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343.7 PART VII - MEDICAL COVERAGE FOR NON-STAFF (MCNS)

343.7.1 GENERAL

.7.11 The plan, which is underwritten by an International Insurance Company in conjunction with a Claims processor (identified in Appendix A) , provides world-wide insurance against accident or illness. Contacts for the settlement of claims (see para. 343.7.8) are with the Claims Processor acting on behalf of the Insurer.

.7.12 Definitions. For the purposes of Part VI of this Manual Section,

.7.121 "Service-incurred" means attributable to the performance of official duties on behalf of the Organization as defined in Manual Section 342.2.13.

.7.122 "Accident" means the unintended impairment of physical or psychological integrity caused by an external factor.

.7.123 "Total disablement" means disablement which entirely prevents the insured person from attending to their business or occupation of any and every kind or, if they have no business or occupation, from attending to their usual duties.

.7.124 "Partial disablement" means disablement which prevents the insured person from attending to a substantial part of their business or occupation, or, if they have no business or occupation, from attending to a substantial part of their usual duties.

.7.125 "Permanent disablement" means disablement lasting twelve calendar months and, at the expiry of that period, being beyond all reasonable hope of improvement.

.7.126 "Specified disease" means a service-incurred disease contracted as a direct consequence of the insured person's presence in tropical or medically-recognized unhealthy areas.

The specified diseases are listed in Appendix C.

.7.127 "Annual Related Remuneration" is defined as the annual net earnings/annual net salary an insured person is receiving at the inception of the illness or time of the accident, as specified by WFP/FAO in its contractual arrangement with the insured person.

In the event of contractual arrangements of less than 12 months, but greater than one month, the annual net earnings will be calculated as the monthly net earnings, as specified in the insured person's contractual arrangement, times 12 calendar months.

In the event of short term contractual arrangements of less than a calendar month, the total earnings within the contractual arrangement period will be deemed as the monthly earnings, for the purpose of calculating the annual net earnings. In the event of more than one within a calendar month, the sum of net earnings of both contractual arrangements will be the monthly net earnings upon which to calculate Annual Related Remuneration.

For any individual serving without any compensation the net salary element is a theoretical annual base honorarium equal to one third of USD 50,000

343.7.2 APPLICATION

.7.21 Coverage is automatic for the following:

(a) the Chairman of the FAO Council, representatives of members of the Council, members of committees, commissions or similar bodies who

receive from FAO either travel costs, or daily subsistence (DSA), or both;

(b) candidates for contractual arrangement;

(c) fellowship holders, counterpart personnel on study tours, and participants in training courses, seminars and meetings;

(d) South South Cooperation experts/technicians.

(e) FAO Interns.

(f) casual labour employed in the field

.7.22 Family members are not eligible for coverage.

343.7.3 COVERAGE

.7.31 Insured persons are covered automatically by the plan from the date travel paid for by the Organization commences, or from the date DSA or remuneration is paid.

.7.32

(a) The persons insured under sub-paras. 343.7.21 categories (a) to e) are covered on a 24-hours-a-day basis during the period when they receive remuneration, DSA or when travel is at the expense of the Organization. Coverage is provided for:

(i) medical expenses resulting from accident or illness occuring respectively during a period of contractual arrangement, an interview journey, a study tour programme and related travel;

(ii) compensation for death and permanent total or partial disablement resulting from an accident.

(iii) compensation for permanent total or partial disablement caused by service- incurred illness or specified disease.

(iv) The persons insured under sub-para. 343.7.21 category (a) are also entitled to the extended cover of compensation for death caused by service -incurred illness or specified disease.
Payment of compensation for death due to service-incurred illness or specified disease is made only if such death occurs within 12 months of cessation of engaging in FAO activities.

(b) The persons insured under sub-para. 343.7.21 category (f) are covered exclusively for:

- medical expenses resulting from a service-incurred accident or illness;

- compensation for death and permanent total or partial disablement resulting from a service-incurred accident.

.7.33 Wherever possible, all insured persons must fill in form Adm. 60, Designation of Beneficiary, and mail it to the Headquarters division concerned, before commencing travel. Persons insured under para. 343.7.21 category (a) may leave the form with the FAO representative, who forwards it to the Headquarters division.

343.7.4 CONTRIBUTIONS

.7.41 The total contribution is paid annually in advance by the Organization.

.7.42 Contributions are charged to the division concerned or project funds, as appropriate.

343.7.5 BENEFITS

.7.51 Medical Expenses resulting from Accidents or Illness

Medical, pharmaceutical and hospital expenses that are medically necessary, reasonable and customary, incurred by the insured person as the result of an accident or illness are reimbursed up to USD 50 000 for any one illness or accident. The Organization is self-insured for the first USD 500 per contractual arrangement for each person insured under 343.7.21 categories (a),(b),(c),(e) and (f), which is charged in accordance with para. 343.7.42. If the contractual arrangement and any extension exceeds 12 months, a new USD 500 deductible will apply. The deductible amount of USD 500 of medical expenses per contractual arrangement is not applicable to South South Cooperation category (d). The hospital expenses at the maximum bed and board rate for a room for two or more patients, include operation fees, cost of surgical appliances but exclude convalescence and optical or dental treatment, unless such treatment is rendered necessary as the result of an accident. These medical expenses are additional to any benefit provided in para. 343.7.52. Medical expenses to cover hospitalization and pharmaceutical costs incurred are extended for up to 90 days from expiration of the contractual arrangement, only in cases where the insured person is hospitalized before his/her contractual arrangement ends with the Organization. After hospitalizaton, this guarantee includes only doctor visits and pharmaceutical costs related to the illness that caused the hospitalization.

.7.52 Compensation Payable for Accidents

.7.521 Permanent total or partial disablement due to accident

(a) For permanent total disablement, the person insured under:

(i) para. 343.7.21 categories (a) to (e) receives three times annual related remuneration subject to a maximum of USD 50 000;

(ii) para. 343.7.21 category (f) receives in case of a service-incurred accident five times the lowest entry level of the local G-1 related remuneration subject to a maximum of USD 20 000.

(b) For permanent partial disablement, the insured person receives an indemnity calculated in accordance with the schedule of compensation set out in Appendix B.

.7.522 Death due to accident. The insured person's designated beneficiary receives the same indemnities as provided in para. 343.7.521(a) for each category.

.7.523 Maximum indemnity. Payments under paras. 343.7.521 and 343.7.522 will not exceed jointly the maximum provided in para. 343.7.521(a) for each insured person.

.7.53 Compensation Payable for Illness

.7.531 Permanent total or partial disablement due to service-incurred illness or specified disease

(a) For permanent total disablement, the person insured under para. 343.7.21 categories (a) to (e) receives three times annual related remuneration subject to a maximum of USD 50 000;

(b) For permanent partial disablement, the person insured under para 343.7.21 categories (a) to (e) receives an indemnity calculated in accordance with the schedule of compensation set out in Appendix B.

.7.532 Death due to service-incurred illness or specified disease. The designated beneficiary of the person insured under para. 343.7.21 category (a) receives the same indemnities as provided in para. 343.7.521(a)(i).

343.7.6 EXCLUSIONS

.7.61 Coverage does not extend to death or disablement

(a) consequent on the insured person engaging or taking part in:
  (i) naval, military or air force service or operations,
  (ii) driving or riding motor cycles or motor scooters over 200 cc.;
  (iii) hunting or driving in any kind of race;
(b) directly or indirectly consequent on the insured person engaging in air travel except as passenger;
(c) resulting from suicide or attempted suicide or intentional self-injury or venereal disease, or from deliberate exposure to exceptional danger (except in an attempt to save human life), or from the insured person's own criminal act, or sustained while the insured person is in a state of insanity.

.7.62 The Plan does not cover compensation payments for temporary total disablement due to pregnancy and confinement with or without complications. With the exception of holders of fellowships, the contractual arrangement does not cover medical expenses resulting from normal pregnancy and confinement; it does cover, however, medical expenses necessarily incurred in the treatment of complications of pregnancy up to the beginning of confinement. Expenses relating to new-born infants are excluded.

.7.63 The coverage does not extend to:

(a) non prescription items, hygienic and cosmetic products, dietary products including artificial milk, syringes;
(b) routine health examinations;
(c) hearing aids, spectacles and costs of spa cures, nature clinics and health farms;
(d) dental and optical treatment, except when necessary as the result of an accident;
(e) rejuvenation cures and cosmetic treatment. Cosmetic treatment is covered, however, when it is necessary as the result of an accident covered by this plan;
(f) the direct or indirect result of ionising radiations or contaminations by radioactivity;
(g) expenses for or in connection with travel or transportation whether by ambulance or otherwise except for a professional ambulance service used to transport the insured person from the place where they are injured by an accident or stricken by a disease to the hospital where treatment is given.

PLEASE NOTE: THE ABOVE EXCLUSIONS SHOULD NOT BE CONSIDERED AN EXHAUSTIVE LIST. PLEASE CONTACT THE PLAN ADMINISTRATORS FOR UPDATED INFORMATION AND ADDITIONAL DETAILS.

343.7.7 SUBMISSION OF CLAIMS

.7.71 General

.7.711 Time limits. Claims should be submitted with the least possible delay, but not until receipts amount to USD 10 or more. Claims for medical expenses arising from illness or accident occurring during the period of coverage must be submitted to the insurers within two years from the date on which the treatment was given. Any medical treatment and/or surgery expenses, incurred after the period of coverage has ended, will not be reimbursed.

Claims for temporary or permanent disablement resulting from an illness occurring during the period of coverage and claims for death and permanent

total or partial disablement resulting from an accident occurring during the period of coverage must be submitted to the insurers within two years from the date on which the illness declared itself or the accident took place (see, however, para. 343.7.32 (a) (iv). Immediate notice of an accident or illness which causes or may cause death or disablement of an insured person, must be given to the Claims Processor through the Organization.

.7.712 Any payment slips showing reimbursement by other medical plans must be attached to the claim.

.7.72 Medical Expenses and Compensation Payments for Permanent Total or Partial Disablement

.7.721 Claims for reimbursement of medical expenses and for compensation for permanent total or partial disablement are submitted by the insured person in a letter or memorandum, together with supporting documentary evidence (see para. 343.7.74), to the responsible HR Officer who, after certification that the claimant was covered by MCNS at the time the accident or illness occurred or the medical expenses were incurred, forwards the claim to the Claims Processor.

.7.722 Fellowship holders should submit claims in a sealed envelope to the FAO Office that awarded the fellowship (FAO representation, Regional Office or FAO technical division)including diagnosis and expenses incurred. These documents should be attached to Claim form “Medical Expenses Form” (ADM 153d) duly completed and signed by the fellow. The said claim form must be certified by the responsible HR Officer or Budget Holder The responsible office should arrange for reimbursement of any expenses not exceeding USD 500 for every accident or illness per contractual arrangement and crediting such amount to the relevant fellowship budgetary provision. The first USD 500 for every accident or illness are charged against the appropriate fellowship budgetary provision. Amounts over and above the ceiling of USD 500 claims have to be submitted to the Claims Processor, which will reimburse the claim expenses directly to the fellowoship holder. If the contractual arrangement and any extension exceeds 12 months a new USD 500 deductible will apply.

.7.723 Participants in training courses, seminars and meetings, or on their behalf disbursing officers to group training activities, should submit claims, including diagnosis in a sealed envelope, to the responsible divisional Budget Holder who is responsible for certifying the duration of the contractual arrangement and coverage and forwarding the claim to the Claims Processor for reimbursement of any expenses exceeding USD 500 for every accident or illness and for proper crediting of any refund received. The first USD 500 for every accident or illness per contractual arrangement contractual arrangement are charged against the appropriate budgetary provision. If the contractual arrangement and any extension exceeds 12 months a new USD 500 deductible will apply.

.7.73 Compensation for Accidental Death. Claims for compensation for accidental death are submitted by the designated beneficiary in a letter or memorandum, together with supporting documentary evidence (see para. 343.7.743), to the responsible HR Officer concerned, which, after certification that the claimant was covered by MCNS, forwards the claim to the Claim Processor together with the deceased's Designation of Beneficiary form.

.7.74 Documents Required for Claims. The following documents must be attached to the claim:

.7.741 For medical expenses:

(a) medical certificate on the physician's own stationery showing diagnosis, treatment prescribed and dates of visits;

(b) itemized original receipted bill for all expenses incurred; such bills and all prescriptions must be on the physician's stationery and show the name of the patient; prescriptions must bear the cancellation or date-stamp of the pharmacy providing the medicines;

(c) summary translation in one of the following languages: English, French, Spanish or Italian.if not already written in one of these languages.

.7.742 For permanent total or partial disablement: a detailed report issued by the insured person's attending physician, together with a completed form Adm. 62, Report of Accident, Illness or Death.

.7.743 For death:

(a) birth certificate of the insured person;

(b) death certificate; medical certificate stating the cause of death, if this is not indicated in the death certificate. If death is due to an accident, the death or medical certificate must state in an unequivocal manner the relationship between the accident and the death;

(c) a completed form Adm. 62 Report of Accident, Illness or Death.

.7.744 The Claims Processor may verify medical certificates by arranging at its own expense for a physician to examine the sick or disabled insured person. Such insured person is required to undergo this examination but may insist on the presence of their own doctor. Refusal of the insured person to permit such examination will result in the withholding of reimbursement by the Claims Processor.

.7.745 In all cases the Claims Processor has the right to request the insured person to provide if necessary through the Organization information regarding the injury or illness and treatment given. Confidential information may be sent under seal to the medical advisers of the Claims Processor.

.7.746 Claims submitted with incomplete documentation are returned to the insured person for completion.

343.7.8 SETTLEMENT OF CLAIMS

.7.81 The responsible HR Officer in receipt of a claim duly certifies the duration of the contractual arrangement and coverage and forwards it to the Claims Processor.

.7.82 The conversion of expenses sustained by the insured person in currencies other than US Dollars is made on the basis of the UN operational rate of exchange prevailing on the date of provision of the claimed medical services.

.7.83 Payments made directly by the Claims Processor to the insured person are by means of a US Dollars cheque in their name except in Eurozone countries where the cheque is drawn in Euro. When the insured person is entitled to reimbursement by another Insurer, reimbursement under this plan will be made as appropriate on the basis of the difference between the costs actually incurred and the reimbursement obtained from other sources.

.7.84 Reimbursement is made as follows:

(a) for medical expenses and permanent total or partial disablement, the insured person is paid directly by the Insurers, normally within two weeks following receipt by the Insurers of the claim and supporting documentary evidence;

(b) claims for death are paid by the Claims Processor to the Organization, normally within two weeks following receipt by the Claims Processor of the supporting documentary evidence. Where no beneficiary has been designated, the benefit is retained by the Claims Processor until a competent court or authority has designated the persons to whom the payment should be made or has ordered the consignment of the benefit. No interest is due by the Claims Processor on the retained or consigned benefit. The Claims Processor shall be entitled to use any means deemed fit to check the veracity of the facts given and also to ask for an autopsy; if the beneficiaries were to refuse they shall not be entitled to payment of the benefit.

.7.85 Disputes

.7.851 The present contractual arrangement includes a provision concerning any disputes which may arise between an insured person or a beneficiary and the Claims Processor on medical questions; Article 18 (b) thereof reads as follows:

"Settlement of disputes between insured persons or beneficiaries and the Claims Processor

Disputes between an insured person and the Claims Processor shall be limited to medical questions. Such disputes, unless settled by negotiation, shall be referred to a medical arbitrator designated jointly by a doctor chosen by the insured person and by the Claims Processor's doctor. If no agreement is reached on the selection of the medical arbitrator, the latter shall be designated by the Chairman of the Executive Board of the Order of Physicians or by some other medical authority having competence in the insured person's domicile. The decision of such medical arbitrator shall be final. The fees payable to the medical arbitrator are shared equally by the insured person and the Claims Processor. The Organization may, if it so wishes, formally associate itself with the complaint of an insured person, in which case the fees payable to the medical arbitrator by the insured person shall be shared equally by the Organization and the insured person."

.7.852 Copies of any correspondence with the Claims Processor on a dispute on medical questions must be sent to Social Security and Payroll Benefits Branch, CSHS

.7.86 Claims against Third Parties. Action against third parties by the insured person as the result of accident or illness of which they were the victim is governed by Article 15 of the contractual arrangement concluded between the Organization and the Claims Processor, which reads as follows:

"Subrogation. Within the limits of the reimbursement provided, the Claims Processor succeeds to the right which the victim of an accident or illness may have against third parties. Under penalty of forfeiture of cover, the said victim is required to confirm this subrogation in writing when the Claims Processor so requires."