ANNEX II

To Request for Proposals (RFP) N° PCD/09/007

WIPO ADMINISTRATIVE MANUAL

MEDICAL INSURANCE

1. PURPOSE OF THE INSURANCE CONTRACT

On the basis of this contract, the persons specified in paragraph 3.2 below are insured for reasonable and customary expenses relating to medical and pharmaceutical treatment resulting from illness, accident or maternity, to preventive care and to dental treatment under a group insurance plan, the conditions of which are set out hereafter.

2. DEFINITIONS--INSURED PERSONS--ADMISSION--WITHDRAWAL FROM THE GROUP INSURANCE PLAN

2.1 Definitions

For the purposes of this contract, the following definitions apply:

(a) reasonable and customary expenses: expenses that do not exceed the normal charge made for the service or supply concerned in the locality in which it is given and under the best prevailing conditions (subject to the limits specified in other chapters of this contract and taking into account the nature and severity of the accident or illness for which treatment is given);

(b) accident: any sudden and involuntary injury to the human body resulting from an exceptional external cause;

(c) day surgery: any surgery requiring the use of an operating theater performed in the course of one day and without an overnight stay;

(d) illness: any deterioration in health confirmed by a competent medical authority;

(e) maternity: any treatment related to pregnancy;

(f) medical treatment: any examination or measure taken to restore and maintain health;

(g) doctor: any person who holds a medical degree from a school of university level recognized by the government of the country in which the person is licensed to practice medicine.

Reference to insured persons in the masculine gender shall apply to both sexes, unless clearly inappropriate from the context.

2.2 Persons Insured

The following persons may be insured, provided that the maximum age on admission shall be 65 years:

(a) staff members and employees of WIPO or of the Union for the Protection of New Varieties of Plants (UPOV);

(b) retired WIPO and UPOV staff, provided that they were covered by the group medical insurance plan for five years before their separation from service, and persons receiving pensions or other retirement benefits from WIPO or from UPOV, hereinafter referred to as "pensioners";

(c) the spouses of staff members and pensioners; with regard to the spouses of pensioners, they must have been members of the group medical insurance scheme for at least five years prior to the staff member's separation from service;

(d) the dependent children of staff members and pensioners; for the purposes of this insurance, dependent children means the unmarried children under 18 years of age, or under 25 years of age if in regular attendance at a school, university or comparable educational establishment; children of pensioners must have been members of the group medical insurance scheme for at least five years before the pensioner's separation from service;

(e) the staff member's or pensioner's unmarried children over 18 and under 30 years of age, living together with the staff member or pensioner and/or for whom the staff member or pensioner provides main and continuing support; children of pensioners must have been members of the group medical insurance scheme for at least five years before the pensioner's separation from service;

(f) unmarried children of the staff member or pensioner who are physically or mentally incapable, owing to illness or accident, of such gainful employment as would enable them to meet their needs; children of pensioners must have been members of the group medical insurance scheme for at least five years before the pensioner's separation from service;

(g) one of the following persons: a father or a mother or a brother or a sister who is considered dependent according to the Staff Regulations and Staff Rules.

However, the widower or the widow of a WIPO or UPOV staff member who remarries will not be able to insure the new dependants resulting from that marriage.

2.3 Admission

2.3.1 Admission takes effect, without medical examination or reservation, on the admission date entered by WIPO on the admission form. Entitlement to benefits begins as of the admission date. However, the staff member, employee or pensioner, or one of the dependents must join the insurance scheme on the date indicated by WIPO, or on the date corresponding to the end of the period of notice in respect of his previous insurer. Persons wishing to join subsequently will be subject to a waiting period of two months following the date on which the application for membership is signed.

2.3.2 On admission, the insured person will receive an insurance card.

2.4 Withdrawal from the Group Insurance Plan - Individual Insurance

2.4.1 Withdrawal from the Group Insurance Plan

Persons who no longer satisfy the conditions set out in paragraph 3.2 will cease to participate in the group insurance plan. They will be covered up to the end of the

month during which they cease to participate in the group insurance plan. The liability of WIPO towards the Insurers terminates as of the date on which the person concerned ceases to participate in the group insurance plan.

2.4.2 Individual Insurance

Any person who no longer participates in the group insurance plan (see paragraph 3.4.1 above) may maintain the insurance coverage described in chapters 4 and 5 below by subscribing an individual contract. The conditions of such contract are as follows:

(a) The intention to remain individually insured must be declared within one month of the day of withdrawal from the group insurance plan. It is not required to undergo any medical examination nor to complete a medical questionnaire.

(b) The individual contract will take effect on the day following the day of withdrawal. It will terminate at the latest after a period of two years. This limitation in time does not apply in those cases where the insured person provides proof that, for medical reasons, he is unable to find alternative coverage.

(c) The monthly premium under the individual contract corresponds to the monthly contribution to the group insurance plan, multiplied by 1.2.

2.4.3 The premiums paid under individual contracts and the corresponding reimbursements are not taken into account for the annual review of the premium under the group insurance plan.

3. INSURANCE FOR MEDICAL AND PHARMACEUTICAL TREATMENT

3.1 Extent of Insurance

3.1.1 Principles

This group insurance plan affords free choice of doctor and hospital establishment. Except where otherwise stipulated, the insurance provides unlimited cover for the cost of treatment for illness or injury due to accident and of preventive treatment, after deduction of the insured person's contribution (franchise and percentage share), if any.

3.1.2 Risks Excluded

Coverage does not extend to:

(a) the consequences of illness or accident resulting from deliberate and intentional action on the part of the insured person, such as attempted suicide or intentional mutilation;

(b) the medical expenses of persons who, in time of war, are enlisted or voluntarily enter military service;

(c) the consequences of injuries resulting from the pursuit of high-level competition sports or sustained in the course of rash or hazardous undertakings, and also the practice of sports classed as dangerous, such as parachuting, flying, hang-gliding, rock-climbing, boxing, combat sports, martial arts, rafting, wrestling, mountaineering, potholing, bungee jumping, skydiving, war games, scuba diving, motor racing and dangerous sporting events at which betting is permitted;

(d) the consequences of brawls, except in cases of self-defense;

(e) rejuvenation and cosmetic treatment, except where cosmetic surgery is necessary as a result of an accident or of an illness covered by the insurance;

(f) direct or indirect results of nuclear explosions and related heat-release or irradiation;

(g) injuries resulting from aircraft accidents if the insured person is on board a non-commercial aircraft without a valid certificate of airworthiness or one piloted by a person not in possession of a valid license for that type of aircraft.

3.1.3 Accidents

(a) Medical expenses are reimbursed by the insurance pending any reimbursement by a liable third party. The Insurers may request an assignment of rights.

(b) The insurance does not cover illnesses or accidents directly attributable to the performance of official duties on behalf of WIPO.

3.1.4 Treatment in Switzerland, the Border Zone and Elsewhere in the World

(a) All reimbursements are based on the reasonable and customary expenses as defined in paragraph 3.1(a) above.

(b) The insurance coverage applies throughout the world. However, where treatment is given outside Switzerland, the French Departments of Ain and Haute-Savoie (border zone) or the insured person's country of residence, reimbursement will be limited, except in the case of emergency or medical necessity, to the rates applied in Geneva for the same or an equivalent treatment.

3.1.5 Franchise and Percentage Share in Expenses

(a) A franchise (that is, a fixed deductible or excess payable by the insured person) of 350 Swiss francs is applied for each calendar year to the cost of out-patient treatment for insured persons of 21 years and over.

(b) All insured persons assume a 10 per cent share of the costs of out-patient treatment in excess, where applicable, of the amount of the franchise. However, the total contribution to expenses in any calendar year may not exceed:

– 2,000 Swiss francs for each insured person of 21 years and over (percentage share and franchise);

– 250 Swiss francs for each insured person under 21 years of age (10 per cent share only) and 500 Swiss francs in total for all the insured persons under 21 years of age belonging to the same family.

(c) Hospital treatment is not subject to the franchise; it is therefore reimbursed in **full**. However, insured persons who have opted for hospital treatment (including maternity) in a **private room** will assume:

- Medical treatment :
  a **10 per cent** share for the cost of hospital treatment; however, such participation may not exceed **1,000** Swiss francs per calendar year;

- Cost of accomodation :
  a **10 per cent** share for the cost of accommodation in a private room, set to a top price of 850 Swiss francs a day, plus any amount above that limit, with an exception for hospitalization in France where the cost of accommodation in a private ward is reimbursed in full.

(d) Lump-sum benefits, such as the cost of spa or convalescent treatments, transport and home treatment, are not subject to either the franchise or the 10 per cent share.

(e) No benefits are paid for appointments not kept.

3.2 Benefits

3.2.1 Basic Benefits

(a) Out-patient treatment

After deduction of the percentage share, and of the franchise in the case of insured persons aged 21 years and over, the following expenses will be reimbursed:

– medical treatment given by a doctor;

– one consultation every six months by a psychiatrist and in cases where psychiatric treatment is needed and approved in advance by the Insurers;

– scientifically recognized treatment carried out by medical or paramedical personnel as prescribed by a doctor (for example, radiological and X-ray examinations, physiotherapy, kinesitherapy or chiropractic, injections, ergotherapy, shiatsu); concerning magnetic resonance imaging (MRI) examinations, they must be approved in advance by the Insurers;

– medicine prescribed by a doctor or a dentist, including homeopathic and phytotherapeutic preparations;

– laboratory tests prescribed by a doctor.

Are excluded all types of non scientifically recognized treatment, as also prophylactic measures other than those specified in paragraph 4.2.4(g) and psychoanalysis.

(b) Hospital treatment

Subject to the limits specified in these rules, the costs of medical care, including day surgery, and board are reimbursed in the case of hospital treatment for serious illness, maternity or accident, in a public or semi-private ward or a private room of a public hospital or a recognized private hospital (hôpital public or clinique reconnue). Treatment in cardiovascular readaptation and physical medicine centers is also considered hospital treatment.

In the case of hospital treatment for psychotherapy, protracted or chronic illnesses, the costs are reimbursed as for hospital treatment for serious illness during the first 90 days; thereafter, they are reimbursed at the public-ward rate of the specialized establishment concerned, increased by a daily lump sum payment of 100 Swiss francs.

Detoxification cures (alcohol, drugs and other dependancies): only the first three stays in hospital for detoxification purposes (by pathology) may be reimbursed within a five-year period.

3.2.2 Maternity Benefits

Pregnancy and confinement afford entitlement to the same benefits as illness. However, the following applies:

(i) prenatal and postnatal exercises are reimbursed in full up to a maximum of 250 Swiss francs;

(ii) in the case of home confinement, the cost of the attendance of a midwife (including materials) or of a doctor are reimbursed as for out-patient treatment;

(iii) a nursing allowance of 200 Swiss francs is granted if the mother nurses her child for at least ten weeks, on production of a statement by a doctor.

(iv) infertility treatments: costs relating to in vitro fertilization are covered as outpatient or inpatient expenses according to the case, taking into account the following limitations:

- it must be a case of primary sterility;
- a maximum of three attempts per successful pregnancy, i.e. a pregnancy of at least 26 weeks;
- maximum age 40;
- costs relating to sperm/ovary donation are not covered;
- costs relating to a surrogate mother are not covered.

As regards artificial insemination, the same limitations are applicable as for in vitro fertilization, but there is no limit on the number of attempts.

3.2.3 Spa and Convalescent Treatment

(a) Spa treatment. For treatment prescribed by a doctor and undertaken in a recognized spa establishment in Switzerland or abroad, a daily amount of maximum

135 Swiss francs is paid once in each period of two calendar years for a maximum of 28 days running, to cover medical and pharmaceutical expenses based on related medical bills. This benefit is subject to the following conditions:

(i) a medical report containing the diagnosis, the proposed treatment and the recommended establishment must reach the Insurers not later than one month before the start of the treatment;

(ii) the treatment must be approved in advance by the Insurers;

(b) Convalescent treatment. The cost of convalescent treatment prescribed by a doctor and undergone in a recognized establishment immediately following a stay in hospital is reimbursed on the same terms as hospital treatment.

3.2.4 Other Benefits

(a) Optical expenses (prescribed by an opthalmologist). Reimbursement of 90 per cent of the cost but with an annual maximum of 1,000 Swiss francs of:

- spectacle lenses
- contact lenses, including the cost of fitting.

A lump sum of 250 Swiss francs is granted towards the frames not more than once every two years.

(b) Cost of search, rescue, repatriation of the body and emergency transport. Are reimbursed up to a maximum of 10,000 Swiss francs in any calendar year:

- the cost of search, rescue and repatriation of the body
- the cost of emergency transport provided by third parties from the place where the insured person falls ill or is the victim of an accident to the nearest doctor or suitable hospital
- the cost of transport (both ways) incurred with respect to consultation for post-operative checks within two months following a surgical operation or incurred with respect to chemotherapy and/or radiotherapy when the transport has been prescribed by a doctor, carried out by a third party and approved by the insurers' medical expert.
- The cost of transport (both ways) incurred with respect to long term or post-operative treatements when the transport has been prescribed by a doctor, carried out by a third party and approved by the insurers' medical expert.

(c) Home treatment. Without prejudice to costs that may be assimilated to the cost of out-patient treatment, a maximum amount of 120 Swiss francs a day is paid during one hundred and eighty days at most in any calendar year for home treatment by a medical assistant with a recognized diploma or certificate of professional competence. This benefit will be subject to prior agreement of the insurers' medical expert.

(d) Orthopaedic equipment and appliances, hearing aids and prosthetic devices. Reimbursement at 90 per cent up to an overall amount of the cost of 12,000 Swiss francs per period of two calendar years:

- orthopaedic appliances such as arch supports, corsets, splints and prosthetic devices other than dental;
- hearing aids;
- the rental of a normal wheelchair and crutches, when medically prescribed.

(e) Alternative medicine. Reimbursement at 75 per cent, up to a maximum overall amount of 3,000 Swiss francs per calendar year, of the cost of the following therapies used in alternative medicine administered by a doctor or prescribed by a doctor and administered by recognized paramedical staff (nurse, physiotherapist, kinesitherapist, osteopath, etiopath, members of the professional register of their countries):

- mesotherapy
- osteopathy
- etiopathy
- lymphatic drainage
- reflexology
- autogenic training (Schultz method)
- Tomatis treatments
- acupunture.

All invoices submitted for the above partial reimbursement must include details of the treatment. Costs relating to non-therapeutic measures are not reimbursed.

(f) Speech correction and therapy, and orthoptic treatment. Reimbursement at 90 per cent, up to a maximum overall amount of 3,000 Swiss francs per calendar year, provided such treatment is administered by a qualified doctor or prescribed by a doctor and administered by the holder of a recognized diploma.

(g) Preventive and prophylactic medicine

- Vaccines, preventive medicinal treatments. Reimbursement at 90 per cent. No reimbursement is made for any vaccine or preventive treatment administered by the international organizations' Joint Medical Service (duty travel and home leave for officials, home leave for officials' families).

- Oral contraceptives and loops/coils. These two contraceptive methods are reimbursed if prescribed by a doctor, to the exclusion of any other method or means.

(h) Long-term non-medical care

<u>New coverage as of July 1, 2008</u>

Reimbursement of fixed sum of 1,000 francs and 2,000 francs respectively, according to the dependency. This sum may then be used by the insured person as he or she sees fit. This allowance will be paid for life if the dependency continues to be recognized, even if the staff member leaves WIPO or UPOV and he or she, or the person insured through him or her, is no longer a member of the insurance scheme (details on procedure and membership in Annex II.1)

<u>For those who do not qualify for the new coverage</u>

The costs incurred for long-term non-medical care in a hospital, convalescent home or other similar institution and for care given at home by qualified persons will be reimbursed in full up to 2,000 Swiss francs per person and per month. Long-term non-medical care is care that is given to an insured person who, for medical reasons, requires assistance for at least three of the following four everyday activities :

- feeding (eating, drinking,…)
- dressing (putting on shoes,…)
- washing (combing hair, shaving,…)
- mobility (getting up, walking,…)

(i) Voluntary termination of pregnancy, sterilization and vasectomy

The cost of the above treatment will be reimbursed within the limits of the insurance contract.

(j) Treatment of psychotherapy

75% reimbursement up to 3,000 Swiss francs per calendar year, provided such treatment is administered by a qualified doctor or prescribed by a doctor and administered by the holder of a recognized diploma, for example, in the case of Swiss psychologists and psychotherapists, persons included in the list of members of the ASP/FSP (Swiss Association of Psychotherapists, Swiss Federation of Psychologists).

Consultations by a psychiatrist are also reimbursed within this limit. However, one consultation every six months, and treatments in cases relating to psychiatry if approved in advance by the Insurers, will be reimbursed as outpatient treatment, i.e. 90% after deduction of the franchise.

4. INSURANCE FOR DENTAL TREATMENT

4.1 Entitlement to Benefits

Entitlement to benefits for dental treatment shall include crowns, pivot teeth, bridges and dental prostheses, and their repair, and orthodontic treatment.

4.2 Benefits

(a) Reimbursement at 75 per cent of the cost of dental treatment administered by a dentist, up to a maximum of 3,500 Swiss francs per calendar year. In France, the rate of reimbursement is 85 per cent.

(b) There is no franchise. Reimbursement is made on submission of bills including details of the treatment.

(c) Where the amounts reimbursed for dental expenses during one calendar year do not reach the maximum amount of 3,500 Swiss francs, the unspent balance may be carried forward to the following year (from one calendar year to the next calendar year).

(d) When a member leaves or enters the collective insurance, dental costs will be reimbursed at a pro rata of the months of membership.

(e) No benefits are paid for appointments not kept.

5. MONTHLY CONTRIBUTIONS

The contributions cover insurance for medical and pharamaceutical treatment, including, on a subsidiary basis, medical and pharmaceutical treatment following an accident, and insurance for dental treatment. There are two age groups for contributions:

– adults, 21 years and over;

– children, less than 21 years.

Transfer from the children's category to the adults' category takes effect on the first day of the month following the child's 21st birthday.

6. ADMINISTRATIVE AND FINAL PROVISIONS

6.1 Claim Procedure

6.1.1 Out-patient Treatment

(a) The insured person is responsible for payment of the cost of out-patient treatment.

(b) The Insurers will process all bills submitted to them, whether the amount of the annual 350 Swiss francs franchise has been reached or not. In the latter case, they note on the statement of account sent to the insured person that the bills submitted have been set off against the annual franchise.

6.1.2 Hospital Treatment

The Insurers will issue a guarantee certificate for admission to a hospital establishment, which relieves the insured person of the obligation to make a guarantee deposit. The hospital establishment may send its bills directly to the Insurers for payment.

6.1.3 Accidents

In the event of an accident, the insured person must state the place and circumstances of the accident and, if possible, the names and addresses of any witnesses or of competent authorities.

6.2 Reimbursement Procedure

6.2.1 The original bills, including any statement of treatment details, are to be sent to the Insurers, together with the claims form. In the case of treatment lasting more than one month, bills may be submitted monthly.

6.2.2. Save in cases of force majeure, the insured person's entitlement to benefits lapses after **18 months** from the date on which treatment has been received.

6.2.3 Reimbursement is effected by the Insurers within ten working days of receipt of the bills. Any change in bank details must be notified to the Insurers.

6.2.4 Reimbursement is normally made in Swiss francs. Where a conversion has to be made from one currency to another, the applicable exchange rate is the official United Nations rate in force on the date of the corresponding bill.

6.2.5 Where the insured person is entitled to a reimbursement from another insurer, the Insurers shall make a reimbursement as appropriate on the basis of the remaining expenses to be borne by the insured person, corresponding to the difference between the costs actually incurred and the amount reimbursed by the other insurer.

6.3 Disputes on Medical Matters

Disputes are settled by an arbitrator designated jointly by a doctor chosen by WIPO and the Insurers' doctor. If no agreement is reached, the arbitrator is designated by the Executive Committee of the Association des médecins du Canton de Genève or by the equivalent medical association having authority at the place of residence of the insured person. The arbitrator's decision shall be final and shall be binding on both parties. Each party shall pay the doctor it has chosen to designate the arbitrator. The cost of arbitration, including the arbitrator's fees, shall be borne in half by WIPO and in half by the Insurers.

6.4 Subrogation

Within the limits of the benefits afforded under these rules, in the event of illness or accident, the insured person or his survivors assign the rights of the insured person to the Insurers. At the request of the Insurers, they will be under an obligation to assist the Insurers in exercising their rights in relation to third parties.

6.5 Subsidiary Cover

6.5.1 In all matters not expressly stipulated in these rules, the contract with the Insurers will apply on a subsidiary basis, on the understanding that no provision herein may affect any clause, even of a general nature, in the contract with the Insurers

6.5.2 A copy of these rules is handed to each staff member or pensioner; the contract with the Insurers is available to the insured persons.