##### United Nations Development Programme



MIP

###### Medical Insurance Plan

List of Reimbursable and Non-Reimbursable Items

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Office of Human Resources

Bureau of Management

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| Document Name | Medical Insurance Plan (MIP)  List of Reimbursable and Non-Reimbursable Items |
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**MEDICAL INSURANCE PLAN (MIP)**

**LIST OF REIMBURSABLE AND NON-REIMBURSABLE ITEMS**[[1]](#footnote-1)

| **IS IT REIMBURSABLE?** | | **REPLY** |
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| **Acne treatment** | | Reimbursable, subject to the limitations and exclusions of the Plan. See dermatology. |
| **Acupuncture** | | Reimbursable at the rate of 80% for chronic pain syndrome treatment only, provided:  a) acupuncture is used to treat a declared and documented pathology  b) treatment is recognized as a valid treatment modality by the competent health authorities of the country; and  c) treatment is rendered by a qualified medical doctor or licensed acupuncturist.  Attending physician’s prescription must specify:  a) the type of treatment to be rendered;  b) the number of sessions; and  c) the actual length of treatment.  If the duration of the treatment 3 months the attending physician must reassess the treatment and issue a new prescription. *See alternative medicine.*  Covered diagnoses for treatment by acupuncture include: tension headache, migraine headache, psychalgia, neuralgia, backache, lumbago, muscle spasm and bursitis.  Acupuncture treatment in lieu of anesthesia is also reimbursable. |
| **Addictionology** | | Reimbursable, subject to the limitations and exclusions of the Plan. *See substance abuse.* |
| **Adolescent medicine** | | Reimbursable, subject to the limitations and exclusions of the Plan. |
| **AIDS medication** | | Reimbursable, subject to the limitations and exclusions of the Plan. *See drugs*. |
| **Air conditioners** | | Non reimbursable. |
| **Air purifiers** | | Non reimbursable. |
| **Alcohol treatment** | | Reimbursable, subject to the limitations and exclusions of the Plan. *See substance abuse.* |
| **Allergy testing and treatment** | | Reimbursable at the rate of 80%. |
| **Alternative medicine** | | Normally non reimbursable. Only certain treatments/therapies included in this document are reimbursable at the rate of 80% provided:  a) there is a medical condition that requires treatment;  b) the treatment is rendered by a qualified medical doctor; and  c) the treatment is recognized as a valid treatment modality by the competent health authorities of the country.  The attending physician must specify:   1. diagnosis 2. number of sessions 3. length of treatment   Concerned treatments:  Traditional Chinese medicine (in Asia), acupuncture, homeopathy  If there is a treatment/therapy not included in this document and there are doubts whether it is reimbursable, please check with the Third Party Administrator (TPA) |
| **Alveolectomy** | | *See oral surgery.* |
| **Ambulance** | **Surface** | Reimbursable at the rate of 80% provided professional ambulance service is to transport a person from the place where he/she is injured or stricken by disease to the first hospital where treatment is given. |
| **Air** | Non reimbursable under MIP. See provisions for medical evacuations. |
| **Amniocentesis** | | Reimbursable at the rate of 80%. |
| **Anesthesiology** | | Reimbursable, subject to the limitations and exclusions of the Plan. *See hospital services and supplies.* |
| **Antiretroviral drugs** | | Reimbursable, subject to the limitations and exclusions of the Plan. *See drugs.* |
| **Apicoectomy** | | *See endodontics*. |
| **Appetite suppressants** | | Normally non reimbursable. Only reimbursable for morbid obesity where the prescription of appetite suppressants is medically necessary and appropriate. Attending physician's prescription must specify the length of treatment. If the duration of the treatment exceeds three months, the attending physician must reassess the treatment and issue a new prescription. |
| **Applied kinesiology** | | Non reimbursable. *See alternative medicine.* |
| **Aromatherapy** | **Fragrance, pleasure, hygiene** | Non reimbursable. |
| **Therapeutic** | Non reimbursable. *See alternative medicine.* |
| **Arthritis treatment** |  | Reimbursable, subject to the limitations and exclusions of the Plan. |
| **Artificial** | **Arms** | Reimbursable, subject to the limitations and exclusions of the Plan. *See prosthetic appliances.* |
| **Ears** |
| **External breast prostheses** |
| **Hands** |
| **Hip joints** |
| **Larynx** |
| **Legs** |
| **Nose** |
| **Artificial insemination** | | Non reimbursable |
| **Assisted hatching (AHA)** | | Non reimbursable. *See infertility treatment*. |

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| **Assisted microfertilization** | | Non reimbursable. See infertility treatment and intra cytoplasmic sperm injection (ICSM). |
| **Auriculotherapy (ear acupuncture)** | | Reimbursable for chronic pain treatment only, subject to the limitation and exclusions of the Plan*. See acupuncture*. |
| **Ayurvedic medicine** | | Non reimbursable. *See alternative medicine*. |
| **Bionergetic therapy** | | Non reimbursable. *See alternative medicine*. |
| **Biofeedback therapy** | | Non reimbursable. *See alternative medicine*. |
| **Blastocyst embryo transfer (BET)** | | Non reimbursable. *See infertility treatment.* |
| **Blepharoplasty** | | Non reimbursable. *See plastic surgery.* |
| **Blood, blood products, blood derivatives** | | Reimbursable if prescribed by the attending physician at the rate of:  a) 80% if out-patient; and  b) 100% if in-patient. |
| **Blood glucose monitors** | | Reimbursable at the rate of 80% if prescribed by the attending physician for the management of diabetes. Includes monitors for the legally blind. Testing strips for the glucose monitors are also covered by the Plan. |
| **Blood pressure measurement devices** | | Reimbursable at the rate of 80% if prescribed by the attending physician to monitor a chronic medical condition. The prescription must indicate the medical condition requiring the device. |
| **Bone marrow transplant** | | Reimbursable subject to the limitations and exclusions of the Plan. *See hospital services and supplies.* |
| **Braces** | | See orthodontics. |
| **Breast plastic surgery** | | Reconstructive surgery following mastectomy of a diseased breast is reimbursable.  Surgery for cosmetic reasons is not reimbursable.  *See plastic surgery* |
| **Breast enlargement or reduction** | **to improve, alter or enhance appearance** | Non reimbursable whether or not for psychological or emotional reasons. |
| **to improve the function of a part of the body** | Normally reimbursable, subject to the limitations and exclusions of the Plan. |
| **Breast reconstruction** | | Surgery following mastectomy of a diseased breast is reimbursable. *See plastic surgery*. |
| **Bridges** | | Reimbursable, subject to the limitations and exclusions of the Plan. *See dental prosthetic services.* |
| **Bunion surgery** | | Reimbursable, subject to the limitations and exclusions of the Plan. *See podiatry.* |
| **Calcium** | | Normally non reimbursable. Only reimbursable if prescribed by the attending physician to treat a medical condition e.g. osteoporosis at the rate of:  a) 80% if out-patient; and  b) 100% if in-patient.  Attending physician must indicate condition to be treated and length of treatment. If the duration of the treatment exceeds three months, the attending physician must reassess the treatment and issue a new prescription. Tests must be attached. |
| **Carbon dioxide therapy** | | Non reimbursable. |
| **Cardiac electrophysiology** | | Reimbursable, subject to the limitations and exclusions of the Plan. |
| **Cardiology** | | Reimbursable, subject to the limitations and exclusions of the Plan. |
| **Cardiovascular surgery** | | Reimbursable, subject to the limitations and exclusions of the Plan. |
| **Cardiovascular treatment** | | Reimbursable, subject to the limitations and exclusions of the Plan. |
| **Carpal Tunnel Syndrome surgery** | | Reimbursable, subject to the limitations and exclusions of the Plan. *See hospital services and supplies.* |

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| **Cataract surgery** | | Reimbursable, subject to the limitations and exclusions of the Plan. Normally performed on an outpatient basis. If the patient is admitted for inpatient treatment, then the normal inpatient benefits apply. |
| **Chemical dependency** | | Reimbursable, subject to the limitations and exclusions of the Plan. *See substance abuse.* |
| **Chemotherapy** | | 100% reimbursable, subject to the limitations and exclusions of the Plan. |
| **Chinese clinics** | | Non reimbursable*. See alternative medicine*. |
| **Chinese taoism** | | Non reimbursable. *See alternative medicine*. |
| **Chiropractic care** | | Reimbursable at the rate of 80% provided:  a) there is a medical condition that requires treatment;  b) the treatment is conducted by a qualified medical doctor or a licensed chiropractor; and   1. the treatment is recognized as a valid treatment modality by the competent health authorities of the country.   Attending physician's prescription must specify:  a) diagnosis  b) the type of treatment to be rendered;  c) the number of sessions; and  d) the actual length of treatment.  If the duration of the treatment exceeds three months, the attending physician must reassess the medical condition and issue a new prescription. *See alternative medicine.* |
| **Chiropody** | | Reimbursable, subject to the limitations and exclusions of the Plan. *See podiatry.* |
| **Circumcision** | | Reimbursable if performed by the attending physician in a recognized medical facility. *See hospital services and supplies*. |
| **Collagen therapy** | | Non reimbursable. |
| **Colonic irrigation** | | Reimbursable at the rate of 80% if prescribed by attending physician to treat a medical condition. The attending physician's prescription must indicate the medical condition requiring colonic irrigation. |
| **Colon cancer screening, including methods such as sigmoidoscopy, barium enema x-ray & colonoscopy** | | Reimbursable, subject to the limitations and exclusions of the Plan. *See hospital services and supplies.* |
| **Colostomy surgery** | | Reimbursable, subject to the limitations and exclusions of the Plan. *See hospital services and supplies.* |
| **Colostomy bags** | | Reimbursable at the rate of 80% if prescribed by the attending physician to treat a medical condition. The attending physician's prescription must indicate the medical condition requiring colostomy bags. |
| **Computerized tomographic (CT)** | | Reimbursable, subject to the limitations and exclusions of the Plan. *See scanning.* |
| **Contact lenses solutions** | | Non reimbursable. |
| **Contraceptive devices and medication** | | Contraceptives, including the contraceptive devices with the exception of condoms will be reimbursed at 80 per cent rate. |
| **Coronary artery bypass surgery** | | Reimbursable, subject to the limitations and exclusions of the Plan. *See hospital services and supplies.* |
| **Correction of eye refractive errors** | | Reimbursable at the rate of 80% subject to a maximum of US$ 150 per eye and subject to a one year waiting period. |
| **Corrective heels** | | *See orthopedic heels.* |
| **Corrective lenses (including contact lenses, disposable lenses, bifocal or trifocal lenses or lenses of progressive focal length or any other corrective lens)** | | Reimbursable at the rate of 80% subject to a waiting period of one year with a maximum of US$150 for disposable lenses or US$ 75 per lens and a maximum of two lenses annually (per eligible patient) provided there is a change in the lens prescription. Prescription must indicate the corrective value in dioptrics. Periodicity is not reduced for the replacement of lenses that are lost, stolen or broken. |
| **Corrective shoes** | | See orthopedic shoes. |
| **Cosmetic surgery** | | Non reimbursable, including breast enlargement or reduction. *See plastic surgery.* |
| **Counselling** | **Bereavement** | Non reimbursable. |
| **Career** |
| **Child** |
| **Family** |
| **Financial** |
| **HIV/AIDS Tests** | Reimbursable at the rate of 100%. *See HIV/AIDS tests*. |
| **Legal** | Non reimbursable. |
| **Pastoral** |
| **Social adjustment** |
| **Craniosacral therapy** | | Non reimbursable. See alternative medicine. |
| **Critical care medicine** | | Reimbursable, subject to the limitations and exclusions of the Plan. |
| **Crohn’s disease treatment** | | Reimbursable at the rate of 80%. |
| **Crowns** | | See dental prosthetic services. |
| **Crutches** | | Reimbursable at the rate of 80 % if prescribed by the attending physician as medically necessary. *See durable medical equipment.* |
| **Custodial care** | | Non reimbursable. |
| **Dandruff lotions and shampoos** | | Non reimbursable. *See parapharmaceutical products and hair lotions and shampoos.* |
| **De-humidifiers** | | Non reimbursable. |
| **Dental prosthetic services (including dental implants)** | | Reimbursable at the rate of 80% subject to the maximum benefit under dental care per calendar year i.e. one-half the MIP reference salary for each eligible patient. The Plan also covers:  a) replacement when ordered in cases of wear, damage, or change in the patient’s condition or body structure; and  b) reasonable costs for repairing, fitting, maintaining and adjusting appliances/devices. |
| **Dental restorations (fillings)** | | Reimbursable at the rate of 80% subject to the maximum benefit under dental care per calendar year i.e. one-half the MIP reference salary for each eligible patient. |
| **Dental floss** | | Non reimbursable. |
| **Dento-facial orthodontics** | | Reimbursable, subject to the limitations and exclusions of the Plan. *See orthodontics.* |
| **Dentures** | | Reimbursable, subject to the limitations and exclusions of the Plan. *See dental prosthetic services.* |
| **Dermatology** | | Reimbursable at the rate of 80% provided it is to treat disorders of the skin. Treatment must be conducted by a qualified medical doctor. |
| **Developmental delays** | | Charges for or related to education testing, services training or treatment are non reimbursable. |
| **Diabetes treatment** | | Reimbursable, subject to the limitations and exclusions of the Plan. |
| **Diagnostic laboratory** | | Reimbursable, subject to the limitations and exclusions of the Plan. *See laboratory tests.* |
| **Dialysis** | | See kidney hemodialysis and peritoneal dialysis. |
| **Dietary food products** | | Non reimbursable. *See parapharmaceutical products.* |
| **Dietician** | | Only reimbursable if prescribed by the attending physician to treat a medical condition e.g. diabetes, at the rate of:  a) 80% if out-patient, and  b) 100% if in-patient.  Attending physician must indicate condition to be treated and length of treatment |
| **Donor Expenses** | | Medical expenses related to the hospitalization and recoveries of the donor are reimbursable. |
| **Drug abuse** | | Reimbursable, subject to the limitations and exclusions of the Plan. (See substance abuse). |
| **Drugs (over-the-counter)** | | Reimbursed at 80% if a medication is prescribed by a physician for a particular disease. |
| **Drugs (prescription)** | **Emergency** | Reimbursable if prescribed by the attending physician at the rate of:  a) 100% if for emergency care and for use in the hospital, or  b) 80% if for non-emergency care or for use outside the hospital.  *See hospital emergency room supplies and services.* |
| **In-patient** | Reimbursable at the rate of 100% if prescribed by the attending physician and for use in the hospital. |
| **Out-patient** | Reimbursable at the rate of 80% if prescribed by the attending physician. Attending physician's prescription must specify the length of treatment. A prescription may cover for up to a one-year drug treatment provided the attending physician clearly and specifically indicates that drug treatment is required for the whole year. Reimbursement is limited to up to a three-month supply at a time. If the duration of the treatment exceeds one year, the attending physician must reassess the treatment and issue a new prescription. |
| **Replacement of drugs resulting from loss, theft or breakage** | Non reimbursable. |
| **Durable medical equipment** | | The Plan reimburses rental (or purchase when more economical or equipment cannot be rented) at the rate of 80% if prescribed by the attending physician as medically necessary. The prescription must indicate the medical condition requiring the equipment. If the equipment is not included in this list and there are doubts as to whether it is reimbursable, please check with the TPA. |
| **Eczema treatment** | | Reimbursable, subject to the limitations and exclusions of the Plan. *See skin diseases.* |
| **Electric toothbrush** | | Non reimbursable. |
| **Embryo coculture** | | Non reimbursable. *See infertility treatment*. |
| **Embryo cryopreservation (freezing)** | | Non reimbursable. *See infertility treatment.* |
| **Employment examinations** | | Non reimbursable. |
| **Endocrinology** | | Reimbursable, subject to the limitations and exclusions of the Plan. |
| **Endodontics** | | Reimbursable at the rate of 80% subject to the maximum benefit under dental care per calendar year i.e. one-half the MIP reference salary for each eligible patient. |
| **Enzyme therapy** | | Non reimbursable except for after cholecystectomy. *See alternative medicine.* |
| **Epididymal aspiration** | | Non reimbursable. *See infertility treatment*. |
| **Erectile dysfunction treatment** | | Non reimbursable, unless approved by the TPA provided the treatment is medically necessary. Diagnosis and laboratory tests results must be provided. |
| **Evacuation** | | Non reimbursable under MIP. *See provisions for medical evacuation.* |
| **Exercise equipment** | | Non reimbursable. |
| **Experimental** | | **Biologicals** |
| **Experimental**  **Eye examinations** | **Devices** | Non reimbursable. |
| **Drugs** |
| **Procedures** |
| **Technology** |
| **Treatment** |
| **Mandatory periodic for drivers** |
| **Eye examinations**  **Facelift** | **Routine** | Non reimbursable under MIP. Reimbursable by the organization at the rate of 100% subject to one exam every two years. |
| **To treat an injury** | Reimbursable at the rate of 80% subject to one exam every 12 months (per eligible patient) up to a maximum of US$100, subject to the usual one-year waiting period. The examination must be carried out by an ophthalmologist. |
| **To treat a medical condition** | Reimbursable at the rate of 80%. The examination must be carried out by an ophthalmologist. |
| Non reimbursable. *See plastic surgery and rhytidectomy.* |
| **Facial chemical peels** | | Non reimbursable. |
| **Facial collagen therapy** | | Non reimbursable. |
| **False teeth** | | Reimbursable, subject to the limitations and exclusions of the Plan. *See dental prosthetic services.* |
| **Family planning - office visits including tests and counselling** | | Reimbursable at the rate of 80%. |
| **Fitness programmes** | | Non reimbursable. |
| **Frames** | | Subject to the one year waiting period, reimbursement at 80% with a maximum of US$50 per frame and a maximum of one frame every two years (per eligible patient). |
| **Foot care** | **Calluses** | Non reimbursable. |
| **Corns** |
| **Toe nails** |
| **Food supplements** | | Non- reimbursable. (See *vitamins and minerals*) |
| **Foot orthotics** | | Normally reimbursable, subject to the limitations and exclusions of the Plan. *See orthotics*. |
| **Foot plastic surgery** | | *See plastic surgery and hospital services/supplies*. |
| **Functional rehabilitation** | | Reimbursable, subject to the limitations and exclusions of the Plan. *See physical therapy.* |
| **Gastroenterology** | | Reimbursable, subject to the limitations and exclusions of the Plan. |
| **Gemstone/crystal/chakra therapy** | | Non reimbursable. *See alternative medicine.* |
| **Gender identity disorders treatment** | | Non reimbursable. |
| **Geriatric medicine** | | Reimbursable, subject to the limitations and exclusions of the Plan. |
| **Gamete intra fallopian transfer (GIFT)** | | Non reimbursable. *See infertility treatment.* |
| **Gynaecology** | | Reimbursable, subject to the limitations and exclusions of the Plan. |
| **Gynecological examination** | | Reimbursable at the rate of 80%. *See routine examinations*. |
| **Haematology** | | Reimbursable, subject to the limitations and exclusions of the Plan. |
| **Hair** | **Implants** | Non reimbursable. |
| **Transplants** |
| **Hair lotions and shampoos** | **Regular** | Non reimbursable. *See parapharmaceutical products*. |
| **Medicated/prescription** | Only reimbursable at the rate of 80% if prescribed by the attending physician to treat a medical condition (e.g. seborrheic dermatitis) and provided the hair lotion/shampoo is not an over the counter product. Attending physician must indicate condition to be treated and length of treatment. If the duration of the treatment exceeds three months, the attending physician must reassess the treatment and issue a new prescription. |
| **Hand plastic surgery** | | See plastic surgery and hospital services/supplies |
| **Hearing aids/devices** | | Reimbursable at the rate of 80% subject to a waiting period of one year with a maximum of US$300 per apparatus and a maximum of one apparatus per ear every three calendar years (per eligible patient). Prescriptions must be accompanied by an audiogram. The periodicity is not reduced for the replacement of aids that are lost, stolen or broken. |
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| **Hearing evaluation and audiometric exam** | | | Reimbursable at the rate of 80% subject to one exam every three years. An otolaryngologist or a certified audiologist must carry out the examination. |
| **Hearing therapy** | | | Reimbursable at the rate of 80% if to improve or restore hearing function which has been lost or impaired as a result of a disease, injury or congenital defect. Benefits are not provided for maintenance therapy designed to prevent deterioration of the hearing function. Attending physician’s prescription must specify:  a) diagnosis  b) type of treatment to be rendered;  c) number of sessions; and  d) the actual length of treatment.  If the duration of the treatment exceeds three months, the treating physician must reassess the treatment and issue a new prescription. |
| **Heart valve replacement surgery** | | | Reimbursable, subject to the limitations and exclusions of the Plan. *See hospital services and supplies.* |
| **Heating pads** | | | Non reimbursable. *See alternative medicine*. |
| **Hepatitis treatment** | | | Reimbursable, subject to the limitations and exclusions of the Plan. *See drugs*. |
| **Herbal medicine** | | | Reimbursable at the rate of 80% provided:  a) there is a medical condition that requires treatment;  b) the treatment is recognized as a valid treatment by the competent health authorities of the country; and  c) the treatment is rendered by a qualified medical doctor.  *See alternative medicine*. |
| **Herpes treatment** | | | Reimbursable, subject to the limitations and exclusions of the Plan. *See skin diseases.* |
| **Hip surgery.** | | | Reimbursable, subject to the limitations and exclusions of the Plan. *See hospital services and supplies.* |
| **HIV tests** | | | Two voluntary blood tests per year (including pre- and post-counselling) for HIV virus are reimbursable at the rate of 100% per eligible family member i.e. no prescription required. Additional tests during the same year require a prescription from a medical doctor. |
| **HIV/AIDS test counselling** | | | Reimbursable at the rate of 80%. |
| **Home health care** | | | Reimbursable at the rate of 80% if prescribed by the attending physician as medically necessary and as an alternative to either hospitalization, or a stay in a skilled nursing facility. Attending physician's prescription must indicate:  a) medical condition requiring home health care; and  b) treatment plan including type and length.  If the duration of the treatment exceeds three months, the attending physician must reassess treatment and issue a new prescription.  Services must be rendered by a qualified nurse or a certified home health care agency duly licensed to operate as such. The benefit does not cover charges made for a person who usually lives with the patient, who is a member of his/her family or who is a member of his/her spouse's family. |
| **Homeopathy** | | | Reimbursable at the rate of 80% provided:  a) there is a medical condition that requires treatment;  b) the treatment is recognized as a valid treatment by the competent health authorities of the country; and  c) the treatment is rendered by a qualified medical doctor.  *See alternative medicine.* |
| **Homeopathic products** | | | Reimbursable at the rate of 80% provided:  a) products are prescribed to treat a medical condition;  b) products are prescribed by a qualified medical doctor; and  c) products are recognized as a valid treatment modality by the competent health authorities of the country.  *See alternative medicine.* |
| **Hospital emergency room services and supplies** | **for emergency care** | | Reimbursable at the rate of 100% if the medical condition, the onset of which is sudden manifests itself by symptoms of such severity, including severe pain, that a prudent layperson with an average knowledge of medicine and health could reasonably expect that the absence of immediate medical attention would result in:  a) placing the health of the afflicted person in serious jeopardy;  b) placing the health of an individual with a behavioral health condition or others in serious jeopardy;  c) causing serious impairment to the individual's bodily functions;  d) causing serious dysfunction of any bodily organ or part; and/or  e) causing serious disfigurement of the afflicted individual. |
| **for non-emergency care** | | Reimbursable at the rate of 80%, when used for example,  a) because it is late at night and the need for treatment is not sudden and serious; or  b) because the patient has no regular physician. |
| **Hospital services and supplies for in-patients and ambulatory or one-day surgeries** | **Accommodation** | | Reimbursable at the rate of:  a) if semi private accommodation (two or more patients in the same room): 100%; and  b) if private accommodation: 70% of the rate of private accommodation or 100% of semi-private accommodation, whichever is greater. ONLY under the following circumstances, subject to provision of documentation satisfactory to the organization, private accommodation will be reimbursable in full:  i) when the nature and gravity of the illness requires private-room care and the need for such care is duly substantiated by the attending physician;  ii) when the patient is admitted on an emergency basis to a hospital that has semi-private accommodation but none is available at the time of admission. This only until semi-private accommodation becomes available; and  iii) when the patient is admitted to a hospital that does not have any semi-private accommodation, i.e., it has no standard of accommodation other than private rooms and general wards. |
| **Drugs and medicines** | | Reimbursable at the rate of 100% as long as they are for use in hospital. |
| **General hospital nursing** | | Reimbursable at the rate of 100%. |
| **Intensive care room** | |
| **Laboratory examinations** | |
| **Medical equipment** | |
| **Operating room/theatre** | |
| **Recovery room** | |
| **X-ray examinations** | |
| **Anesthesiologist’s fees** | | Reimbursable at the rate of 100% |
| **Physician's fees (specialists and non-specialists)** | |
| **Surgeon's fees** | |
| **Extra bed** | | Non reimbursable. |
| **Food for persons other than the patient** | |
| **Telephone/fax** | |
| **Television** | |
| **Hospital-type beds** | | | The Plan reimburses rental (or purchase when more economical) at the rate of 80%, if prescribed as medically necessary. Prescription must indicate the medical condition requiring the hospital-type bed. *See durable medical equipment.* |
| **Hot water bottle** | | | Non reimbursable. |
| **Hypnosis** | | | Non reimbursable. |
| **Immunizations** | **Children up to 19th birthday** | | The following immunizations are reimbursable at the rate of 100%: DPT (diphtheria, pertussis and tetanus), Hepatitis A, Hepatitis B, Hepatitis A+B, hemophilus, Influenza, MMR (measles, mumps and rubella), meningococcal, pneumococcal, polio, varicella (chicken pox), tetanus-diphtheria and tetramune, and any other immunization recommended by both the local health authorities and the World Health Organization *See routine examinations*. |
| **Adults** | | Influenza, Hepatitis A, Hepatitis B, Hepatitis A+B and any other immunization recommended by both the local health authorities and the World Health Organization are reimbursable at the rate of 100%. |
| **Personal travel** | | Non reimbursable. |
| **Official travel** | | Non reimbursable. Immunizations required for official travel are considered travel expenses and, therefore, non-reimbursable under MIP; staff member should include expenses as part of his/her travel claim. |
| **Immunology** | | | Reimbursable, subject to the limitations and exclusions of the Plan. |
| **Infertility treatment** | | | Procedures for correction of infertility are non-reimbursable unless they are related to the stimulation for natural fertility. Assisted reproductive treatments are non-reimbursable, e.g. blastocyst embryo transfer (BET); gamete intrafallopian transfer (GIFT); in- vitro fertilization (IVF); intra cytoplasmic sperm injection (ICSI); intrauterine insemination (IUI); percutaneous Epididymal sperm aspiration (PESA); testicular sperm extraction (TESE); testicular sperm aspiration (TESA); tubal embryo transfer (TET); and zygote intrafallopian transfer (ZIFT). |
| **Infra-red lamp** | | | Reimbursable at the rate of 80% if prescribed by the attending physician to treat a medical condition. The attending physician's prescription must indicate the medical condition requiring the infra-red lamp. |
| **Insulin** | | | Reimbursable if prescribed by the attending physician, at the rate of:  a) 80% if out-patient; and  b) 100% if in-patient. |
| **Insulin** | **Cartridges for the legally blind** | | Reimbursable at the rate of 80% if prescribed by the attending physician for the management of diabetes. |
| **Infusion devices** | |
| **Injection aids** | |
| **Pumps and appurtenances** | |
| **Syringes** | |
| **Intentional accidents/injuries** | | | Non reimbursable. *See self-inflected accidents/injuries*. |
| **Internal medicine** | | | Reimbursable, subject to the limitations and exclusions of the Plan. |
| **Intra cytoplasmic sperm injection (ICSI), assisted microfertilization** | | | Non reimbursable. *See infertility treatment*. |
| **Intrauterine insemination (IUI)** | | | Non reimbursable. *See infertility treatment*. |
| **Intravenous oxidative therapy** | | | Non reimbursable. |
| **Investigational** | **Biologicals** | | Non reimbursable. |
| **Devices** | |
| **Drugs** | |
| **Procedures** | |
| **Technology** | |
| **Treatments** | |
| **In-vitro fertilization (IVF)** | | | Non reimbursable. *See infertility treatment*. |
| **Iridology** | | | Non reimbursable. *See alternative medicine*. |
| **Karate** | | | Non reimbursable. *See alternative medicine*. |
| **Kidney** | **Hemodialysis** | | Plan covers treatment at home, in hospital-based facility or in a free-standing facility. For home treatment, the Plan reimburses rental (or purchase when more economical or equipment cannot be rented) at the rate of 80% of equipment and all necessary supplies required for physician-ordered home dialysis treatment. Coverage, however, does not include any of the following:  a) furniture;  b) electrical, plumbing or other fixtures; and  c) professional assistance needed to perform home dialysis treatment. |
| **Peritoneal dialysis** | |
| **Knee brace contour** | | | Reimbursable, subject to the limitations and exclusions of the Plan. *See orthotic appliances/devices.* |
| **Labial frenum removal** | | | Reimbursable, subject to the limitations and exclusions of the Plan. *See oral surgery.* |
| **Laboratory tests** | **Emergency room** | | Reimbursable at the rate of:  a) 100% if for emergency care; or  b) 80% if for non-emergency care.  *See hospital emergency room services and supplies.* |
| **In-patient** | | Reimbursable at the rate of 100%. |
| **Out-patient** | | Reimbursable at the rate of 80% if prescribed by the attending physician. |
| **Laser optical treatment of myopia and astigmatism** | | | Reimbursable at the rate of 80% subject to a maximum of US$150 per eye and subject to a one year waiting period. |
| **Laser removal of hair** | | | Normally non reimbursable. ONLY reimbursable at the rate of 80 % if prescribed by the attending physician as medically necessary. |
| **Laser removal of tattoos** | | | Non reimbursable. |
| **Learning disabilities** | | | Charges for or related to education testing, services, training or treatment are non-reimbursable. |
| **Lenses** | | | Corrective lenses are reimbursable, subject to the limitation and exclusions of the Plan*. See corrective lenses*. |
| **Lingual frenum removal** | | | Reimbursable, subject to the limitations and exclusions of the Plan. *See oral surgery.* |
| **Liposuction** | | | Non reimbursable. *See cosmetic surgery and removal of excess fat.* |
| **Magnetic-field therapy** | | | Non reimbursable. *See alternative medicine*. |
| **Magnetic resonance imaging (MRI)** | | | Reimbursable, subject to the limitations and exclusions of the Plan. *See scanning.* |
| **Mammography** | | | Reimbursable at the rate of 80%. *See routine examinations*. |
| **Mandible surgery** | | | Reimbursable, subject to the limitations and exclusions of the Plan. *See oral surgery.* |
| **Massage devices** | | | Non reimbursable. |
| **Massage therapy** | | | Non reimbursable. *See alternative medicine.* |
| **Maternity** | | | Reimbursable, subject to the limitations and exclusions of the Plan. *See hospital services.* |
| **Maxilar surgery** | | | Reimbursable, subject to the limitations and exclusions of the Plan. *See oral surgery.* |
| **Maxillofacial surgery** | | | Reimbursable, subject to the limitations and exclusions of the Plan. *See oral surgery.* |
| **Medications over-the-counter** | | | Non reimbursable. |
| **Medicinal wines** | | | Non reimbursable. *See parapharmaceutical products*. |
| **Meditation therapy** | | | Non reimbursable. *See alternative medicine.* |
| **Megavitamin therapy** | | | Non reimbursable. |
| **Mental health and nervous care** | **In-patient** | | Reimbursable, subject to the limitations and exclusions of the Plan. See hospital services and supplies. The out-patient reimbursable rate of 80% and the maximum of one MIP reference salary in each calendar year (per eligible patient), do not apply. Treatment limited to 90 days in a calendar year. This limit may, however, be waived for active staff members upon request from the United Nations Medical Director. |
| **Out-patient** | | Reimbursable at the rate of 80% and to a maximum of one MIP reference salary in each calendar year (per eligible patient). Services must be provided by a licensed psychiatrist, licensed psychoanalyst, licensed psychologist or a licensed psychiatric social worker. *See psychiatry, psychology and psychotherapy.* |
| **Midwifery services** | | | Reimbursable at the rate of 80%. |
| **Military service accidents/injuries in time of war** | | | Non reimbursable. |
| **Mind/body therapy** | | | Non reimbursable. *See alternative medicine.* |
| **Mineral waters** | | | Non reimbursable. *See parapharmaceutical products.* |
| **Mouth wash** | | | Non reimbursable. |
| **Multiple Sclerosis treatment** | | | Reimbursable, subject to the limitations and exclusions of the Plan. |
| **Music therapy** | | | Non reimbursable. *See alternative medicine*. |
| **Naturophatic therapy** | | | Non reimbursable. *See alternative medicine.* |
| **Nebuliser** | | | Reimbursable at the rate of 80% if prescribed by the attending physician to treat a medical condition. The attending physician's prescription must indicate the medical condition requiring the nebulizer. |
| **Neonatology** | | | Reimbursable, subject to the limitations and exclusions of the Plan. |
| **Nephrology** | | | Reimbursable, subject to the limitations and exclusions of the Plan. |
| **Neurology** | | | Reimbursable, subject to the limitations and exclusions of the Plan. |
| **Neuro surgery** | | | Reimbursable, subject to the limitations and exclusions of the Plan. *See hospital services and supplies.* |
| **Non-smoking cures** | | | Non reimbursable. |
| **Non-surgical facelift** | | | Non reimbursable. |
| **Nuclear medicine** | | | Reimbursable, subject to the limitations and exclusions of the Plan. |
| **Nuclear radiology** | | | Reimbursable, subject to the limitations and exclusions of the Plan. *See radiology.* |
| **Nursing services** | **General hospital nursing** | | Reimbursable at the rate of 100%. |
| **Private hospital duty nursing** | | Non reimbursable. |
| **Private home duty nursing** | | Reimbursable at the rate of 80% if prescribed by attending physician as medically necessary. Attending physician's prescription must indicate:  a) medical condition requiring home health care; and  b) treatment plan including type and length.  If the duration of the treatment exceeds three months, the attending physician must reassess the treatment and issue a new prescription.  Services must be rendered by a qualified nurse. This benefit does not cover charges made for a person who usually lives with the patient, who is a member of his/her family or who is a member of his/her spouse’s family. |
| **Nutritional supplements** | | | Normally non reimbursable. Only reimbursable if prescribed by the attending physician to treat a medical condition e.g. anaemia, at the rate of:  a) 80% if out-patient; and  b) 100% if in-patient.  Attending physician must indicate condition to be treated and length of treatment. If the duration of the treatment exceeds three months, the attending physician must reassess the treatment and issue a new prescription. Laboratory tests must be attached. |
| **Nutrition support therapy (feeding tube of IV administration** | | | The provision of nutrients either enterally (i.e. by a feeding tube) or parenterally (i.e. by intravenous administration) to treat or prevent malnutrition is reimbursable, in order to restore and maintain the optimal overall health status.  Are also reimbursable special medical foods used for the treatment of specific metabolic disorders (histidinemia, homocystinuria, maple syrup urine disease, phenylketonuria, tyrosinemia).  Dietary supplements, vitamins and minerals and regular infant formulas are not reimbursable.  Nutrition support therapy is only reimbursable if prescribed by the attending physician at the rate of:  a) 80% if out-patient and  b) 100% if in-patient.  The attending physician must indicate the condition to be treated and the length of treatment.  If the duration of the treatment exceeds three months, the attending physician must reassess the treatment and issue a new prescription. |
| **Obesity treatment** | | | Reimbursable at a rate of 80% if prescribed by attending physician as medically necessary. |
| **Obstetrics** | | **Spouse** | Reimbursable, subject to the limitations and exclusions of the Plan. |
| **Child under 25 years old** | Only reimbursable, subject to the limitations and exclusions of the Plan, if the child under 25 lives with staff member. The newborn child is NOT covered under the plan. |
| **Occupational therapy** | | | Reimbursable, subject to the limitations and exclusions of the Plan. *See physical therapy.* |
| **Oncology** | | | Reimbursable, subject to the limitations and exclusions of the Plan. |
| **Ophthalmology** | | | Reimbursable, subject to the limitations and exclusions of the Plan. |
| **Orthomolecular therapy** | | | Non reimbursable. *See alternative medicine.* |
| **Osteoporosis Treatment** | | | Reimbursable, subject to the limitations and exclusions of the Plan.  Test results must be provided (bone osteodensitometry). |
| **Otolaryngology** | | | Reimbursable, subject to the limitations and exclusions of the Plan. |
| **Otology** | | | Reimbursable, subject to the limitations and exclusions of the Plan. |
| **Otorhinolaryngology** | | | Reimbursable, subject to the limitations and exclusions of the Plan. |
| **Oral biopsy and examination of oral tissue** | | | *See oral surgery.* |
| **Oral cyst removal** | | | *See oral surgery.* |
| **Oral extractions** | | | *See oral surgery.* |
| **Oral incision and drainage of abscess** | | | *See oral surgery.* |
| **Oral irrigator** | | | Non reimbursable. |
| **Oral surgery** | | | Reimbursable at the rate of 80% and normally, subject to the maximum benefit under dental care per calendar year i.e. one-half the MIP reference salary for each eligible patient.  ONLY the following surgeries are not subject to the maximum dental care benefit:  a) to treat a fracture, dislocation, or wound;  b) to cut out:  i) teeth partly or completely impacted in the bone of the jaw;  ii) teeth that will not erupt through the gum;  iii) other teeth that cannot be removed without cutting into bone;  iv) the roots of a tooth without removing the entire tooth; and  vi) cysts, tumors, or other diseased tissues;  c) to cut into gums and tissues of the mouth. This is only covered when not done in connection with the removal, replacement or repair of teeth;  d) to alter the jaw, jaw joints, or bite relationships by a cutting procedure when appliance therapy alone cannot result in functional improvement; and  e) to remove impacted damaged teeth injured in an accident, the treatment must be done within 12 months of the accident. Any such teeth must have been: free from decay; or in good repair; and firmly attached to the jaw bone at the time of the injury.  If there are doubts whether an oral surgery is not subject to the maximum dental care benefit, please contact the TPA. |
| **Oral water pik** | | | Non reimbursable. |
| **Orthodontics** | | | Reimbursable at the rate of 80% if treatment started before 15 years old, except accident cases, subject to the maximum benefit under dental care per calendar year i.e. one-half the MIP reference salary for each eligible patient. Maximum treatment period is four years. |
| **Orthopaedics** | | | Reimbursable, subject to the limitations and exclusions of the Plan. |
| **Orthopaedics appliances/devices** | | | Normally reimbursable at the rate of 80% if prescribed by the attending physician as medically necessary to treat a medical condition. The prescription must indicate the medical condition requiring the appliance/device. If the appliance/device is not included in this list and there are doubts as to whether it is reimbursable, please check with the TPA  The Plan covers:  a) replacement of purchased appliances/devices when ordered by the attending physician in cases of wear, damage, or change in the patient’s condition or body structure, and it costs less to replace than repair; and  b) reasonable costs for repairing, fitting, maintaining and adjusting appliances/devices. |
| **Orthopaedic heels** | | | Reimbursable, subject to the limitations and exclusions of the Plan. *See orthopaedic appliances/devices.* |

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| **Orthopaedic shoes** | Reimbursable, subject to the limitations and exclusions of the Plan. *See orthopaedic appliances/devices.* |
| **Orthotic appliances/devices** | Normally reimbursable at the rate of 80% if prescribed by attending physician as medically necessary to support part or all of a body function or organ. The prescription must indicate the medical condition requiring the appliance/device. If the appliance/device is not included in this list and there are doubts as to whether it is reimbursable, please check with the TPA.  The Plan covers:  a) replacement of purchased appliances/devices when ordered by the attending physician in cases of wear, damage, or change in the patient's condition or body structure, and it costs less to replace than to repair; and  b) reasonable costs for repairing, fitting, maintaining and adjusting appliances/devices. |
| **Oxidative therapy** | See intravenous oxidative therapy. |
| **Oxygen equipment** | The plan reimburses rental (or purchase when more economical or equipment cannot be rented), at the rate of 80%, if prescribed by the attending physician as medically necessary. Prescription must indicate the medical condition requiring the oxygen equipment. *See durable medical equipment.* |
| **Pacemaker** | Reimbursable, subject to the limitations and exclusions of the Plan. *See hospital services and supplies.* |
| **Pacemaker implantation surgery** | Reimbursable, subject to the limitations and exclusions of the Plan. *See hospital services and supplies.* |
| **Painless delivery preparation** | Reimbursable at the rate of 80%. |
| **Pap Smear** | Reimbursable at the rate of 80%. *See routine examinations*. |
| **Parapharmaceutical products** | Non reimbursable. |
| **Pathology** | Reimbursable, subject to the limitations and exclusions of the Plan. |
| **Paediatric orthotic appliances/devices** | Reimbursable, subject to the limitations and exclusions of the Plan. *See orthotic appliances/devices.* |
| **Paediatrics** | Reimbursable, subject to the limitations and exclusions of the Plan. |
| **Percutaneous epididymal sperm aspiration (PESA)** | Non reimbursable. *See infertility treatment*. |
| **Perinatology** | Reimbursable, subject to the limitations and exclusions of the Plan. |
| **Periodontics** | Reimbursable at the rate of 80%, subject to the maximum benefit under dental care per calendar year i.e. one-half the MIP reference salary for each eligible patient. |
| **Permanent cosmetic make-up (e.g. eyeliners, eyebrows, lipliners)** | Non reimbursable. |
| **Physical medicine and rehabilitation** | Reimbursable, subject to the limitations and exclusions of the Plan. *See physical therapy.* |
| **Physical therapy** | Reimbursable at the rate of 80 per cent rate as prescribed by a physician if to improve or restore bodily function which has been lost or impaired as a result of a disease, injury or congenital defect. The prescription must specify the number of sessions and the actual length of treatment.  Benefits are not provided for maintenance therapy designed to prevent deterioration of bodily functions. Attending physician’s prescription must indicate: a) bodily function to be improved or restored;  b) type of treatment;  c) number of sessions; and  d) actual length of treatment.  If this period **exceeds six months**, the treating physician must reassess the treatment after six months and issue a new prescription. Treatments requiring more than 60 sessions per calendar year are subject to the prior authorization of the Third Party Administrator’s Medical Doctor. |

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| **Physicians’ services-both specialists and non-specialists (except for mental health and substance abuse)** | **Home visits** | Reimbursable at the rate of 80%. |
| **In-hospital visits** |
| **Office visits** |
| **Surgery** |
| **Plastic facial surgery** | | *See plastic surgery.* |
| **Plastic surgery** | **to improve, alter or enhance appearance** | Non reimbursable whether or not for psychological or emotional reasons. |
| **to improve the function of a part of the body** | Reimbursable subject to the limitations and exclusions of the Plan when the part of the body is malformed:  a) as a result of a severe birth defect; this includes harelip or webbed fingers or toes; or  b) as a direct result of disease or surgery performed to treat a disease or injury. |
| **to repair an injury** | Reimbursable, subject to the limitations and exclusions of the Plan. *See hospital services and supplies.* |
| **Podiatry** | | Reimbursable at the rate of 80% provided it is to treat disorders of the foot. Treatment must be conducted by a qualified medical doctor. |
| **Positron emission tomographic (PET)** | | Reimbursable, subject to the limitations and exclusions of the Plan. *See scanning.* |
| **Pregnancy tests** | | Non reimbursable. |
| **Premarital examinations** | | Non reimbursable. |
| **Primal therapy** | | Non reimbursable. |
| **Proctology** | | Reimbursable, subject to the limitations and exclusions of the Plan. |

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| **Prophylaxes (tooth cleaning)** | Reimbursable at the rate of 80% subject to two per calendar year (per eligible patient) and the maximum benefit under dental care per calendar year i.e. one-half the MIP reference salary for each eligible patient. |
| **Prostate specific antigen (PSA)** | Reimbursable at the rate of 80%. *See routine examinations*. |
| **Prosthetic appliances/devices** | Normally reimbursable at the rate of 80% if prescribed by attending physician as medically necessary to support part or all of a body function or organ. The prescription must indicate the medical condition requiring the appliance/device. If the appliance/device is not included in this list and there are doubts as to whether it is reimbursable, please check with the TPA.  The Plan covers:  a) replacement of purchased appliances/devices when ordered by the attending physician in cases of wear, damage, or change in the patient’s condition or body structure, and it costs less to replace than to repair; and  b) reasonable costs for repairing, fitting, maintaining and adjusting appliances/devices. |
| **Prosthodontics** | Reimbursable at the rate of 80% subject to the maximum benefit under dental care per calendar year i.e. one-half the MIP reference salary for each eligible patient. |
| **Proteins** | Normally non reimbursable. Only reimbursable if prescribed by the attending physician to treat a medical condition e.g. anaemia, at the rate of:  a) 80% if out-patient; and  b) 100% if in-patient.  Attending physician must indicate condition to be treated and length of treatment. If the duration of the treatment exceeds three months, the attending physician must reassess the treatment and issue a new prescription. Laboratory tests must be attached. |

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| **Psychiatry** | Reimbursable at the rate of 80% subject to the maximum benefit under mental and nervous care of one month MIP reference salary in any calendar year (per eligible patient). |
| **Psychodrama treatment** | Non reimbursable. |
| **Psychology** | Reimbursable at the rate of 80% subject to the maximum benefit under mental and nervous care of one month MIP reference salary in any calendar year (per eligible patient). Attending physician must indicate medical condition to be treated and length of treatment. If the duration of the treatment exceeds three months, the attending physician must issue a new prescription. |
| **Psychotherapy** | Reimbursable at the rate of 80% subject to the maximum benefit under mental and nervous care of one month MIP reference salary in any calendar year (per eligible patient). Attending physician must indicate medical condition to be treated and length of treatment. If the duration of the treatment exceeds three months, the attending physician must issue a new prescription. |
| **Pulpotomy** | *See endodontics*. |
| **Pulmonary medicine** | Reimbursable, subject to the limitations and exclusions of the Plan. |
| **Radiation oncology** | *See radiological treatment* |
| **Radiological treatment** | Reimbursable, subject to the limitations and exclusions of the Plan. Chemotherapy and radiation treatments **outside of the hospital** are reimbursed at 100 per cent rate if the patient has been referred to the specialist by the attending physician.  Attending physician’s prescription must specify the number of sessions and the actual length of the treatment. If the duration of the treatment exceeds three months, the treating physician must reassess must issue a new prescription.  Chemotherapy and radiation treatments outside of the hospital are reimbursed at 100 per cent rate for all Plan participants. |

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| **Radionuclide** | | | Reimbursable, subject to the limitations and exclusions of the Plan. *See scanning.* |
| **Reconstructive surgery** | | | *See plastic surgery and hospital services/supplies.* |
| **Reflexology** | | | Non reimbursable. *See alternative medicine*. |
| **Reflexotherapy** | | | Non reimbursable. |
| **Rejuvenation cure** | | | Non reimbursable. |
| **Removal of bags around the eyes** | | | Non reimbursable. *See cosmetic surgery and blepharoplasty.* |
| **Removal of** | **Tattoos** | | Non reimbursable. *See cosmetic surgery*. |
| **Excess tissue and fat from the abdomen** | |
| **Bunions** | | Reimbursable, subject to the limitations and exclusions of the Plan. |
| **Rest cures** | | | Non reimbursable. |
| **Reshaping the nose** | | | *See plastic surgery and rhinoplasty.* |
| **Reverse salpingectomy (surgical sterilization)** | | | Non-reimbursable. |
| **Reverse vasectomy** | | | Non-reimbursable. |
| **Rheumatology** | | | Reimbursable, subject to the limitations and exclusions of the Plan. |
| **Rhinoplasty** | | | *See plastic surgery.* |
| **Rhytidectomy** | | | Non reimbursable. *See cosmetic surgery and facelift.* |
| **Rolfing treatment** | | | Non reimbursable. |
| **Root canal therapy (RCT)** | | | *See endodontics*. |
| **Routine Examinations[[2]](#footnote-2)** | **Children (including immunizations)** | | Birth to 1 year of age every 2 months  1 through 2 years of age every 6 months  3 through 6 years of age every year  7 years until 19th birthday every 2 years  At the rate of 100%. |
| **Men** | | One routine urological examination per year, including one prostate specific antigen (PSA) screening, at the rate of 80%. |
| **Women** | | One routine gynecological examination per year, including one pap smear and one mammography, at the rate of 80%. |
| **Routine Physical** | | | One routine physical for patients ages 20 and above, every 12 months, at the rate of 80% subject to the reasonable and customary costs in the duty station. Includes related x-rays, laboratory and any other charges (*See Annex D to MIP Rules*). |
| **Salpingectomy (surgical sterilization)** | | | Reimbursable, subject to the limitations and exclusions of the Plan (reverse salpingectomy non reimbursable). |
| **Scanning** | **Computerized tomographic (CT)** | | Reimbursable if prescribed by the attending physician at the rate of:  a) 80% if out-patient; and  b) 100% if in-patient. |
| **Magnetic resonance imaging (MRI)** | |
| **Positron emission tomographic (PET)** | |
| **Radionuclide (also called radioi isotope)** | |
| **Ultrasonic imaging** | |
| **Second surgical opinion** | | | Reimbursable at the rate of 80%. |
| **Semen cryopreservation (freezing)** | | | Non reimbursable. *See infertility treatment and embryo cryopreservation.* |
| **Sexually transmitted diseases (STDs) treatment** | | | Reimbursable, subject to the limitations and exclusions of the Plan. |
| **Shampoos and hair lotions** | | **Regular** | Non reimbursable. *See parapharmaceutical products*. |
| **Medicated/Prescription** | Only reimbursable at the rate of 80% if prescribed by the attending physician to treat a medical condition (e.g. seborrheic dermatitis) and provided the hair lotion/shampoo is not an over the counter product. Attending physician must indicate condition to be treatedand length of treatment. If the duration of the treatment exceeds three months, the attending physician must reassess the treatment and issue a new prescription. |
| **Shiatsu** | | | Non reimbursable. *See alternative medicine*. |
| **Sign language lessons** | | | Non reimbursable. |
| **Skilled nursing** | | | *See nursing services*. |
| **Skin diseases** | | | Reimbursable, subject to the limitations and exclusions of the Plan. |
| **Skin food** | | | Non reimbursable. *See parapharmaceutical products*. |
| **Sleeping cures** | | | Non reimbursable. |
| **Smoking cessation aids or drugs** | | | Non reimbursable. |
| **Spa cures** | | | Non reimbursable. |
| **Speech therapy** | | | Reimbursable at the rate of 80% if to improve or restore speech function (the ability to express thoughts, speak words, and form sentences) which has been lost or impaired as a result of a disease, injury or congenital defect. Benefits are not provided for maintenance therapy designed to prevent deterioration of speech function. Attending physician’s prescription must specify:  a) type of treatment,  b) number of sessions; and  c) actual length of treatment.  If the duration of the treatment exceeds three months, the treating physician must reassess the treatment and issue a new prescription. |
| **Spinal orthotic appliances/devices** | | | Reimbursable, subject to the limitations and exclusions of the Plan. *See orthotic appliances/devices.* |
| **Sport accidents/injuries** | **Dangerous hazardous or violent sports, for example, motorized sports, parachuting, gliding, boxing and martial arts** | | Non reimbursable. |
| **Normal sports, skiing, swimming** | | Reimbursable, subject to the limitations and exclusions of the Plan. |
| Stomach ulcer treatment | | | Reimbursable, subject to the limitations and exclusions of the Plan. |
| **Substance abuse** | **In-patient treatment for detoxification and rehabilitation** | | The cost of treatment for substance (alcohol and/or drug) abuse is covered, under certain conditions. The coverage includes in-patient treatment (see MIP Rule 3.2) for detoxification and rehabilitation at a facility certified for such treatment, subject to the prior approval of the TPA. Such treatment will normally be limited to 90 days in a calendar year. This limit may, however, be waived for active staff members upon request from the United Nations Medical Director. |
| **Out-patient counselling for the purpose of diagnosis and treatment** | | Reimbursable at the rate of 80% subject to the maximum benefit under mental and nervous care of one month MIP reference salary in any calendar year (per eligible patient). Services must be provided by a licensed psychiatrist, licensed psychoanalyst, licensed psychologist or licensed psychiatric social worker. *See psychiatry, psychology and psychotherapy.* |
| **Suction lipectomy** | | | Non reimbursable. *See cosmetic surgery, liposuction and removal of excess fat.* |
| **Sugar free tablets** | | | Non reimbursable. |
| **Sun blocks/screen** | | | Non reimbursable. |
| **Sunglasses** | **Prescription** | | Reimbursable, subject to the limitations and exclusions of the Plan. *See corrective lenses.* |
| **Non prescription** | | Non reimbursable. |
| **Support stockings for varicose veins** | | | Reimbursable, subject to the limitations and exclusions of the Plan. |
| **Surgery** | | | *See hospital services.* |
| **T’ai Chai** | | | Non reimbursable. *See alternative medicine*. |
| **Teeth Whitening** | | | Non reimbursable |
| **Telephone alert systems** | | | Non reimbursable. |
| **Temporo-mandibular joint (TMJ) surgery** | | | Reimbursable, subject to the limitations and exclusions of the Plan. *See oral surgery.* |
| **Testicular sperm aspiration (TESA)** | | | Non reimbursable. *See infertility treatment*. |
| **Testicular sperm extraction (TESE)** | | | Non reimbursable. *See infertility treatment*. |
| **Therapeutic touch** | | | Non reimbursable. *See alternative medicine.* |
| **Thermometers** | | | Non reimbursable. |
| **Toiletries** | | | Non reimbursable. |
| **Tooth restorations** | | | Reimbursable, subject to the limitations and exclusions of the Plan. *See dental restorations.* |
| **Toothbrush** | | | Non reimbursable. |
| **Toothpaste** | | **Regular** | Non reimbursable. |
| **Medicated/prescription** | Only reimbursable at the rate of 80% if prescribed by the attending dentist to treat a medical condition and provided the toothpaste is not an over the counter product. Attending dentist must indicate condition to be treated and length of treatment. If the duration of the treatment exceeds three months, the attending dentist must reassess the treatment and issue a new prescription. |
| **Tubal ligation (surgical sterilization)** | | | Reimbursable, subject to the limitations and exclusions of the Plan. *See salpingectomy.* |
| Ultrasonic imaging | | | Reimbursable, subject to the limitations and exclusions of the Plan. *See scanning.* |
| Urology | | | Reimbursable, subject to the limitations and exclusions of the Plan. |

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| **Varicose vein surgery** | | Reimbursable at the rate of 80% if prescribed by the attending physician as medically necessary. |
| **Vasectomy (surgical sterilization)** | | Reimbursable (reverse vasectomy not reimbursable). |
| Viagra | | Reimbursable subject to a maximum of 6 tablets per month. See drugs. |
| Vision perception training | | Non reimbursable. |
| Vision therapy | | Reimbursable at the rate of 80% if to improve or restore vision function which has been lost or impaired as a result of a disease, injury or congenital defect. Benefits are not provided for maintenance therapy designed to prevent deterioration of vision function. Attending physician's prescription must specify:  a) type of treatment;  b) number of sessions; and  c) actual length of treatment.  If the duration of the treatment exceeds three months, the treating physician must reassess the treatment and issue a new prescription. |
| Vitamins | | **Vitamins and minerals**:  Not covered unless the vitamin or mineral in question is taken to cure an existing deficit. Laboratory tests must indicate the deficit. Examples of treatments that qualify for reimbursement:  Calcium for osteoporosis  Iron for iron deficiency anemia  Vitamin C for HIV  Vitamin D for osteoporosis and for children  Attending physician must indicate condition to be treated and length of treatment. If the duration of the treatment exceeds there months, the attending physician must reassess the treatment and issue a new prescription. Laboratory tests must be attached.  **Multivitamin**s: not covered  For vitamins and are minerals that are covered based on the above provisions, they will be reimbursed at the rate of:  a) 80% if out-patient; and  b) 100% if in-patient. |
| **Voluntary accidents/injuries** | | Non reimbursable. *See self-inflicted accidents/injuries*. |
| **Walking cane** | | Reimbursed at the rate of 80%, if prescribed by the attending physician as medically necessary. See durable medical equipment. |
| **Wheelchair** | | The Plan reimburses rental (or purchase when more economical or wheelchair cannot be rented), at the rate of 80%, if prescribed by the attending physician as medically necessary. The prescription must indicate the medical condition requiring the wheelchair. *See durable medical equipment.* |
| **Yeast infection treatment.** | | Reimbursable, subject to the limitations and exclusions of the Plan. *See drugs.* |
| **Yoga** | | Non reimbursable. *See alternative medicine*. |
| **X-rays** | **Emergency room** | Reimbursable at the rate of:  a) 100% if used for emergency care; or  b) 80% if used for non-emergency care.  *See hospital emergency room services and supplies.* |
| **In-patient** | Reimbursable at the rate of 100%. |
| **Out-patient** | Reimbursable at the rate of 80% if prescribed by the attending physician. |
| **Zygote intrafallopian transfer (ZIFT)** | | Non-reimbursable. *See infertility treatment.* |

1. 1 **This list is not exhaustive. If an item is not listed and there are doubts on the coverage, contact the Third Party Administrator (TPA).** [↑](#footnote-ref-1)
2. **A routine examination is an examination given by a physician for a reason other than to diagnose or treat a suspected or identified injury or disease.** [↑](#footnote-ref-2)