants is the Aetna Open Choice PPO.¹⁰ The Aetna Open Choice PPO is a different U.S. network from the Health Systems International PPO used by International Option participants. These two PPO networks are completely independent. (Indeed, they are competitors.) Unless your provider is affiliated with both Health Systems International and Aetna (which is possible, especially for hospitals), your coverage will be "out-of-network" if you are enrolled with Vanbreda and use an Aetna provider, or if you are enrolled with Aetna and use a Health Systems International provider.

17.06 Dental Services

Neither Vanbreda nor Health Systems International has a dental network or agreements with any dental providers. Thus, International Option participants are covered at one benefit level for all dental services, with no distinction between "in-network" and "out-of-network" services. International Option participants do not have access to the Aetna Dental PPO for "in-network" dental care in the U.S. If an International Option participant uses an Aetna Dental PPO dentist, the care would be considered "out-of-network," the claim would be filed with Vanbreda, and the dentist would likely charge a higher "retail" rate for services than he/she would charge clients who participate in the Aetna Dental PPO.

17.07 Pharmacy Services

The MIP covers the cost of drugs prescribed by a licensed doctor for medically necessary treatment of illness, in accordance with the MIP contract. Coverage details are provided in Section 10 and Section 11. Qualifying prescription drug purchases made (a) outside the U.S., or (b) inside the U.S. but not at a PharmaCare-affiliated pharmacy, are reimbursed as medical expenses for both brand-name and generic drugs, and are subject to your medical deductible and out-of-pocket limits. In the U.S., brand-name and generic drugs differ sharply in price, but not quality. Use of generic drugs offers significant savings for you and the MIP. (Section 10.01)

17.08 PharmaCare Out-of-Pocket Maximum Coordination

PharmaCare administers a separate out-of-pocket limit for each MIP participant on all brand-name prescription drug purchases at PharmaCare-affiliated pharmacies. For Aetna participants, the medical out-of-pocket limit and the PharmaCare out-of-pocket limit are administered independently by Aetna and PharmaCare, respectively. For International Option participants, PharmaCare will send U.S. network pharmacy

¹⁰ Aetna's "Managed Choice POS" product for Option C participants.

purchase information to Vanbreda annually for reconciliation. International Option participants who met their medical out-of-pocket expenses during a calendar year and who also had PharmaCare out-of-pocket expenses for U.S. drug purchases during the same calendar year will receive reimbursement of the out-of-pocket PharmaCare costs from Vanbreda after the reconciliation.¹¹ A similar reconciliation will be conducted annually for Aetna participants who switched from Vanbreda during a calendar year.

17.09 Identification Cards

Section 01.07.6

17.10 Direct Billing and Negotiated Fees

17.10.1 Direct Billing

One major advantage of using Vanbreda is “direct payment.” Vanbreda has established direct billing arrangements at many hospitals and clinics throughout the world, and is constantly expanding this list of providers. If you use one of these direct payment providers, you will receive medical care simply by showing your Vanbreda card. You will not be required to complete claims forms, prepay for medical services, or provide a certificate of guarantee of your insurability. The provider will bill Vanbreda directly. Vanbreda will pay the hospital or provider the portion covered by the MIP. At the same time, Vanbreda will inform you of any coinsurance that you owe the medical provider.

For more information on Vanbreda providers or to identify a Vanbreda provider, see Vanbreda’s web site, www.vanbreda-international.com, or contact their Contact Center.

17.10.2 Negotiated Fees

Vanbreda also has negotiated discounted fees with many providers in many countries, including many of the same providers with whom they have direct payments arrangements. Using such providers offers you and the MIP savings, since the costs of any given procedure are lower for persons associated with Vanbreda through the MIP than for other persons. 17.11 Vanbreda Claims Processing and Services

¹¹ For example, assume a retiree in Retiree Plan 1, enrolled with Vanbreda with individual coverage, receives care in both the U.S. and Europe. In a calendar year, she meets her out-of-pocket maximum for medical expenses. Additional covered medical expenses during the calendar year are reimbursed at 100%. Assume, though, that in addition to the medical expenses, she had \$329 out-of-pocket expenses purchasing prescription drugs in the U.S. at PharmaCare-affiliated pharmacies. There are no claims forms for these purchases. Once per year, PharmaCare and Vanbreda will coordinate claims data. Vanbreda would, in this example, reimburse the retiree \$329 since she had met the total medical out-of-pocket maximum.

17.11.1 Customer Service

Vanbreda processes claims and operates a contact center at their Headquarters in Antwerp, Belgium and in Kuala Lumpur, Malaysia. This facility is staffed 24/7 (weekdays, weekends and holidays). The Vanbreda staff are multilingual with fluency in Dutch, English, French, German, Spanish and Italian. Other languages are also available via real-time translation services. Contact Center members are able to assist you with questions concerning coverage, guarantees of payment, eligibility and any other questions related to your medical plan. They are also highly experienced in adjudicating medical and dental claims from most countries.

17.11.2 How to File a Claim

If you elect the International Option, you no longer use Aetna for MIP claims processing for claims incurred on or after your Vanbreda start date. Thus, staff and retirees who elect the International Option must file all old claims with Aetna prior to switching. Failure or delay in doing so may be financially disadvantageous (Section 17.17).

Vanbreda's claim form is available on the World Bank Group websites (type MIP on the Intranet for active staff, and www.worldbank.org/humanresources for retirees), on the Vanbreda website, www.vanbreda-international.com and from their Contact Center. Vanbreda provides a blank form (suitable for photocopying) to new participants upon enrollment. Each time you or a covered dependent incurs medical or dental claims, you must complete a Vanbreda claim form, providing your name, UPI, banking information, etc., and mail it to Vanbreda with the original, itemized bill or receipt from the provider (Section 15.02).

Note: Scanned and faxed claim submissions are now accepted by Vanbreda, but full claim documentation is still required, including a Vanbreda claim form.

Do not submit Aetna claim forms to Vanbreda, or vice versa.

17.11.3 Translation of Claims

Vanbreda will translate MIP claims as needed.

17.12 Claims Adjudication

17.12.1 Fiduciary Responsibility

As with Aetna, the World Bank Group has contractually provided fiduciary responsibility to Vanbreda to process MIP claims. Accordingly, Vanbreda must adjudicate claims according to the MIP plan design, and can disburse MIP funds on behalf of the MIP to pay claims. Vanbreda (like Aetna) has no financial incentive related to claims decisions (except to process them quickly and accurately). They (like Aetna) are paid a service fee based on the number of insured lives, not how many claims are processed, reduced or denied.

17.12.2 Medical Necessity

Vanbreda, like Aetna, determines medical necessity for each claim in accordance with the MIP contract and this document. The World Bank Group cannot intervene in issues of medical necessity. Such decisions must be adjudicated through Vanbreda, including the appeal of decisions (Section 17.14).

17.13 Claims Reimbursement

17.13.1 Claim Processing Service Standard

Vanbreda's processing service standard is 90% claims completed within 14 calendar days, identical to Aetna's service standard.

17.13.2 Usual and Customary Charges

Vanbreda reimburses MIP participants in accordance with the MIP contract, based on medical necessity and subject to the "usual and customary" level of fees for that service. Vanbreda maintains an extensive database of the cost of all medical and dental procedures in countries and cities around the world which reflects their international claims payment experience since the 1970s. Under the provisions of the MIP contract, charges that exceed the usual and customary level are reduced and reimbursement will be based on the maximum usual and customary level.¹²

17.13.3 Payment Option: Electronic Funds Transfer Versus Paper Check

Vanbreda pays each claim reimbursement via electronic funds transfer or by paper check if the reimbursement is made in a major currency. Reimbursement in other currencies is possible but only by paper check. You may elect the mode of payment with each claim. If you fail to do so, reimbursement will be made by paper check in U.S. dollars.

Vanbreda currently supports EFT in the following currencies (subject to change): Australian dollar, Thai baht, Canadian dollar, Swiss franc, Euro, British pound, Norwegian crown, Philippine peso, Swedish crown, U.S. dollar, Hong Kong Dollar, Kenyan Shilling, Singapore Dollar, New Zealand Dollar.

There are no restrictions in 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, Vanbreda attempts such arrangements. However, this delays the processing of the claim.

¹² For care within the U.S., Vanbreda uses the same database, percentile and tolerance levels as Aetna. "In-network" care through Health Systems International providers is not subject to Usual and Customary charge limitations.

17.13.4 Currency of Reimbursement

Normally, claims are reimbursed in U.S. dollars. If you elect reimbursement in the currency in which the claim was incurred, the exchange rate used will be the United Nations Operational Rates of Exchange (<http://www.un.org/Depts/treasury/>) on the date of service. Also, deductible balances, out-of-pocket expenses and other financial accumulators will be calculated in U.S. dollars using the United Nations Operational Rates of Exchange as of the date of service.

17.13.5 Explanation of Benefits

Each claim processed by Vanbreda will generate an Explanation of Benefits detailing the patient, the amount of the claim, the amount covered, and other information. Please retain these Explanations of Benefits for your records; annual summaries are not provided. Explanations of Benefits can be viewed online, (Section 19.02.2).

17.13.6 Mailing Address

See Section 16.05.

17.14 Disputed Claims and Appeals Process

Vanbreda is obligated to adjudicate MIP claims in accordance with the MIP contract, including determination of medical necessity and application of Usual and Customary limits. If a claim is denied, you should first take steps to ensure Vanbreda possessed and processed complete information with regard to the diagnosis and treatment. If the claim is still denied, you may appeal it by sending a full description of the issues and documentation to the Deputy Director of the Medical Claims Center of Vanbreda.

If your appeal is denied and you wish further review, Vanbreda will participate in arbitration using an independent medical examiner who is mutually agreeable to you and Vanbreda. (Aetna's appeal mechanism is different; Section 16.18) The disputed claim must be for at least \$500. If no agreement can be reached to identify an arbitrator, the arbitrator will be designated by the Président du Conseil de l'Ordre des Médecins in Belgium or by a similar medical authority in your country. Such arbitration is binding on you and Vanbreda, and it represents the final level of appeal.

The World Bank Group will assist you with service issues relating to claims adjudication, should such issues arise. You may contact the HR Service Center, for example, if the Insurance Administrator does not respond to your appeal within the specified time frame.

The World Bank Group cannot intervene on substantive claim issues, and is prohibited (due to medical confidentiality) from reviewing your claim. 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.

17.15 Predetermination of Benefits

If you have planned a medical or dental procedure, you may ask Vanbreda to predetermine your benefits. Predetermination means asking your doctor or hospital to complete a claim form specifying all anticipated procedures, and submitting this claim form by mail or fax to Vanbreda. Vanbreda will “preprocess” the claim, and inform you in general of the level of coverage. This will be processed within 14 calendar days.

Vanbreda also uses a cost estimate form used for hospitalization only, which gives a patient an idea on the reasonableness of the expenses to be incurred, and serves as a basis for a letter of guarantee. The form is available from Vanbreda in English and French.

17.16 Eligibility Changes, Continuation and Conversion

Please see Section 14

17.17 Coordination Between Vanbreda and Aetna

If you elect to switch Insurance Administrators, Vanbreda and Aetna will exchange information about you and your family’s accruals of deductibles, dates of last medical exams, etc. In order to effectively manage this transition, you should be up-to-date with filing of claims with the prior Insurance Administrator before you switch to the new Insurance Administrator.

Claims must be processed with the Insurance Administrator in effect when the participant received the medical or dental service. Since the MIP allows claims submission for the previous calendar year, participants who do not file claims in a timely manner may send claims to Aetna after a switch to Vanbreda, or vice versa. Once Vanbreda and Aetna exchange information regarding mid-year accumulation of deductibles, lifetime maximums, out-of-pocket expenses, etc., claims received thereafter by the prior Insurance Administrator for services prior to the switch date will be processed without coordination. This could reduce your financial benefits.

17.18 National Medical Plans

Retiree MIP participants are obligated to join any national health plan for which they are eligible(Section 15.02). Aetna and Vanbreda will coordinate your MIP coverage with any national health plan coverage.

17.19 Switching Between Aetna and Vanbreda

17.19.1 Retirees

17.19.1.1 General

Each December, retirees with a non-U.S. pension mailing address who are enrolled with Aetna may switch to the International Option effective the following calendar

year. Also each December, any retiree who elected Vanbreda may switch to Aetna.¹³ Retirees must stay with the option (Aetna or Vanbreda) they elected for the full calendar year. Retirees with U.S. pension addresses must elect Aetna.

17.19.1.2 Active Staff Who Retire

Within the first 12 months after initial participation in the Retiree MIP, a retiree whose Pension mailing address is non-U.S. may elect to switch to Vanbreda, as long as the request is made prior to June 15 of any calendar year.

17.19.2 Active Staff

17.19.2.1 General

If a staff member is reassigned to the U.S., administration by Vanbreda, if elected, ends, and administration by Aetna begins. The coverage transfer occurs at the same MIP Option (A or B) as that administered by Vanbreda. Within 31 days of the transfer from Vanbreda to Aetna, a staff member may elect Option C (Aetna Managed Choice POS) by contacting the HR Service Center¹⁴. However, all changes to or from Vanbreda are only processed prior to June 15 of any calendar year. For changes later in a calendar year, the effective date of the change in Insurance Administrator will be January 1 of the following year.

If a staff member in MIP Option C elects Vanbreda, he or she must choose Option A or Option B, since there is no equivalent Option C (Point of Service) plan under the International Option.

17.19.2.2 Extended Assignment

Eligible active staff¹⁵ may elect Vanbreda within 31 calendar days of the start date of an extended assignment away from Headquarters (see Staff Rule 6.17B, Benefits on Change in Duty Station). Thereafter, staff on extended assignment will have the opportunity to elect Vanbreda each December for effect during the following calendar year. 17.19.2.3 Leave Without Pay, External Service, Telecommuting

Staff on Leave Without Pay, External Service (with or without pay), or telecommuting assignments who are residing outside the U.S. and who are participating in the MIP may also elect Vanbreda, provided the assignment is over one year in duration and includes a full calendar year (January to December).

¹³ Aetna's Open Choice PPO is larger than the Health Systems International network, so U.S.-based retirees have better access to in-network care (especially hospitals) in the U.S. with Aetna than with Vanbreda.

¹⁴ Active staff eligibility for the International Option is subject to the provision of Section 17.01

¹⁵ Each December, all staff elect to switch between Option A and Option B (if with Vanbreda), or between Option A, Option B and Option C (if with Aetna).

18 Aetna Programs

The following information is offered as a service to members who participate with Aetna. These programs are subject to change, and the World Bank Group may not update this SPD when such programs change. You are encouraged to research each program thoroughly before you use it. These programs are not available to Vanbreda participants.

Charges for the alternative health programs, fitness programs and Vision One described below may not be covered under the MIP. Call Aetna Member Services to confirm coverage before you incur any charge.

18.01 Alternative Health Care Program

If you are interested in alternative therapies, Aetna's Natural Alternatives program offers discounted rates, including visits to acupuncturists, chiropractors, massage therapists and nutritional counselors. You can also save on vitamins and nutritional supplements purchased through mail-order, over the phone, by fax, or over the Internet. You also can save on many health-related products, including aromatherapy, foot care and natural body care products. For more information, contact Aetna Member Services or visit Aetna on the web at www.aetna.com and search for "Alternative Health Care Program."

18.02 Vision One Discount Program

MIP participants are eligible for discounts on eyeglasses, contact lenses and nonprescription items such as sunglasses and contact lens solutions through the Vision One program at many locations nationwide. Call 800-793-8616 for information and locations.

Participants are also eligible to receive a discount off the provider's usual retail charge for Lasik surgery (the laser vision corrective procedure) offered by Cole/LCA-Vision LLC through the national Lasik network of LCA Vision, Inc. The discounted price includes patient education, initial screening, the laser procedure and follow-up care. The MIP does not cover laser surgery. To find Lasik surgeons, call 800-422-6600.

18.03 Fitness Program

Aetna offers participants access to discounted fitness services provided by GlobalFit™. Depending upon your location, you may be eligible for one of two programs. Under *GlobalFit A*, participants join the GlobalFit network and receive discounts on their health club membership rate. Under *GlobalFit B*, participants join clubs directly at the lowest corporate rate for the type of membership selected. Both programs offer MIP participants:

- Low or discounted membership rates at independent GlobalFit health clubs.
- Free guest passes at some participating clubs to allow you to try facilities before joining.

- Guest privileges at other participating GlobalFit health clubs.
- Discounts on certain home exercise equipment.

To determine which program is offered in your area and to view a list of included clubs, visit the GlobalFit website at www.globalfit.com/fitness. To speak with a GlobalFit representative, you can call the GlobalFit Health Club Help Line at 800-298-7800.

18.04 Aetna Informed Health Line

All Aetna MIP members have access to Aetna's Informed Health Line Services. This is a free 24-hour service providing simple medical information and advice for illnesses and injuries. Members are able to speak to a qualified health professional and nurse about medical concerns and receive guidance on appropriate medical care. The Aetna Health Line is confidential. It is not intended to be a substitute for emergency care or talking with a member's physician, but it may be a valuable resource in non-emergency situations. Members can also receive a free resource book from Aetna addressing common medical concerns and treatments upon request. The Informed Health Line number is 1-800-556-1555.

18.05 Aetna Vital Savings Program

Aetna Vital Savings program may be of interest to those Aetna MIP participants with G5 employees, family members or other dependents living in the U.S. who are not eligible for the MIP, and others without dental or vision insurance. For a small monthly fee, an enrollee has access to Aetna's network of service discounts on U.S. dental and vision services. Contact Vital Savings on 1-866-368-4825 or www.vitalsavings.com for more information or to enroll. This plan does NOT provide insurance, and is not affiliated with the MIP.

19 Member Services and Online Services

19.01 Member Services

Aetna, Vanbreda and PharmaCare customer service professionals are trained to answer your questions and to assist you in using the MIP properly and efficiently.

19.01.1 Aetna Member Services

Contact Aetna Member Services by phone, fax or e-mail to:

- Ask questions about benefits and coverage;
- Query claim status;
- Receive information on appeals;
- Assist in finding an Aetna network provider;
- Select or change your PCP (Option C participants only);
- Notify Aetna about an emergency;
- Register a hospitalization;
- Discuss Patient Management;
- Discuss Aetna Navigator; or order a new or replacement Aetna/MIP ID card.

19.01.2 Vanbreda/Health Systems International

Contact Vanbreda Member Services to:

- Ask questions about benefits and coverage;
- Query claim status;
- Assist in finding a participating Vanbreda provider;
- Notify Vanbreda about an emergency;
- Register a hospitalization; or order a new or replacement ID card for Vanbreda or Health Systems International.

19.01.3 PharmaCare

Contact PharmaCare Member Services for assistance to:

- Ask questions about in-network pharmacy benefits and coverage;
- Assist in finding a participating retail or mail-order pharmacy;
- Obtain information about PharmaCare Direct and filling prescriptions via mail-order;
- Discuss prescriptions that require preauthorization; Formulary alternatives
- Order a new or replacement PharmaCare ID card.

19.02 Online Services

In addition to accessing Member Services, all MIP participants can access online services via the Internet to receive health information, perform transactions, find participating providers, and more.

19.02.1 Aetna

Aetna's web site, www.aetna.com, contains extensive health information and tools:

- The **DocFind** online provider directory allows you to find in-network providers sorted by specialty, geographic area, and other criteria. The appropriate Aetna products for World Bank Group programs are Open Choice PPO (for Option A, Option B, Retiree Plan 1 and Retiree Plan 2), Managed Choice POS (for Option C only) and the Dental PPO (for all Aetna participants). Section 01.07.4.1
- **Aetna Navigator** is a password protected website that provides a single online location for personalized health information and convenient self-service functions. Aetna Navigator offers online customer service functions that allow you to order ID cards, check the status of a claim, view and print online Explanation of Benefits statements, annual claim summaries, send e-mails to Member Services, etc. You must register online using your member ID. Navigator is a secure web site with password protection and a strong browser encryption requirement (128-bit encryption). If you access DocFind via Navigator, many of your elections (such as the Aetna products associated with the MIP, e.g., Dental PPO) are pre-populated automatically based on your enrollment information.
- **InteliHealth** is a comprehensive online health information network associated with Harvard Medical School. Through InteliHealth, you can find comprehensive information on a vast number of health topics. You also can get wellness and fitness tips, plus savings on health-related products. Interactive "cool tools," including a medical dictionary, allergy and asthma quizzes, a pregnancy due-date calculator and a heart and breath odometer.
- A preventive care planner that includes recommendations for screenings and immunizations. Such recommendations may differ from MIP coverage. Contact Aetna Member Services with inquiries.
- **Aetna Global Benefits** for members using Aetna who are living or traveling outside the U.S., additional information on non-U.S. services is available from Aetna Member Services, or members can access the protected website <http://www.aetna.com/agb> using the same User ID and password that they use for Aetna Navigator access.
 - A global doctor/hospital search engine;
 - Health and security information for over 200 countries;
 - Translation guides for drug and medical terminology in nine languages;
 - Global health-related news and feature stories; and
 - Frequently Asked Questions.

19.02.2 Vanbreda

Vanbreda offers a "settlement data online" service which allows participants with access to the Internet to review all Explanations of Benefits processed including reimbursement details, payment details and comments. Vanbreda participants will receive specific information on this optional service when it is available.

If elected, the online service will replace the receipt of paper copy versions of the Explanations of Benefits. (Claims that are reimbursed by paper check will continue to be printed on paper and sent via mail.) Online settlement data presents several advantages:

- Better management and comprehension of your claims information.
- Reduced processing and delivery time, since online data is available two working days after processing.
- More efficient MIP utilization, as all information regarding the medical plan(coverage, forms, contacts, provider list, Explanations of Benefits, etc.) is centralized online.
- You may print a paper version of the Explanation of Benefits from the Internet for your permanent record and possible use for follow-up or appeal.
- Continuous accessibility, 24 hours a day.
- Access to data is available up to 24 months after the date that MIP coverage ends.

19.02.3 PharmaCare

PharmaCare's web site, www.pharmacare.com/members/worldbank, allows users to access information and tools regarding the MIP's network prescription drug benefit, including:

- A locator tool to find a participating pharmacy in the U.S.;
- Latest list of formulary drugs, including a formulary calculator tool;
- A co-payment counselor; online pharmacy services;
- Forms including PharmaCare Direct applications for mail-order prescriptions;
- disease information; and
- A drug reference guide.

A protected website is available at www.pharmacare.com for those who wish to enroll for ongoing mail order services and other member specific services.

20 MIP Contact Information

20.01 How to Contact Aetna

Claims service, plan coverage queries, pre-determination of benefits, replacement of ID cards, online responses to common questions. In all correspondence, please include your UPI number and contact information.		
Email:	mclaims@aetna.com	
Web:	www.aetna.com	
To find providers and hospitals outside the US	www.aetnaglobalbenefits.com Note, provider information is password protected. Use your Aetna Navigator user ID and password to access	
Member Services	1-800-723-8897 (toll-free) or 1-202-473-8666 Collect calls accepted: 1-813-775-0190 Available 24 hours, 7 days a week	
Fax:	Medical: 1-800-475-8751 (toll free) or 1-813-775-0625 Dental: 1-860-754-0302 Always note - ATTN: WORLD BANK CLAIMS and include your UPI/Staff Number	
Mailing Address (not for use in appeals):	AETNA/WORLD BANK MIP P.O. BOX 14199 LEXINGTON KY 40512-4199	AETNA/WORLD BANK MIP MSN MC C3-309 WASHINGTON DC 20433
Courier Address:	AETNA/WORLD BANK MIP 2031 GEORGETOWN RD STE 200 LEXINGTON, KY 40511	
Mailing Address for Appeals Only	AETNA/WORLD BANK MIP APPEALS P.O. BOX 14463 LEXINGTON, KY 40512-4463	

20.02 How to Contact PharmaCare

Replacement of network pharmacy ID cards, participating PharmaCare network pharmacies in the U.S., formulary information, mail-order prescription drugs from PharmaCare Direct	
Web:	www.pharmacare.com/members/worldbank for general information or www.pharmacare.com for member customized website
Customer Service:	1-800-947-3826 (toll free) Although PharmaCare is for prescriptions in the US, this number is toll free from most countries if you need information before you travel to US. US pharmacies may only fill prescriptions from US licensed physicians.

20.03 How to Contact Vanbreda

Email:	mcc200@vanbreda.com
Web	<p>www.vanbreda-international.com</p> <p>To search for providers:</p> <ul style="list-style-type: none"> ● Click on "Personal Access." ● In the first line, "Personal Reference Number," in the leftmost box, type 200 ● In the right box of "Personal Reference Number," type WB0000 (case sensitive) ● In the second line, "Date of Birth," type 05 / 05 / 1962 (slashes not required) ● Click on ENTER
Contact Center Available 24/7	++32 (3) 217.57.98 +800.3.217.57.98 toll-free from selected countries ¹⁶
Fax:	++32 (3) 236.75.38
Mailing Address:	Vanbreda International Postbox 69 B-2140 Antwerpen BELGIUM
Health Systems International Customer Service:	U.S. in-network medical claims only: +1-800-962-6831 (toll-free within the U.S.)
Health Systems International Web:	www.us-hsi.com

¹⁶ To access the toll-free number, first dial the international prefix in your country, and then dial the toll-free number. The Vanbreda toll-free number may be used from the following countries (subject to change): Australia, Austria, Canada, China, Denmark, Finland, France, Germany, Hong Kong, Hungary, Ireland, Israel, Italy, Japan, Netherlands, Norway, Portugal, Singapore, South Korea, Spain, Sweden, United Kingdom and U.S.

20.04 How to Contact the HR Service Center

Contact the HR Service Center for enrollment, including national health scheme enrollments, eligibility changes and queries. Active Staff should use the HR Kiosk to make their address changes. Retiree address changes must be reported to the Bank Group's Pension Administration (Section 20.05 below).

Mail	HR Service Center, World Bank MSN G2-202, P.O. Box 27290, Washington, DC 20038-7290, USA
E-Mail	hrservicecenter@worldbank.org. ALWAYS include your UPI/Staff Number in all correspondence.
Telephone	202-473-2222 from 9 a.m. to 5 p.m. (Washington time), Monday through Friday. We have voice mail for after-hours, weekend or holiday calls.
Fax	202-522-2150. ALWAYS include your UPI/Staff Number in all correspondence.
Location	1776 G Street NW in Washington, D.C. in Room G2-132, but this is not our mailing address! Our walk-in hours are 10 a.m. to 5 p.m. or call to make an appointment

20.05 How to Contact Pension Administration

Contact Pension Administration for pension mailing address changes.

Mail	Pension, World Bank MSN MC7-710, Washington, DC 20433, USA
E-Mail	1pension@worldbank.org. ALWAYS include your UPI/Staff Number in all correspondence.
Phone	202-458-2977
Fax	202-522-1723. ALWAYS include your UPI/Staff Number in all correspondence.
Location	1818 H Street NW in Washington, D.C. in Room MC7-201, but this is not our mailing address!

21 Benefit Summaries

The Benefits Summaries in this section highlight the covered expenses and the corresponding coinsurance or co-payment amounts that apply to each expense. Domestic Administrator summaries are first, International summaries appear second.

21.01 How Do I Determine Which Benefits Summary to Use?

You may contact your Insurance Administrator's Member Services to determine your precise coverage. Active staff may also review their payroll stub or medical insurance benefits in the HRKiosk (<http://hrkiosk>). The HR Service Center can also assist you.

21.01.1 Active Staff (Aetna)

The easiest way to determine your Active Staff Option is to look at your Aetna insurance card. Option A and Option C list a \$15 office visit co-payment, and Option B lists a \$20 office visit co-payment. Option C will list a "Primary Care Physician" and have "MC/NAP" printed on the top right, near the World Bank Group logo.

21.01.2 Active Staff (Vanbreda)

If you are enrolled with Vanbreda, you can review your Health Systems International card to determine your MIP coverage. An office visit co-payment of \$15 means you are enrolled in Option A, and an office visit co-payment of \$20 means you are enrolled in Option B.

21.01.3 Retirees (Aetna)

If your Aetna insurance card lists a \$15 office visit co-payment, you are enrolled in Retiree Plan 1. If a \$20 office visit co-payment is listed, you are in Retiree Plan 2.

21.01.4 Retirees (Vanbreda)

If you are enrolled with Vanbreda, you can review your Health Systems International card to determine your MIP coverage. An office visit co-payment of \$15 means you are enrolled in Retiree Plan 1, and an office visit co-payment of \$20 means you are enrolled in Retiree Plan 2.

21.02 Aetna Active Staff Medical and Pharmacy Benefit Summaries for Options A, B, C

Option A (Page 1 of 2)		
Effective January 1, 2007	US Network – Aetna Open Choice PPO	Out-of-Network
General		
Medical Deductible (per person)	\$250 per calendar year	
Medical Deductible (per family)	\$500 per calendar year	
PharmaCare Deductible (per person)	\$50	
Medical Out-of-pocket limits (excludes co-payments and out-of-pocket expenses for mental health and substance abuse office visits and dental services).		
Medical out-of-pocket limits per person	\$2,500 per calendar year	
Medical out-of-pocket limits per family	\$5,000 per calendar year	
Office visits		
Routine physical, well baby visits, illness, ObGyn, Pap smear, Specialist	100% after \$15 co-pay	80% after deductible
Immunizations	100%, co-pay waived if no office visit	
Mammograms, routine PSA test	100%, once per calendar year	
Emergency room related		
Emergency Room	90%, no deductible 80% after deductible if non-emergency use	
Ambulance Services	90%, no deductible	
Inpatient		
Hospital costs including anesthesia	90%, no deductible	80% after deductible
Surgery (physician)		
Hospice		
Outpatient		
Facility charges, anesthesia, surgeon fees	90%, no deductible	80% after deductible
Hospice		
Laboratory and X-rays		
All services (including those provided during office visits and routine exams)	90%, no deductible	80% after deductible
Chemotherapy and Radiation Therapy		
Chemotherapy and Radiation Therapy	100%, no deductible for in-office/facility administration Does not include oral medications purchased through pharmacy	
Maternity		
Obstetrics: Single fee/delivery charge incl. Office visits	90%, no deductible	80% after deductible
Obstetrics: Office visits billed separately from single fee	100% after \$15 co-pay	
Infertility	90%, no deductible	
Infertility Lifetime Limits	Artificial Insemination or Ovulation Induction: 6 attempts each Advanced Reproduction Therapy: \$50,000 for medical services and prescription drugs combined	
Mental Health and Substance Abuse		
Inpatient hospitalization	90%, no deductible	80% after deductible
Outpatient facility		
Office visit		
Annual limits	50 office visits per calendar year Combined Mental Health and Substance Abuse	
Lifetime maximum	90 days hospitalization for Substance Abuse only	
Nursing and Home Health Care		
Skilled Nursing Facility (e.g., Rehabilitation Center) <i>Maximum 60 days per condition per calendar year</i>	90%, no deductible	80% after deductible
Visiting Nurse <i>Maximum 120 days per condition per calendar year</i>		
Private Duty Nursing		

Option A (Page 2 of 2)		
Effective January 1, 2007	US Network – Aetna Open Choice PPO	Out-of-Network
Short Term Rehabilitation		
Physical, occupational or speech therapy – <i>Restorative service after illness or accident</i>	100% after \$15 office co-pay	80% after deductible
Physical, occupational or speech therapy – <i>For diagnosis of Development Delay a maximum 60 visits PT, OT, ST combined, per year, per child</i>		
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	80% after deductible
Vision Care		
Routine eye exams (one per calendar year) including refraction	100% after \$15 co-pay	80% after deductible
Frames, lenses, contacts	Up to \$100 per year, claim form required	
Hearing Aids		
Hearing Aids	Maximum \$2,000 per person, every five years, claim form required	
Prescription drugs	US Network - PharmaCare	All other
Out-of-pocket limits per person	\$1,000 per calendar year	Medical out-of-pocket limits above apply
Out-of-pocket limits per family	\$2,000 per calendar year	
Generic (retail or mail order)	100%, no deductible	80% after medical deductible
Brand-name (retail)	80% after \$50 deductible	80% after medical deductible
Brand-name (mail order)	\$30/90-day supply, no deductible	Not applicable
Specialty drugs	80% after \$50 brand-name deductible. Dispensed only through PharmaCare Specialty Pharmacy	80% after medical deductible
Dental	US Network – Aetna Dental PPO	All other
Deductibles		
Deductible (per person)	\$250	
Deductible (per family)	\$500	
Maximum Coverage		
Dental Expenses per person	\$3,200 per calendar 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 for permanent molars		
Minor Restorative and other dentally necessary services as determined by administrator, e.g., third cleaning		
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	

Option B (Page 1 of 2)		
Effective January 1, 2007	US Network – Aetna Open Choice PPO	Out-of-Network
General		
Medical Deductible (per person)	\$600 per calendar year	
Medical Deductible (per family)	\$1,200 per calendar year	
PharmaCare Deductible (per person)	\$50	
Medical Out-of-pocket limits (excludes co-payments and out-of-pocket expenses for mental health and substance abuse office visits and dental services).		
Medical out-of-pocket limits per person	\$2,500 per calendar year	
Medical out-of-pocket limits per family	\$5,000 per calendar year	
Office visits		
Routine physical, well baby visits, illness, ObGyn, Pap smear, Specialist	100% after \$20 co-pay	80% after deductible
Immunizations	100%, co-pay waived if no office visit	
Mammograms, routine PSA test	100% - once per calendar year	
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		
Facility charges, anesthesia, surgeon fees	90%, after deductible	80% after deductible
Hospice		
Laboratory and X-rays		
All services (including those provided during office visits and routine exams)	90%, after deductible	80% after deductible
Chemotherapy and Radiation Therapy		
Chemotherapy and Radiation Therapy	100%, no deductible - in office/facility administration Does not include oral medications purchased through pharmacy	
Maternity		
Obstetrics: Single fee/delivery charge incl. Office visits	90%, after deductible	80% after deductible
Obstetrics: Office visits billed separately from single fee	100% after \$20 co-pay	
Infertility	90%, after deductible	
Infertility Lifetime Limits	Artificial Insemination or Ovulation Induction: 6 attempts each. Advanced Reproduction Therapy: \$50,000 for medical services and prescription drugs combined	
Mental Health and Substance Abuse		
Inpatient hospitalization	90%, after deductible	80% after deductible
Outpatient facility		
Office visit		
Annual limits	50 office visits per calendar year Combined Mental Health and Substance Abuse	
Lifetime maximum	90 days hospitalization for Substance Abuse only	
Nursing and Home Health Care		
Skilled Nursing Facility (e.g., Rehabilitation Center) <i>Maximum 60 days per condition per calendar year</i>	90%, after deductible	80% after deductible
Visiting Nurse <i>Maximum 120 days per condition per calendar</i>		
Private Duty Nursing		

Option B (Page 2 of 2)		
Effective January 1, 2007	US Network – Aetna Open Choice PPO	Out-of-Network
Short Term Rehabilitation		
Physical, occupational or speech therapy – <i>Restorative service after illness or accident</i>	100% after \$20 office co-pay	80% after deductible
Physical, occupational or speech therapy – <i>For diagnosis of Development Delay a maximum 60 visits PT, OT, ST combined, per year, per child</i>		
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		
Routine eye exams (one per calendar year) including refraction	100% after \$20 co-pay	80% after deductible
Frames, lenses, contacts	Up to \$100 per year, claim form required	
Hearing Aids		
Hearing Aids	Maximum \$2,000 per person, every five years, claim form required	
Prescription drugs		
	US Network - PharmaCare	All other
Out-of-pocket limits per person	\$1,000 per calendar year	Medical out-of-pocket limits above apply
Out-of-pocket limits per family	\$2,000 per calendar year	
Generic (retail or mail order)	100%, no deductible	80% after medical deductible
Brand-name (retail)	80% after \$50 deductible	
Brand-name (mail order)	\$30/90-day supply, no deductible	Not applicable
Specialty drugs	80% after \$50 brand-name deductible. Dispensed only through PharmaCare Specialty Pharmacy	80% after medical deductible
Dental		
	US Network – Aetna Dental PPO	All other
Deductibles		
Deductible (per person)	\$250	
Deductible (per family)	\$500	
Maximum Coverage		
Dental Expenses per person	\$3,200 per calendar year	
Periodontal-Surgical expenses	No limit	
Orthodontia Lifetime Limit	\$2,400 per insured	
Preventative Care		
Two routine oral exams per year including cleaning	100%, after deductible	80%, after deductible
Diagnostic X-rays, fluoride treatment, sealants for permanent molars		
Minor Restorative and other dentally necessary services as determined by administrator, e.g., third cleaning		
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	

Option C (Page 1 of 2)		
Effective January 1, 2007	US Network – Aetna Managed Choice POS	Out-of-Network
General		
Medical Deductible (per person)	\$300 per calendar year	
Medical Deductible (per family)	\$600 per calendar year	
PharmaCare Deductible (per person)	\$50	
Medical Out-of-pocket limits (excludes co-payments and out-of-pocket expenses for mental health and substance abuse office visits and dental services).		
Medical out-of-pocket limits per person	\$3,000 per calendar year	
Medical out-of-pocket limits per family	\$6,000 per calendar year	
Office visits		
Routine physical, well baby visits, illness with PCP. <i>Must have referral for Specialist from PCP in network</i>	100% after \$15 co-pay ObGyn – no referral required	80% after deductible
Immunizations	100%, co-pay waived if no office visit	
Mammograms, routine PSA test	100% - once per calendar year	
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%, if referred by PCP	80% after deductible
Surgery (physician)		
Hospice		
Outpatient		
Facility charges, anesthesia, surgeon fees	100%, if referred by PCP	80% after deductible
Hospice		
Laboratory and X-rays		
All services (including those provided during office visits and routine exams)	100%, if referred by PCP	80% after deductible
Chemotherapy and Radiation Therapy		
Chemotherapy and Radiation Therapy	100%, no deductible - in office/facility administration Does not include oral medications purchased through pharmacy	
Maternity		
Obstetrics: Single fee/delivery charge incl. Office visits	100%	80% after deductible
Obstetrics: Office visits billed separately from single fee	100% after \$15 co-pay	
Infertility	100%, if referred by PCP	
Infertility Lifetime Limits	Artificial Insemination or Ovulation Induction: 6 attempts each. Advanced Reproduction Therapy: \$50,000 for medical services and prescription drugs combined	
Mental Health and Substance Abuse		
Inpatient hospitalization	100%, if referred	80% after deductible
Outpatient facility		
Office visit	100% after \$15 co-pay No referral required from PCP	
Annual limits	50 office visits per calendar year combined Mental Health and Substance Abuse	
Lifetime maximum	90 days hospitalization for Substance Abuse only	
Nursing and Home Health Care		
Skilled Nursing Facility, (e.g., Rehabilitation Center). <i>Maximum 60 days per condition per calendar year</i>	100%, if referred by PCP	80% after deductible
Visiting Nurse – <i>Maximum 120 days per condition per calendar year</i>		
Private Duty Nursing		

Option C (Page 2 of 2)		
Effective January 1, 2007	US Network – Aetna Managed Choice POS	Out-of-Network
Short Term Rehabilitation		
Physical, occupational or speech therapy – <i>Restorative service after illness or accident</i>	100% after \$15 office co-pay, if referred by PCP	80% after deductible
Physical, occupational or speech therapy – <i>For diagnosis of Development Delay a maximum 60 visits PT, OT, ST combined, per year, per child</i>		
Chiropractor (30 visit limit per year)		
Acupuncture (30 visit limit per year)	Currently no providers	
Durable Medical Equipment		
Durable Medical Equipment rentals. Purchases only if approved by Insurance Administrator	100%, if PCP refers	80% after deductible
Vision Care		
Routine eye exams (one per calendar year) including refraction. No PCP referral required for routine exam	100% after \$15 co-pay	80% after deductible
Frames, lenses, contacts	Up to \$100 per year, claim form required	
Hearing Aids		
Hearing Aids	Maximum \$2,000 per person, every five years, claim form required	
Prescription drugs		
	US Network - PharmaCare	All other
Out-of-pocket limits per person	\$1,000 per calendar year	Medical out-of-pocket limits above apply
Out-of-pocket limits per family	\$2,000 per calendar year	
Generic (retail or mail order)	100%, no deductible	80% after medical deductible
Brand-name (retail)	80% after \$50 deductible	80% after medical deductible
Brand-name (mail order)	\$30/90-day supply, no deductible	Not applicable
Specialty drugs	80% after \$50 brand-name deductible. Dispensed only through PharmaCare Specialty Pharmacy	80% after medical deductible
Dental		
	US Network – Aetna Dental PPO	All other
Deductibles		
Deductible (per person)	\$250	
Deductible (per family)	\$500	
Maximum Coverage		
Dental Expenses per person	\$3,200 per calendar year	
Periodontal-Surgical expenses	No limit	
Orthodontia Lifetime Limit	\$2,400 per insured	
Preventative Care		
Two routine oral exams per year including cleaning	100%, after deductible	80%, after deductible
Diagnostic X-rays, fluoride treatment, sealants for permanent molars		
Minor Restorative and other dentally necessary services as determined by administrator, e.g., third cleaning		
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	

21.03 Aetna Retiree Benefit Summaries for Plans 1 and 2

Plan 1 (Page 1 of 2)		
Effective January 1, 2007	In-Network Aetna Open Choice PPO	Out-of-Network
General		
Medical Deductible (per person)	\$400 per calendar year	
Medical Deductible (per family)	\$800 per calendar year	
Out-of-pocket limits (excludes co-payments and out-of-pocket expenses for mental health and substance abuse office visits and dental services)		
Medical out-of-pocket limit per person	\$3,250 per calendar year	
Medical out-of-pocket limits per family	\$6,500 per calendar year	
Pharmacy out-of-pocket limit per person	\$1,250 per calendar year	Apply to Medical out-of-pocket limit above
Pharmacy out-of-pocket limits per family	\$2,500 per calendar year	Apply to Medical out-of-pocket limit above
Office visits		
Routine physical or OB/GYN, Pap smear, well baby visit	100% after \$15 copay	80% after deductible
Illness		
Immunizations	100% if no office visit	
Mammogram, routine PSA test	100%	80% after deductible
Emergency room related		
Emergency Room	90% after deductible (80% after deductible if non-emergency use)	
Ambulance Services	90% after deductible	90% after deductible
Inpatient		
Hospital costs including anesthesia	90% after deductible	
Surgery (physician)		
Hospice		
Outpatient		
Facility charges, anesthesia, surgery (physician)	90% after deductible	
Hospice		
Laboratory and X-rays		
All services	90% after deductible	80% after deductible
Chemotherapy and Radiation Therapy		
Chemotherapy and Radiation Therapy	100% - in office/facility administration Does not include oral medications purchased through pharmacy	
Maternity		
Obstetrics: Single fee/delivery charge incl. Office visits	90% after deductible	80% after deductible
Obstetrics: Office visits billed separately from single fee	100% after \$15 copay	80% after deductible
Infertility	90% after deductible	80% after deductible
Infertility Lifetime Limits	Artificial Insemination or Ovulation Induction: 6 attempts each. Advanced Reproduction Therapy: \$50,000 for medical services and prescription drugs combined	
Mental Health and Substance Abuse		
Inpatient hospitalization	90% after deductible	90% after deductible
Outpatient facility	90% after deductible	90% after deductible
Office visit	100% after \$15 copay	80% after deductible
Annual limits	50 office visits per calendar year combined Mental Health and Substance Abuse	
Lifetime maximum	90 days hospitalization (Substance Abuse only)	
Nursing and Home Health Care		
Skilled Nursing Facility (e.g., Rehabilitation Center) <i>Maximum 60 days per condition per calendar year</i>	90% after deductible	80% after deductible
Visiting Nurse <i>Maximum 120 days per condition per calendar</i>		
Private Duty Nursing		

Plan 1 (Page 2 of 2)		
Effective January 1, 2007	In-Network Aetna Open Choice PPO	Out-of-Network
Short Term Rehabilitation		
Physical, occupational or speech therapy – Restorative service after illness or accident	100% after \$15 co-pay	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		
Routine eye exams (one per calendar year) including refraction	100% after \$15 copay	80% after deductible
Frames, lenses, contacts	Up to \$100 per year, claim form required	
Hearing Aids		
Hearing Aids	Up to \$2,000 per person, every five plan years, claim form required	
Prescription drugs		
	PharmaCare	All other
Pharmacy out-of-pocket limits per person	\$1,250 per calendar year	Apply to medical out-of-pocket limits above
Pharmacy out-of-pocket limits per family	\$2,500 per calendar year	
Annual deductible, per person	\$100	Generics and Brand Names 80% after medical deductible
Generic (retail or mail order)	100%, no deductible	
Brand-name Formulary	80%, subject to deductible	
Brand-name Non-Formulary	70%, subject to deductible	Not applicable
Brand-name Mail Order	Co pay based on Formulary or Non Formulary - No deductible	
Specialty Pharmacy	80%, subject to deductible	80% after medical deductible
Dental		
	Aetna Dental PPO	All other
Deductibles		
Deductible (per person)	\$250	
Deductible (per family)	\$500	
Maximum Coverage		
Dental Expenses per person	\$3,200 per calendar year	
Periodontal-Surgical expenses	No limit	
Orthodontia	\$2,400 per insured (lifetime limit)	
Preventative Care		
Two routine oral exams per year including cleaning	100%, no deductible	80%, no deductible
Diagnostic X-rays, fluoride treatment, sealants		
Minor Restorative and other dentally necessary services as determined by administrator, eg, third cleaning		
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	

Plan 2 (Page 1 of 2)		
Effective January 1, 2007	In-Network Aetna Open Choice PPO	Out-of-Network
General		
Medical Deductible (per person)	\$600 per calendar year	
Medical Deductible (per family)	\$1,200 per calendar year	
Out-of-pocket limits (excludes co-payments and out-of-pocket expenses for mental health and substance abuse office visits and dental services)		
Medical out-of-pocket limits per person	\$4,000 per calendar year	
Medical out-of-pocket limits per family	\$8,000 per calendar year	
Pharmacy out-of-pocket limits per person	\$1,250 per calendar year	Apply to Medical out-of-pocket limits above
Pharmacy out-of-pocket limits per family	\$2,500 per calendar year	Apply to Medical out-of-pocket limits above
Office visits		
Routine physical or OB/GYN, Pap smear, well baby visit	100% after \$20 co-pay	80% after deductible
Illness		
Immunizations	100% if no office visit charge	
Mammograms, routine PSA test	100%	80% after deductible
Emergency room related		
Emergency Room	80% after deductible	80% after deductible
Non-emergency use of Emergency Room		
Ambulance Services		
Inpatient		
Hospital costs including anesthesia	80% after deductible	80% after deductible
Surgery (physician)		
Hospice		
Outpatient		
Facility charges, anesthesia, surgery (physician)	80% after deductible	80% after deductible
Hospice		
Laboratory and X-rays		
All services	80% after deductible	80% after deductible
Chemotherapy and Radiation Therapy		
Chemotherapy and Radiation Therapy	100%,no deductible - in office/facility administration Does not include oral medications purchased through pharmacy	
Maternity		
Obstetrics: Single fee delivery charge incl. Office visits	80% after deductible	80% after deductible
Obstetrics: Office visits billed separately from single fee	100% after \$20 co-pay	
Infertility	80% after deductible	
Infertility Lifetime Limits	Artificial Insemination or Ovulation Induction: 6 attempts each. Advanced Reproduction Therapy: \$50,000 for medical services and prescription drugs combined	
Mental Health and Substance Abuse		
Inpatient hospitalization	80% after deductible	80% after deductible
Outpatient facility	80% after deductible	
Office visit	100% after \$20 co-pay	
Annual limits	50 office visits per calendar year combined Mental Health and Substance Abuse	
Lifetime maximum	90 days hospitalization (Substance Abuse only)	
Nursing and Home Health Care		
Skilled Nursing Facility (e.g., Rehabilitation Center) <i>Maximum 60 days per condition per calendar year</i>	80% after deductible	80% after deductible
Visiting Nurse <i>Maximum 120 days per condition per calendar year</i>		
Private Duty Nursing		

Plan 2 (Page 2 of 2)		
Effective January 1, 2007	In-Network Aetna Open Choice PPO	Out-of-Network
Short Term Rehabilitation		
Physical, occupational or speech therapy <i>Restorative services after illness or accident</i>	100% after \$20 co-pay	80% after deductible
Physical, occupational or speech therapy <i>For diagnosis of Development Delay a maximum 60 visits PT, OT, ST combined, per year, per child</i>		
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	80% after deductible	80% after deductible
Vision Care		
Routine eye exams (one per calendar year) including refraction	100% after \$20 co-pay	80% after deductible
Frames, lenses, contacts	Up to \$100 per year, claim form required	
Hearing Aids		
Hearing Aids	Up to \$2,000 per person, every five plan years, claim form required	
Prescription drugs		
	PharmaCare	All other
Pharmacy out-of-pocket limits per person	\$1,250 per calendar year	Apply to medical out-of-pocket limits above
Pharmacy out-of-pocket limits per family	\$2,500 per calendar year	
Annual deductible, per person	\$100	Generics and Brand Names 80% after medical deductible
Generic (retail or mail order)	100%, no deductible	
Brand-name Formulary	80%, subject to deductible	
Brand-name Non-Formulary	70%, subject to deductible	Not applicable
Brand-name Mail Order	Copay based on Formulary or Non Formulary - No deductible	
Specialty Pharmacy	80%, subject to deductible	
Specialty Pharmacy	80%, subject to deductible	80% after medical deductible
Dental		
	Aetna Dental PPO	All other
Deductibles		
Deductible (per person)	\$250	
Deductible (per family)	\$500	
Maximum Coverage		
Dental Expenses per person	\$2,000 per calendar year	
Periodontal-Surgical expenses	No limit	
Orthodontia	\$1,000 per insured (lifetime limit)	
Preventative Care		
Two routine oral exams per year including cleaning	100%, no deductible	80%, no deductible
Diagnostic X-rays, fluoride treatment, sealants		
Minor Restorative and other dentally necessary services as determined by administrator, eg, third cleaning		
Periodontics, endodontics, fillings, extractions	80% after deductible	
Major Restorative		
Crowns, inlays, bridges, dentures, implant devices	50% after deductible	
Special Periodontics and Oral Surgery		
Gingivectomy, gingioplasty, alveoplasty, vestibuloplasty, osseous surgery, implant surgery, oral surgery	50% after deductible	
Orthodontics		
Orthodontics	50% after deductible	

21.04 Vanbreda Active Staff Medical and Pharmacy Benefit Summaries for Options A and B

International Option Plan A (Page 1 of 3)		
Effective January 1, 2007	In-Network (HSI-US)	Out-of-Network
General		
Deductible (per person)	\$250 per calendar year	
Deductible (per family)	\$500 per calendar year	
Medical Network (U.S. only)	Health Systems International	Not applicable
Pharmacy Network (U.S. only)	See PharmaCare below	
Dental Network (U.S. only)	Not applicable	
Out-of-pocket limits (excludes co-payments and out-of-pocket expenses for outpatient mental health, substance abuse office visits and dental services)		
Medical out-of-pocket limits per person	\$3,000 per calendar year	
Medical out-of-pocket limits per family	\$6,000 per calendar year	
Office visits		
Routine physical, OB/GYN visit, Pap smear, well baby visit	100% after \$15 co-pay	80% after deductible
Illness / Specialist		
Immunizations	100% Co-pay waived if no office visit	
Mammograms, routine PSA test	100%	
Emergency room related		
Emergency Room	90%, no deductible 80% after deductible if non-emergency use	
Ambulance Services	90%, no deductible	
Inpatient		
Hospital costs including anesthesia	90%, no deductible	80% after deductible
Surgery (physician)		
Hospice		
Outpatient		
Facility charges, anesthesia, surgery (physician)	90%, no deductible	80% after deductible
Hospice		
Laboratory and X-rays		
All services (including those provided during office visits)	90%, no deductible	80% after deductible
Chemotherapy and Radiation Therapy		
Chemotherapy and Radiation Therapy	100%, no deductible - in office/facility administration Does not include oral medications purchased through pharmacy	
Maternity		
Obstetrics: Single fee/delivery charge incl. Office visits	90%, no deductible	80% after deductible
Obstetrics: Office visits billed separately from single fee	100% after \$15 co-pay	
Infertility	90%, no deductible	
Infertility Lifetime Limits	Artificial Insemination or Ovulation Induction: 6 attempts each. Advanced Reproduction Therapy: \$50,000 for medical services and prescription drugs combined	
Mental Health and Substance Abuse		
Inpatient hospitalization	90%, no deductible	80% after deductible
Outpatient facility		
Office visit		
Annual limits	50 office visits per calendar year - Combined Mental Health and Substance Abuse	
Lifetime maximum	90 days hospitalization for Substance Abuse only	

International Option Plan A (Page 2 of 3)		
Effective January 1, 2007	In-Network (HSI – US)	Out-of-Network
Nursing and Home Health Care		
Skilled Nursing Facility (e.g., Rehabilitation Center), Limited to 60 days per condition per calendar year	90%, no deductible	80% after deductible
Visiting Nurse, Limited to 120 days per condition per calendar year		
Private Duty Nursing		
Short Term Rehabilitation		
Physical, occupational or speech therapy – <i>Restorative service after illness or accident</i>	100% after \$15 office co-pay	80% after deductible
Physical, occupational or speech therapy – <i>For diagnosis of Development Delay a maximum 60 visits PT, OT, ST combined, per year, per child</i>		
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	80% after deductible
Vision Care		
Routine eye exams (one per calendar year), including refraction	100% after \$15 co-payment	80% after deductible
Frames, lenses, contacts	Up to \$100 per year, claim form required	
Hearing Aids		
Hearing Aids	Maximum \$2,000 per person, every five plan years, claim form required	
Prescription drugs		
	PharmaCare (U.S. only)¹⁷	All other
Out-of-pocket limits per person	\$1,000 per calendar year	Medical out-of-pocket limits above apply
Out-of-pocket limits per family	\$2,000 per calendar year	
Generic (retail or mail order)	100%, no deductible	80% after medical deductible ; mail-order not applicable
Brand-name (retail)	80% after \$50 deductible	80% after medical deductible
Brand-name (mail order)	\$30/90-day supply, no deductible	Not applicable
Specialty drugs	80% after \$50 brand-name deductible. Dispensed only through PharmaCare Specialty Pharmacy.	80% after medical deductible

¹⁷ For International Option participants, PharmaCare will send U.S. network pharmacy purchase information to Vanbreda annually for reconciliation. International Option participants who met their medical out-of-pocket expenses during a calendar year and who also had PharmaCare out-of-pocket expenses for U.S. drug purchases during the same calendar year will receive reimbursement of the out-of-pocket PharmaCare costs from Vanbreda after the reconciliation.

International Option Plan A (Page 3 of 3)	
Dental Benefits - No Dental Network available for Vanbreda	
General	
Network	No dental network available for Vanbreda
Deductibles	
Deductible (per person)	\$250
Deductible (per family)	\$500
Year-end carryover	None
Maximum Coverage	
Dental Expenses per person	\$3,200 per calendar 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
Diagnostic X-rays, fluoride treatment, sealants	
Minor Restorative and other dentally necessary services as determined by administrator, e.g., third cleaning	
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	80% after deductible
Orthodontics	
Orthodontics	80% after deductible

International Option Plan B (Page 1 of 3)		
Effective January 1, 2007	In-Network (HSI – US)	Out-of-Network
General		
Deductible (per person)	\$600 per calendar year	
Deductible (per family)	\$1,200 per calendar year	
Medical Network (U.S. only)	Health Systems International	Not applicable
Pharmacy Network (U.S. only)	PharmaCare – see below	
Dental Network (U.S. only)	Not applicable	
Out-of-pocket limits (excludes co-payments and out-of-pocket expenses for outpatient mental health, substance abuse office visits and dental services)		
Medical out-of-pocket limits per person	\$3,000 per calendar year	
Medical out-of-pocket limits per family	\$6,000 per calendar year	
Office visits		
Routine physical, OB/GYN visit, Pap smear, well baby visit	100% after \$20 co-pay (Option B)	80% after deductible
Illness / Specialist		
Immunizations	100%	
Mammograms, routine PSA test	100%	
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		
Facility charges, anesthesia, surgery (physician)	90% after deductible	80% after deductible
Hospice		
Laboratory and X-rays		
All services (including those provided during office visits)	90% after deductible	80% after deductible
Chemotherapy and Radiation Therapy		
Chemotherapy and Radiation Therapy	100%, no deductible - in office/facility administration Does not include oral medications purchased through pharmacy	
Maternity		
Obstetrics: Single fee/delivery charge incl. Office visits	90% after deductible	80% after deductible
Obstetrics: Office visits billed separately from single fee	100% after \$20 co-pay	
Infertility	90% after deductible	
Infertility Lifetime Limits	Artificial Insemination or Ovulation Induction: 6 attempts each. Advanced Reproduction Therapy: \$50,000 for medical services and prescription drugs combined	
Mental Health and Substance Abuse		
Inpatient hospitalization	90% after deductible	80% after deductible
Outpatient facility		
Office visit	100% after \$20 co-pay	
Annual limits	50 office visits per calendar year Combined Mental Health and Substance Abuse	
Lifetime maximum	90 days hospitalization for Substance Abuse only	

International Option Plan B (Page 2 of 3)		
Effective January 1, 2007	In-Network (HSI – US)	Out-of-Network
Nursing and Home Health Care		
Skilled Nursing Facility (e.g., Rehabilitation Center), Limited to 60 days per condition per calendar year	90%, no deductible	80% after deductible
Visiting Nurse, Limited to 120 days per condition per calendar year		
Private Duty Nursing		
Short Term Rehabilitation		
Physical, occupational or speech therapy – <i>Restorative service after illness or accident</i>	100% after \$20 office co-pay	80% after deductible
Physical, occupational or speech therapy – <i>For diagnosis of Development Delay a maximum 60 visits PT, OT, ST combined, per year, per child</i>		
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		
Routine eye exams: One per calendar year including refraction	100% after \$20 co-pay	80% after deductible
Frames, lenses, contacts	Up to \$100 per year, claim form required	
Hearing Aids		
Hearing Aids	Maximum \$2,000 per person, every five plan years, claim form required	
Prescription drugs		
	PharmaCare (U.S. only)¹⁸	All other
Out-of-pocket limits per person	\$1,000 per calendar year	Medical out-of-pocket limits above apply
Out-of-pocket limits per family	\$2,000 per calendar year	
Generic (retail or mail order)	100%, no deductible	80% after medical deductible mail-order not applicable
Brand-name (retail)	80% after \$50 deductible	80% after medical deductible
Brand-name (mail order)	\$30/90-day supply, no deductible	Not applicable
Specialty drugs	80% after \$50 brand-name deductible. Dispensed only through PharmaCare Specialty Pharmacy.	80% after medical deductible

¹⁸ For International Option participants, PharmaCare will send U.S. network pharmacy purchase information to Vanbreda annually for reconciliation. International Option participants who met their medical out-of-pocket expenses during a calendar year and who also had PharmaCare out-of-pocket expenses for U.S. drug purchases during the same calendar year will receive reimbursement of the out-of-pocket PharmaCare costs from Vanbreda after the reconciliation.

International Option Plan B (Page 3 of 3)	
Dental - Effective January 1, 2007	
General	
Network	No dental network available for Vanbreda
Deductibles	
Deductible (per person)	\$250
Deductible (per family)	\$500
Year-end carryover	None
Maximum Coverage	
Dental Expenses per person	\$3,200 per calendar 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
Diagnostic X-rays, fluoride treatment, sealants	
Minor Restorative and other dentally necessary services as determined by administrator, e.g., third cleaning	
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	80% after deductible
Orthodontics	
Orthodontics	80% after deductible

21.05 Vanbreda Retiree Medical and Pharmacy Benefit Summaries for Plans 1 and 2

International Retiree Plan 1 (Page 1 of 3)		
Benefit	Plan 1 (effective January 1,2007)	
	Coverage except HSI	HSI network (in U.S. only)
General		
Medical Deductible (per person)	\$400 per calendar year	
Medical Deductible (per family)	\$800 per calendar year	
Out-of-pocket limits (excludes co-payments and out-of-pocket expenses for mental health and substance abuse office visits and dental services).		
Medical out-of-pocket limits per person	\$4,500 per calendar year	
Medical out-of-pocket limits per family	\$9,000 per calendar year	
Office visits		
Routine physical or OB/GYN, Pap smear, well baby visit	80% after deductible	100% after \$15 co-pay
Illness		100% Co-pay waived if no office visit
Immunizations		
Mammograms, routine PSA test	80% after deductible	100%
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	
Surgery (physician)		
Hospice		
Outpatient		
Facility charges, anesthesia, surgery (physician)	90% after deductible	
Hospice	90% after deductible	
Laboratory and X-rays		
All services	80% after deductible	90% after deductible
Chemotherapy and Radiation Therapy		
Chemotherapy and Radiation Therapy	100%,no deductible - in office/facility administration Does not include oral medications purchased through pharmacy	
Maternity		
Obstetrics: Single fee/delivery charge incl. Office visits	80% after deductible	90% after deductible
Obstetrics: Office visits billed separately from single fee		100% after \$15 co-pay
Infertility		90% after deductible
Infertility Lifetime Limits	Artificial Insemination or Ovulation Induction: 6 attempts each. Advanced Reproduction Therapy: \$50,000 for medical services and prescription drugs combined.	
Mental Health and Substance Abuse		
Inpatient hospitalization	90% after deductible	
Outpatient facility	90% after deductible	
Office visit	80% after deductible	100% after \$15 co-pay
Annual limits	50 office visits per calendar year combined Mental Health and Substance Abuse	
Lifetime maximum	90 days hospitalization (Substance Abuse only)	
Nursing and Home Health Care		
Skilled Nursing Facility (e.g., Rehabilitation Center) Maximum 60 days per condition per calendar year	80% after deductible	90% after deductible
Visiting Nurse (per condition per calendar year) Maximum 120 days per condition per calendar year		
Private Duty Nursing		

International Retiree Plan 1 (Page 2 of 3)		
Plan 1 (effective January 1, 2007)		
	Coverage except HSI	Coverage in U.S. using HSI
Short Term Rehabilitation		
Physical, occupational or speech therapy – restorative service after illness or accident	80% after deductible	100% after \$15 co-pay
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	80% after deductible	90% after deductible
Vision Care		
Routine eye exams (one per calendar year) including refraction	80% after deductible	100% after \$15 co-pay
Frames, lenses, contacts	Up to \$100 per year, claim form required	
Hearing Aids		
Hearing Aids	Up to \$2,000 per person, every five plan years, claim form required	
Prescription drugs		
	PharmaCare (U.S. only)¹⁹	All except PharmaCare
Pharmacy out-of-pocket limits per person	\$1,250 per calendar year	Medical out-of-pocket limits above apply
Pharmacy out-of-pocket limits per family	\$2,500 per calendar year	
Annual deductible, per person	\$100	Medical Deductible
Generic (retail or mail order)	100%, no deductible	80% after medical deductible
Brand-name Formulary	80%, subject to deductible	Mail order not applicable
Brand-name Non-Formulary	70%, subject to deductible	80% after medical deductible
Brand-name Mail Order	Co-pay based on Formulary or Non Formulary - No deductible	Not applicable
Specialty Pharmacy	80%, subject to deductible	80% after medical deductible

¹⁹ For International Option participants, PharmaCare will send U.S. network pharmacy purchase information to Vanbreda annually for reconciliation. International Option participants who met their medical out-of-pocket expenses during a calendar year and who also had PharmaCare out-of-pocket expenses for U.S. drug purchases during the same calendar year will receive reimbursement of the out-of-pocket PharmaCare costs from Vanbreda after the reconciliation.

International Retiree Plan 1 (Page 3 of 3)	
Benefit	Plan 1 (effective January 1, 2007)
Dental (no dental network available)	
Deductibles	
Deductible (per person)	\$250
Deductible (per family)	\$500
Maximum Coverage	
Dental Expenses per person	\$3,200 per calendar year
Periodontal-Surgical expenses	No limit
Orthodontia	\$2,400 per insured (lifetime limit)
Preventative Care	
Two routine oral exams per year including cleaning	100%, no deductible
Diagnostic X-rays, fluoride treatment, sealants	
Minor Restorative and other dentally necessary services as determined by administrator, e.g., third cleaning	
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
Orthodontics	
Orthodontics	80% after deductible

International Retiree Plan 2 (Page 1 of 3)		
Benefit	Plan 2 (effective January 1,2007)	
	Coverage except HSI	HSI network (in U.S. only)
General		
Medical Deductible (per person)	\$600 per calendar year	
Medical Deductible (per family)	\$1,200 per calendar year	
PharmaCare Deductible (per person)	\$100	
Out-of-pocket limits (excludes co-payments and out-of-pocket expenses for mental health and substance abuse office visits and dental services)		
Medical out-of-pocket limits per person	\$5,250 per calendar year	
Medical out-of-pocket limits per family	\$10,500 per calendar year	
Office visits		
Routine physical or OB/GYN, Pap smear, well baby visit	80% after deductible	100% after \$20 co-pay
Illness		100%
Immunizations		Co-pay waived if no office visit
Mammograms, routine PSA test	80% after deductible	100%
Emergency room related		
Emergency Room	80% after deductible	
Ambulance Services	80% after deductible	
Inpatient		
Hospital costs including anesthesia	80% after deductible	
Surgery (physician)		
Hospice		
Outpatient		
Facility charges, anesthesia, surgery (physician)	80% after deductible	
Hospice	80% after deductible	
Laboratory and X-rays		
All services	80% after deductible	80% after deductible
Chemotherapy and Radiation Therapy		
Chemotherapy and Radiation Therapy	100%,no deductible - in office/facility administration Does not include oral medications purchased through pharmacy	
Maternity		
Obstetrics: Single fee/delivery charge incl. Office visits	80% after deductible	80% after deductible
Obstetrics: Office visits billed separately from single fee		100% after \$20 co-pay
Infertility		80% after deductible
Infertility Lifetime Limits	Artificial Insemination or Ovulation Induction: 6 attempts each. Advanced Reproduction Therapy: \$50,000 for medical services and prescription drugs combined	
Mental Health and Substance Abuse		
Inpatient hospitalization	80% after deductible	
Outpatient facility	80% after deductible	
Office visit	80% after deductible	100% after \$20 co-pay
Annual limits	50 office visits per calendar year combined Mental Health and Substance Abuse	
Lifetime maximum	90 days hospitalization (Substance Abuse only)	
Nursing and Home Health Care		
Skilled Nursing Facility (e.g., Rehabilitation Center) Up to 60 days per condition per calendar year	80% after deductible	80% after deductible
Visiting Nurse Up to 120 visits per condition per calendar year		
Private Duty Nursing		

International Retiree Plan 2 (Page 2 of 3)		
	Plan 2 (effective January 1, 2007)	
Benefit	Coverage except HSI	Coverage in U.S. using HSI
Short Term Rehabilitation		
Physical, occupational or speech therapy – Restorative service after illness or accident	80% after deductible	100% after \$20 co-pay
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	80% after deductible	80% after deductible
Vision Care		
Routine eye exams: One per calendar year including refraction	80% after deductible	100% after \$20 co-pay
Frames, lenses, contacts	Up to \$100 per year, claim form required	
Hearing Aids		
Hearing Aids	Up to \$2,000 per person, every five plan years, claim form required	
Prescription drugs		
	PharmaCare (U.S. only)²⁰	All except PharmaCare
Pharmacy out-of-pocket limits per person	\$1,250 per calendar year	Non PharmaCare prescriptions
Pharmacy out-of-pocket limits per family	\$2,500 per calendar year	Covered under Medical
Annual deductible, per person	\$100	80% after medical deductible
Generic (retail or mail order)	100%, no deductible	80% after medical deductible
Brand-name Formulary	80%, subject to deductible	Mail order not applicable
Brand-name Non-Formulary	70%, subject to deductible	80% after medical deductible
Brand-name Mail Order	Co-pay based on Formulary or Non Formulary - No deductible	Not applicable
Specialty Pharmacy	80%, subject to deductible	80% after medical deductible

²⁰ For International Option participants, PharmaCare will send U.S. network pharmacy purchase information to Vanbreda annually for reconciliation. International Option participants who met their medical out-of-pocket expenses during a calendar year and who also had PharmaCare out-of-pocket expenses for U.S. drug purchases during the same calendar year will receive reimbursement of the out-of-pocket PharmaCare costs from Vanbreda after the reconciliation.

International Retiree Plan 2 (Page 3 of 3)	
Benefit	Plan 2 (effective January 1, 2007)
Dental (no dental network available for Vanbreda)	
Deductibles	
Deductible (per person)	\$250
Deductible (per family)	\$500
Maximum Coverage	
Dental Expenses per person	\$3,200 per calendar year
Periodontal-Surgical expenses	No limit
Orthodontia	\$2,400 per insured (lifetime limit)
Preventative Care	
Two routine oral exams per year including cleaning	100%, no deductible
Diagnostic X-rays, fluoride treatment, sealants	
Minor Restorative and other dentally necessary services as determined by administrator, eg, third cleaning	
Periodontics, endodontics, fillings, extractions	80% after deductible
Major Restorative	
Crowns, inlays, bridges, dentures, implant devices	50% after deductible
Special Periodontics and Oral Surgery	
Gingivectomy, gingioplasty, alveoplasty, vestibuloplasty, osseous surgery, implant surgery, oral surgery	50% after deductible
Orthodontics	
Orthodontics	50% after deductible

21.06 Aetna Sponsored Plan Medical, Dental and Pharmacy Benefit Summary

Effective January 1, 2007	In-Network Aetna Open Choice PPO	Out-of-Network
General		
Deductible (per person)	\$1,000 per calendar year	
Deductible (per family)	Not applicable	
Out-of-pocket limits (excludes co-payments and out-of-pocket expenses for outpatient mental health, substance abuse office visits and dental services)		
Medical out-of-pocket limits per person	\$5,000 per calendar year	
Pharmacy out-of-pocket limits per person	\$1,000 per calendar year	Apply to Medical out-of-pocket limits above
Office visits		
Routine physical	Not covered	
Routine OB/GYN, Pap smear	100% after \$20 co-pay	75% after deductible
Illness	100% after \$20 co-pay	
Immunizations	100% Co-pay waived if no office visit	
Mammograms, routine PSA test	100%	
Emergency room related		
Emergency Room	75% after deductible	
Non-emergency use of Emergency Room		
Ambulance Services		
Inpatient		
Hospital costs including anesthesia	75% after deductible	
Surgery (physician)		
Hospice		
Outpatient		
Facility charges, anesthesia, surgery (physician)	75% after deductible	75% after deductible
Hospice	75% after deductible	75% after deductible
Laboratory and X-rays		
All services	75% after deductible	75% after deductible
Chemotherapy and Radiation Therapy		
Chemotherapy and Radiation Therapy	100% no deductible for in-office/facility administration Does not include oral medications purchased through pharmacy	
Maternity		
Obstetrics	Not covered	
Infertility		
Infertility Lifetime Limits		
Mental Health and Substance Abuse		
Inpatient hospitalization	75% after deductible	75% after deductible
Outpatient facility	75% after deductible	
Office visit	100% after \$20 co-pay	
Annual limits	50 office visits per calendar year combined Mental Health and Substance Abuse	
Lifetime maximum	90 days hospitalization (Substance Abuse only)	
Nursing and Home Health Care		
Skilled Nursing Facility (e.g., Rehabilitation Center) <i>Maximum 60 days per condition per calendar year</i>	75% after deductible	
Visiting Nurse (per condition per calendar year) <i>Maximum 120 days per condition per calendar year</i>		
Private Duty Nursing		

Effective January 1, 2007	In-Network Aetna Open Choice PPO	Out-of-Network
Short Term Rehabilitation		
Physical, occupational or speech therapy - <i>Restorative service after illness or accident</i>	100% after \$20 co-pay	75% after deductible
Chiropractor (30 visit limit per year)		
Acupuncture (30 visit limit per year)	Currently no providers	75% after deductible
Durable Medical Equipment		
Durable Medical Equipment Rentals Purchases only if approved by Insurance Administrator	75% after deductible	75% after deductible
Vision Care		
Routine eye exams (one per calendar year) including refraction	100% after \$20 co-pay	75% after deductible
Frames, lenses, contacts	Up to \$100 per year, claim form required	
Hearing Aids		
Hearing Aids	Up to \$2,000 per person, every five plan years, claim form required	
Oral Surgery		
Gingivectomy, gingioplasty, alveoplasty, vestibuloplasty, osseous surgery, implant surgery, oral surgery	75% after deductible	
Prescription drugs		
	PharmaCare – see note	All other
Pharmacy out-of-pocket limits per person	\$1,000 per calendar year	Apply to medical out-of-pocket limits above
Annual deductible, per person	\$50	
Generic (retail or mail order)	100%, no deductible	Generics and Brand Names 80% after medical deductible
Brand-name Formulary	80%, subject to deductible	
Brand-name Non-Formulary	70%, subject to deductible	
Brand-name Mail Order	Co pay based on Formulary or Non Formulary - No deductible	Not applicable
Specialty Pharmacy	80%, subject to deductible	80% after medical deductible
Dental		
	Aetna Dental PPO	All other
All Dental Services		
All dental services except gingivectomy, gingioplasty, alveoplasty, vestibuloplasty, osseous surgery, implant surgery, oral surgery (see "Oral Surgery" above)	Not covered	

Note - On July 1, 2006, a three tier prescription Formulary was introduced for the Sponsored Parent Plan for drugs purchased through PharmaCare.

22 Glossary

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

Biologics. The term "biologics" applies to synthetic or recombinant versions of natural biologic substances, including proteins such as enzymes, soluble receptors, cytokines or antibodies, and nucleic acids such as DNA or RNA. Biologic drugs are much more complicated than conventional drugs and are injected.

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 USA.

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 an Licensed Practical Nurse (LPN) directed by a full-time RN;
- Physical restoration services to help patients to meet a goal of self-care in daily living activities.
- 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.

Coinsurance. The percentage of a covered amount you need to pay, with or without paying your calendar year deductible first. For example, if out-of-network care is reimbursed by the MIP at 80% after deductible, your coinsurance is 20%.

Co-payment. The flat fee you pay for certain types of covered services and supplies. The co-payments that apply are shown in the Benefit Summary chart. For example, for an in-network physician office visit, you would pay a \$15 or \$20 co-payment at the time of service. Additional services such as lab tests or x-rays are typically not included in this office visit co-payment and you are responsible for coinsurance for such additional Covered expenses.

Covered expenses. Those expenses which are Usual and Customary Charges for specified services and supplies that are 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 participant or family of participants must pay each calendar year before the MIP will begin to pay benefits. Some expenses do not count towards a deductible, such as office visit co-payments.

Dental Benefit Maximum. The maximum dental benefit payable for each participant each year. This maximum applies to all dental expenses except implant surgery, oral surgery, gingivectomy, gingivoplasty, alveoplasty, vestibuloplasty, osseous surgery and orthodontia. A separate lifetime maximum applies to orthodontia benefits for each insured person. These maximums are subject to change and the current amount is shown in the Benefit Summary for each MIP option (Section 02.02).

Dentist. A legally qualified dentist, or a physician licensed to do the dental work he or she performs.

Dependent. Your spouse (or registered domestic partner) and qualifying children only. A dependent child must be unmarried. A dependent child is defined as under age 19, or if aged 19-24, either a full-time student or earning less than \$10,712 gross per calendar year and for whom you provide more than half the financial support. Dependent children are also foster children who live in your household. Any dependent child who reaches age 25 remains eligible as long as the child is unmarried and incapable of self-sustaining employment by reason of mental retardation or physical handicap, as determined by the Insurance Administrator. Grandchildren may be dependent under exceptional, predefined circumstances (Section 14.05).

Durable Medical and Surgical 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.

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 fetus (in the case of a pregnant woman).

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 to be 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 have 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.

Family Deductible. The amount of Covered expenses a family must pay each calendar year before the MIP will begin to pay benefits. If your family incurs Covered expenses equal to the Family Deductible, the MIP will process claims as if each person's deductible has been met for the balance of that calendar year. Any amount of Covered expenses that you or any dependent pays during a year for a covered service will contribute towards the Family Deductible. A Sponsored Plan participant is not included in the MIP Family Deductible.

Formulary. A list of drugs (generic or brand name) that have been found to be most effective for the most number of patients by an independent group of pharmacists and physicians. Formulary prescriptions are usually less expensive to member and the plan.

Generic Drug. A prescription drug that is not protected by trademark registration, but is produced and sold under the same chemical formulation and sold under the chemical name as the brand name.

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 which 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 which 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, care for drug addicts or alcoholics, or a nursing home, and must make charges for services provided.

In-Network Benefits. Benefits for services obtained through a participating medical, dental 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. 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 participants for a negotiated charge. In general, in-network providers file all reimbursement requests and you are responsible only for your co-payment and/or coinsurance at the time of service. Also called "participating provider."

Insurance Administrator. The vendor with whom the Bank Group has contracted to provide administrative services. The Insurance Administrator has fiduciary responsibility to adjudicate claims per this document. There are two medical/dental administrators, Aetna and Vanbreda. Vanbreda is available only to Retiree MIP participants who have a pension mailing address outside of the U.S., and to Active Staff stationed for at least one calendar year outside of the U.S. In addition, PharmaCare provides prescription drug benefits management.

Investigational. See "Experimental."

Late Enrollment. Enrollment in the MIP that is subject to medical underwriting with the right of the MIP to deny applicants with pre-existing medical conditions. Late enrollment requires you to provide the Insurance Administrator with detailed medical information on each applicant. The Insurance Administrator then decides (based on general medical underwriting criteria) whether or not the individual should be insured and allowed entry into the MIP. Medical information is sent directly to the Insurance Administrator, and the decision is solely that of the Insurance Administrator. The Bank Group has no

influence or control over late enrollment decisions, and cannot overrule the Insurance Administrator. Please note that currently Aetna approves late enrollments, even if the MIP participant is enrolled in the International Option with Vanbreda. Late enrollment is not available in the Retiree MIP.

Medical Emergency. See “Emergency Condition.”

Medical Necessity. 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, both as to 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, a mental health or a 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.

MIP Plan Year. A calendar year, from January 1 to December 31.

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

On the Job. Employment with any employer or self-employment.

Out-of-Network Benefits. Benefits for services obtained through a non-participating provider. (For Active Staff Option C participants, out-of-network also includes self-referred services except those explicitly allowed in Section 13.02. 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 you must file the claim.

Out-of-Pocket Maximum. Also called a “medical stop-loss,” the maximum amount a participant must pay toward out-of-network expenses in a calendar year. Once you reach your 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 pre-certification for covered hospitalizations if they were to apply in the MIP;
- Co-payments for physician’s office visits;
- Co-payments and coinsurance amounts paid for dental and in network prescription drug purchases.

Outpatient. An MIP participant 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 PharmaCare mail-order pharmacy facility at which MIP participants may buy prescriptions at a discount through a mail-order system in accordance with the MIP’s Prescription Drug insurance provisions. Mail-order pharmacies can only deliver to U.S. addresses, and cannot deliver to World Bank Group addresses in Washington or elsewhere.

Participating Network Pharmacy. A retail pharmacy, participating in the PharmaCare network throughout the U.S., at which MIP participants can buy prescriptions at a discount in accordance with the MIP’s Prescription Drug insurance provisions. This is also known as an “in-network” pharmacy.

Participating Provider. See “In-Network Provider.”

Patient Management. Free programs designed to assist MIP participants with large or complex cases to assess opportunities to coordinate care, identify treatment options to improve the quality of care, quality of life and to control costs. Patient Management and Case Management are recommended for all participants, and required for Retiree MIP participants, Active Staff Option C participants, and Sponsored Plan participants.

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.

Pre-certification. 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 participants in Option C. Pre-certification is required for members in Active Staff Option C, for all MIP members in the Retiree MIP for Aetna participants, and for Sponsored Plan participants. There are two components to pre-certification: 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 Benefit Management Administrator (PBM). For all participants, this is PharmaCare. PharmaCare is independent from Aetna or Vanbreda and holds a separate contract for prescription drug management services for the MIP for prescription drug management services for drugs dispensed in the U.S. at participating network pharmacies, including mail order.

Prescription Drug Out-of-Pocket Maximum. A separate calendar year limit for out-of-pocket expenses on prescription drugs purchases at PharmaCare network pharmacies. This is a separate limit from the out-of-pocket maximum for medical expenses and is tracked separately by PharmaCare. When PharmaCare 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.

Reasonable and Customary Charges. See Usual and Customary Charges

Registration. See "Pre-certification."

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 U&C 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.

Topics Index

A

Abortion	20
Accutane.....	41
Actiq.....	41
Acupuncture	15
Address changes	<i>See Mailing address</i>
Adjustable brassieres.....	16
Administrative Tribunal	72, 75, 83
Adoption	53, 57
Advance payment fees	<i>See Registration fees</i>
Advanced Reproductive Technology	<i>See Infertility</i>
Aetna	1, 2
Coverage Policy Bulletin	26
Customer Service.....	11
Dental PPO	4, 77, 79
DocFind	5, 89, 141
Informed Health Line Services	87
Intelihealth	89
Managed Choice POS.....	4, 5, 48, 50, 79, 85, 89
Moms-to-Babies Maternity Management Program	50
National Medical Excellence Program.....	46
National Special Case Program.....	46
National Transplantation Program.....	46
Natural Alternatives Program	86
Navigator	88, 89, 91, 141
Open Choice PPO	4, 5, 79, 85, 89
Out of Country Care Program.....	46
Vital Savings Program.....	87
Air cleaners	29
Air conditioners.....	29
Alcoholism	21, 28
Allergy	89
Alopecia	16
Alveoplasty	<i>See Periodontal surgery</i>
Ambulance services.....	25
Ambulette	25
American Board of Surgery	24
American Speech and Hearing Association.....	16
Anesthesia	20, 34, 35
Annual change season	57
Anorexics	44
Appeals	30, 66
Aetna	3, 72
Pharmacare.....	42
Vanbreda.....	83

Appetite suppressants	44
Appliances	35, 36, 44
Aquatherapy	31
Arbitration	See Appeal
ART	See Infertility
Artificial eyes	15
Artificial insemination	18
Artificial limbs	15
A-splinting	See Splinting teeth
Assignment of benefits	67
Assignment of Benefits	119
Assisted hatching	18
Audiology	See Hearing care
Audiometric exam	See Hearing care
Automatic default enrollment	56
Autopsies	30
Avita	41
Avonex	42
Azelex	41

B

Beauty aids	44
Behavioral health	See Mental health
Behavioral training	29
Benign prostatic hypertrophy	31
Bereavement counseling	17
Betaseron	42
Bio-energetic therapy	32
Biological sera	40
Biologics	42
Blood or blood plasma	15
Blood pressure kit	28
Bone marrow transplant	46
Braces	16
Brand-name drugs	9, 38, 39, 77, 79, 119
Breast pumps	29
Bridges	34, 36, 37
Bunion	31

C

Calluses	See Feet
Carbon dioxide therapy	32
Cards	6, 80
Aetna	6, 89, 91, 94
Health Systems International	6, 94
Pharmacare	6, 92

Vanbreda 6
 Caretaker services 28
 Cataract surgery 25, 30
 Change season See Annual change season
 Chelation therapy 32
 Chemical dendency See Substance abuse
 Chemotherapy 16, 20, 39
 Children 23, 45, 48, 53, 54, 55, 58, 64, 77, 120
 Chiropractic care 15
 Chronic brain syndrome 28
 Claim disputes See Appeals
 Claim form 13, 33, 66, 67, 68, 69, 81, 84, 119
 Cleft lip or palate 24
 Cognitive rehabilitation 29
 Colony-stimulating drugs 41
 Companion services 28
 Confidentiality 7, 67
 Congenital defect See Congenital malformation
 Congenital malformation 24
 Conseil de l'Ordre des Médecins 83
 Contact lenses 25, 30, 86
 Contagious disease 19, 20
 Continuation coverage 59, 60
 Contributions 3, 1, 55, 77
 Convalescent facility 19, 119
 Conversion coverage 61
 Copaxone 42
 Corns See Feet
 Cosmetic drugs 44
 Cosmetic surgery 24, 28
 Counseling 28, 31
 Coverage Policy Bulletin See Aetna Coverage Policy Bulletin
 Cremation 30
 Crowns 34, 36, 37
 Crutches 16
 Cryo-preserved embryo transfer 19
 Currency 68, 82, 83
 Custodial services 28
 Cyro-preserved embryo transfer 30

D

Day Treatment See Mental health
 Deductible 3, 4, 5, 8
 PharmaCare brand name 40
 Dehumidifiers 29
 Dental PPO See Aetna Dental PPO
 Dental services 13, 33, 34, 36, 37, 49, 79

Dentures	25, 34, 35, 36, 37
Desoxyn	41
Developmental delay	23
Dexedrine.....	41
Diabetes	31, 49
Diabetic supplies	40, 44
Dietary counseling	16, 17, 122
Dietary supplements.....	41, 44
Digital rectal exam.....	23
Direct deposit form	68
Disability.....	26, 52, 58
Disciplinary action	70
Dislocation	24
Dispensing limit.....	42
Disputes.....	See Appeals
Divorce.....	58, 59, 67
DocFind	See Aetna DocFind
Domestic disputes.....	67
Domestic partner.....	54, 57, 62, 120
Drug addiction	See Substance abuse
Durable medical equipment.....	15, 28, 78, 120

E

Education.....	29
Emergency care	14, 21, 50, 87
Emergency room	See Emergency care
Enbrel	42
Endodontics	34
EOB	See Explanation of Benefits
Equine therapy	31
Estrangement	67
Evacuation.....	See Transportation
Exercise equipment.....	29, 87
Expedited External Review	74
Experimental treatment	47
Explanation of Benefits	5, 67, 69, 71, 83, 89, 90
Extended Term Appointments	51
Extraction (of teeth).....	25, 34, 36
Eyeglasses	86
Eyes.....	30

F

Family practitioner	48
Feet	31
Fillings	34, 36

Financial counseling 28
 Fissure sealants..... See Tooth sealants
 Flat feet See Feet
 Fluoride 33
 Food and Drug Administration 38, 44, 45, 121
 Formulary..... See Prescription drug formulary
 Foster children 120
 Fraud 7, 58, 61, 70, 74
 Funeral Arrangements..... 30

G

Gamete intra-fallopian transfer 18
 General practitioner 48
 Generic drugs 38, 39, 79
 Gestational carrier programs..... 30
 GIFT See Gamete intra-fallopian transfer
 Gingival curettage See Periodontics
 Gingivectomy See Periodontal surgery
 Gingivoplasty..... See Periodontal surgery
 Gold 34, 36
 Grandchildren..... 53, 120
 Grievance..... See Appeals
 Growth hormones 41
 Gynecological exam 22, 23

H

Hair loss..... 16, 44
 Hairpieces 16
 Halfway houses 31
 Handicapped child 55
 Harelip See Cleft lip or palate
 Health club..... 29, 86
 Health Insurance Portability and Accountability Act 7
 Health Systems International..... 3, 4, 5, 6, 78, 79, 82, 88, 92, 94
 Health Systems International card See Cards
 Hearing aids..... 16
 Hearing care 16
 High noble metal rate See Noble metal rate
 HIPAA..... See Health Insurance Portability and Accountability Act
 Home health care 16, 30
 Home Health Care Agency 122
 Home ovulation predictor kits 30
 Hospice 16, 17, 18, 26, 28, 32, 44, 122
 Hospital beds 15
 HR Service Center..... 4, 53, 57, 58, 59, 61, 62, 68, 69, 74, 77, 83, 85, 93, 94
 Humira 42

I

ID cards	See Cards
Identification cards	See Cards
Immunizations	18, 22, 89
Implant devices.....	34
Implant surgery.....	See Dental implant surgery
Infertility	10, 18, 25, 30
Infertility drugs.....	39, 40, 41
Informed Health Line Services	See Aetna Informed Health Line Services
Injectable drugs	40, 41
Injectable products	42
Inlays	See Crowns
Insulin	See Diabetic supplies
InteliHealth	See Aetna InteliHealth
Intensive Care Unit	19
Intensive Outpatient Program.....	21
Intercoms.....	29
Interferon drugs	41
Internal medicine specialists.....	48
Intravenous Immunoglobulin	25
Investigational treatment.....	See Experimental treatment
In-vitro fertilization.....	18
IVF	See In-vitro fertilization
IVIG	See Intravenous Immunoglobulin

J

Jacuzzi	29
---------------	----

K

Ketone	40
Kineret	42

L

Laboratory services	20
Lancets.....	40
Laparoscope.....	19
Laser surgery.....	See Radial keratotomy
Lasik	See Radial keratotomy
Late enrollment	36, 56, 57, 58, 123
Learning disorders	29
Leg.....	31
Legal counseling.....	28
Legal fees.....	30
Leukine	41

Leukoplakia 24
 Licensed Practical Nurse 17, 21, 119
 Life event..... 4, 57, 58
 Lisps 31
 Local Currency option 68
 Lodging..... 46, 47
 LPN See Licensed Practical Nurse
 Lump sum fee 12
 Lupus 16

M

Mail order pharmacy..... See PharmaCare Direct
 Mailing address 66, 67, 76, 83, 84, 85
 Mammography 7, 20
 Computer-Aided Detection 20
 Managed Choice POS..... See Aetna Managed Choice POS
 Marital counseling..... 28
 Massage therapy..... 31
 Mastectomy 16, 24
 Maternity See Pregnancy
 MBP See Medical Benefits Plan
 Medicaid 26
 Medical Benefits Plan..... 51
 Medical emergency See Emergency care
 Medical necessity..... 23, 24, 33, 41, 44, 72, 73, 82, 83, 124
 Medical underwriting 54
 Medicare 62
 Medicare Part D (Prescription Drug Benefits) 65
 Medicare Direct..... 62, 65, 69
 Medicare Savings 63, 64, 65
 Medicare Secondary Payer rules 64
 Megavitamin therapy 32
 Mental health 9, 11, 28, 31, 49, 124
 Day treatment 21
 Mental Health..... 21
 Mental retardation..... 28, 120
 Metatarsalgia 31
 Midwife See Nurse midwife
 Minoxidil 44
 MIP cards See Cards
 MIP Continuation See Continuation coverage
 MIP Continuation billing..... 58
 Misstatement of fact..... 70
 Moms-to-Babies Maternity Management Program..... See Aetna Moms-to-Babies
 Maternity Management Program
 Multiple sclerosis 39
 Myasthenia Gravis 25

N

Nail roots	31
Nasal reconstruction	24
National health plans	62
National Medical Excellence Program	<i>See Aetna National Medical Excellence Program</i>
National Special Case Program.....	<i>See Aetna National Space Program</i>
National Transplantation Program .	<i>See Aetna National Transplantation Program</i>
Nervous conditions	<i>See Mental health</i>
Neulasta	41
Neupogen	41
Newborn	23, 53
Nicotine	<i>See Smoking cessation products</i>
NME	<i>See National Medical Excellence Program</i>
Noble metal rate	34
Nurse	<i>See Registered Nurse or Licensed Practical Nurse</i>
Nurse midwife	20
Nystatin	40

O

Occupational therapy.....	16, 17, 23, 122
Oocyte retrieval	19
Open Choice PPO	<i>See Aetna Open Choice PPO</i>
Ophthalmologist	25, 49
Optician	25, 30
Optometrist	25, 49
Oral surgery	33, 34, 35, 37, 49, 77, 120
Organ transplant	46
Orthodontia	10, 33, 35, 37, 120
Orthopedic shoes	31
Orthotics.....	31
Osseous surgery.....	33, 35, 120
Otolaryngologist	16
Out-of-Country Care Program	<i>See Aetna Out-of-Country Care Program</i>
Out-of-network pharmacy	40, 45
Out-of-pocket maximum	5, 9, 10, 40, 77, 79, 125, 126
Overpayments	58, 67
Ovulation induction	18
Ovum microsurgery	19
Oxygen	15, 20

P

Palliative medication	<i>See Anesthesia</i>
Pap smear	22

Pap Smear	23
Pastoral counseling	28
Patient Management.....	10, 11, 16, 46, 88, 125
PCP	See Primary Care Physician
Pediatricians	48
Pension Administration.....	67, 69, 93
Pension mailing address.....	See Mailing address
Periodontal surgery	33
Periodontics.....	34
Personal comfort items	31
PharmaCare 1, 2, 3, 4, 5, 6, 9, 10, 13, 18, 19, 38, 39, 40, 41, 42, 43, 44, 45, 65, 77, 79, 88, 90, 92, 123, 125, 126	
Advice on brand-name drugs	38
Cards	See Cards
Customer service	88
In-network discounts.....	13
Medical necessity.....	41
Out-of-pocket limit	77, 79
Website	90
Physical therapy.....	7, 16, 17, 23, 31
Physiotherapist	See Physical therapy
Plan year.....	2, 124
Pontics	36
Porcelain.....	See Crowns
Posts.....	See Implant devices
Preauthorization (prescription drugs)	41, 88
Pre-certification.....	6, 8, 10, 21, 125, 126
Mental/nervous conditions at licensed institutions.....	21
Pregnancy	See Maternity
Premature birth	8
Prenatal vitamins	40, 44
Primal therapy.....	32
Primary Care Physician	46, 48, 94
Private duty nursing	17, 21
Private room	See Semi-private room
Progesterone.....	40
Pronuclear stage tubal embryo transfer.....	18
Prophylaxis	See Routine dental cleaning
Prosthetic appliances.....	16
Protruding mandible	24
PROUST	See Pronuclear stage tubal embryo transfer
Provision splinting.....	See Splinting teeth
PSA test	23
Psychiatric treatment	See Mental health
Psychodrama	32
Purging.....	32

R

Rabies vaccine 18

Radial keratotomy 30

Radiation therapy 16, 20

Radiology *See X-rays*

Reconstructive surgery 24

Referrals 3, 7, 49, 50

Refunds from providers 70

Registered domestic partner *See Domestic partner*

Registered Nurse 17, 21, 50, 119, 122, 123

Registration fees 27

Rehabilitation services 23

Religious counseling 28

Remedial education..... 29

Respirators *See Oxygen*

Respite care..... 28

Restoration 34, 36, 37, 119

Retin-A 41

Rheumatoid arthritis..... 39

Rhinoplasty 24

Right of recovery 70

RN..... *See Registered Nurse*

Rogaine 41, 44

Rolfing 32

Root planing..... *See Periodontics*

Routine dental care 77

Routine dental cleaning..... *See Routine dental exam*

Routine eye exam 25, 30, 49

Routine nursery care 23

Routine oral exam..... 33

Routine physical exam 22

S

Scaling *See Periodontics*

School tuition 31

Self-employment 26, 124

Semi-private room 17, 19, 20

Senility 28

Sex change 32

Sex counseling 28

Skilled Nursing Facility 19, 123

Skilled nursing services..... 19

Smoking cessation products 40, 41

Social worker 30, 122

Spa Treatments..... 31

Space maintainers..... 33, 37
Special education See Education
Specialty drugs 38
Speech therapy 20, 23, 31
splinting teeth 36
Splints..... 16
Sponsored Plan 53
Sponsored Plan 7, 56, 76, 117, 121, 125, 126
 Coverage start 53
 Medical underwriting requirement 56
Staff Rule 2.01, Confidentiality of Personnel Information 7, 67
Staff Rule 2.02, Confidentiality of Medical Information and Medical Records ... 7
Staff Rule 6.02, Dependency (Tax Equivalency) Allowances 53
Staff Rule 6.12, Participation in the Medical Insurance Plan 51, 72, 75, 83
Staff Rule 6.17 85
Staff Rule 6.17 Benefits on Change of Duty Station 76
Staff Rule 6.22, Disability Insurance Program 52, 60
Staff Rule 8.01, Disciplinary Measures 70
Stair lifts..... 29, 120
Stannous fluoride..... See Fluoride
Stepchildren..... 58
Sterilization 18, 20, 25
Sterilization reversal 31
Stethoscopes 29
Stop-loss limit..... See Out-of-pocket Maximum
Stuttering..... 31
Subrogation 30, 70
Substance abuse..... 9, 21, 49
Surgery (mouth, jaws, teeth) 24
Surgical services..... 23
Surviving spouse 52, 54, 55

T

Taxi..... 25
Temporary restoration See Restoration
Terminally ill..... See Hospice
TET See Tubal embryo transfer
Third surgical opinions See Second surgical opinions
Toenails..... See Feet
Tooth sealants 34
Traction devices..... 29
Tranquilizers See Anesthesia
Transplants..... See Organ transplants
Transportation 15, 25, 29, 32, 46
Transportation of remains 30
Transsexual surgery..... See Sex change
Transvaginal needle aspiration of follicles..... 19

Travel expenses 46
 Treatment plan 33, 68
 Tubal embryo transfer 18
 Tuberculosis..... 22
 Tuition See School tuition

U

United Nations Operational Rates of Exchange 83
 Usual and Customary Charges 9, 14, 33, 45, 73, 82, 119, 126
 Appeals..... 72
 Computation by Vanbreda 82
 Dental services..... 33
 Emergency room..... 14
 Pharmacy expenses 45

V

Vanbreda 1, 2, 3, 4, 5, 10, 67, 68, 69, 76, 78, 79, 80, 88, 89, 92, 94
 Aetna discount programs..... 86
 Appeals..... 83
 Cards See Cards
 Care in the U.S..... 78
 Claim form..... 81
 Claims processing..... 82
 Conversion coverage..... 61
 Coordination of out-of-pocket limits..... 84
 Coordination with Aetna 84
 Coordination with PharmaCare..... 79
 Currency option..... 68
 Dental network 79
 Dental services..... 79
 Determination of medical necessity..... 82
 Direct billing arrangements..... 80
 Direct deposit option 68
 Domestic disputes..... 67
 Explanation of Benefits..... 83, 89
 Languages..... 81
 Late enrollment 123
 Letter of guarantee 84
 National Medical Excellence Program..... 46
 Negotiated fees..... 80
 Predetermination of benefits 84
 Switching with Aetna 84
 U.S. Network..... 3
 Usual and customary charges..... 82
 Website 5
 Vasectomy 25
 Veneer crowns See Crowns
 Vestibuloplasty See Periodontal surgery

Veterans Administration 26
Viagra 41
Vision..... *See Eyes and Routine Eye Care*
Vision perception training 32
Vitamins *See Prenatal vitamins*
Vocational training..... 29
Volunteer services 32

W

Water beds 29
Water filters 29
Well baby care..... 22
Wheelchairs 15
Whirlpool equipment 29
Wigs 16
Wilderness programs..... 31
Workers compensation 26, 44

X

Xenical 41
X-rays 22, 33, 50, 68, 78, 119

Y

Yocon..... 41

Z

ZIFT..... *See Zygote intra-fallopian transfer*
Zygote intra-fallopian transfer..... 18

SERVICE	PHONE	FAX	EMAIL or WEBSITE
HR Service Center Eligibility, report NHP or Medicare enrollment	202-473-2222	202-522-2150	hrservicecenter@worldbank.org www.worldbank.org/humanresources - view the MIP Summary Plan Description online, download MIP claim forms, links to more retiree resources
Aetna/Aetna Global Benefits Claims and coverage questions	1-800-723-8897 OR 202-473-8666 <i>Now available 24/7</i>	1-800-475-8751 OR 813-775-0625	mclaims@aetna.com www.aetna.com for DocFind, Navigator and other online health resources www.aetnaglobalbenefits.com for non-US providers and hospitals, travel alerts, more. Must use Navigator password to access proprietary list of providers and hospitals.
Aetna Informed Health Line	1-800-556-1555 - available 24/7		
Vanbreda, Inc. Claims and coverage questions	800-3-217-5798 OR 32-(3)-217-5798 <i>Now available 24/7</i>	32-(3) 236-7538	mcc200@vanbreda.com www.int.vanbreda.be for non-US providers and hospitals. Must use a password to access proprietary list of providers and hospitals.
HSI, Inc. for US network of physicians/hospitals for those using Vanbreda	1-800-962-6831		www.us-hsi.com
PharmaCare US Prescription Drug Discount program - retail and mail order	1-800-947-3826		www.pharmacare.com - member sets up password protected account for prescription benefit information or mail order www.pharmacare.com/members/worldbank for plan and formulary information without password
Pension Administration Change address, report death of retiree or spouse	202-458-2977	202-522-1723	1pension@worldbank.org
1818 Society	202-458-1956	202-522-2417	1society@worldbank.org
US Medicare	1-800-633-4227		www.medicare.gov
US Social Security	1-800-772-1213		www.ssa.gov