Medical care out of duty location (EME, NEME, Out-of-Country Care and Travel Benefit)

The Medical Benefits Plan (MBP) focuses on providing medical coverage in the duty country, although its coverage also extends worldwide. This guideline applies to MBP participants who may need to access health care services outside of their dutry station, either on developmental assignments (DA) or short-term assignments (STA); or if the services needed are not adequately available in their duty location.

Brochure: Out-of-Country Care (OOCC) Travel Request Guide

While on Official Mission Travel

Staff are covered for medical costs arising out of **an emergency** while on mission.

This applies to expenses incurred for a medical/dental emergency and participant needs treatment for a sudden acute illness or injury and the treatment cannot be postponed until the return to the duty country. Actual expenses for covered medical/dental treatment will be reimbursed based on the reasonable and customary rates of the country where the care was given.

The Insurance administrator (Cigna) will determine if the treatment rendered was for an emergency while processing claims. In the above circumstances, the actual charges are reviewed for processing under the terms of the MBP. Transport costs if any will be covered at 100 percent by the World Bank Group.

All other non-emergency covered medical care for staff and enrolled family members will be reimbursed subject to the cost index of the duty country.

Staff in medical emergencies while on mission should immediately call the numbers on their MERC card.

While on Personal Travel

Medical costs incurred while on travel for personal reasons are covered based on the reasonable and customary rates of the staff member's duty location except for emergency cases as determined by the MBP insurance administrator. If in an emergency, members are advised to call the numbers behind their Cigna cards.

Actual expenses for covered emergency medical/dental will be reimbursed, if expenses are for a medical/dental emergency and participant needs treatment for a sudden acute illness or injury and the treatment cannot be postponed until the return to the duty country.

Cigna will determine when an emergency has occurred while processing claims. In the above circumstances, the actual charges are reviewed for processing under the terms of the MBP. Travel costs, if any to the nearest center of appropriate care will be paid for by the plan and not to your home country or duty location.

All other non-emergency covered medical care for staff and enrolled family members will be reimbursed subject to the cost index of the duty country.

While Telecommuting

Medical/dental costs incurred while telecommuting will be processed based on the reasonable and customary (R&C) rates of the staff member's duty location and not the country where they are telecommuting from. Only emergency care, as confirmed by the insurance administrator will be covered at the usual and customary cost for the actual location of care.

While on Developmental and Short Term Assignments

For staff:

- During the DA or STA, members continue to be covered by MBP
- Covered emergency services will be reimbursed based on actual expenses regardless of the duration of the assignment
- If the assignment is for three months and more, the usual and customary index for the country of care will be used
- Those on assignment to HQ may use the Health Services Department (HSD) on-site health clinic for urgent care on workdays
- Staff in HQ can use their Cigna cards and access the Cigna network in the U.S.

Note: Staff on DA or STA within the U.S. or in a country office may send an email to Cigna for assistance in identifying a Cigna network medical provider to reduce their out-of-pocket costs. Staff may also consult the provider directory on Cigna's website.

For enrolled family members:

For STAs and DAs beginning January 1, 2016 that are under the Global Mobility Support Framework and exceed three months in length, the assignment must have managerial approval, from the receiving manager, for dependents to accompany the staff member and receive the U&C coverage at the assignment duty station. Dependents who accompany the staff member without managerial approval will not be eligible for coverage at U&C rates of the assignment location. Dependents who accompany staff on these assignments are still covered at the U&C rates of the home duty station for all services, except for expenses from emergency medical treatments.

This change in coverage will be triggered when the STA or DA exceeds three months in length.

The staff member's family members are eligible to be seen for urgent care matters or preventive health screening. Those on Bank Group insurance can be seen without co-pays; those not on Bank Group insurance, can use their own insurance or pay by credit.

Note: Staff who have approval, will receive plastic cards if their DA/STA is longer than six months. Those with a DA/STA of less than six months but greater than three months will only be issued electronic temporary cards. The expanded coverage for dependents can only be granted if the receiving manager at your DA/STA location grants approval for dependent accompaniment to receive the expanded coverage.

Medical care for LRS while out of duty location and not on Mission or on Assignment

LRS staff can access medical services under the Out Of Country Care (OOCC) benefit which is a result of the need to have increased access to appropriate care outside of a member's duty station in countries where appropriate care is not available. Before OOCC, care outside the specified duty could be only be reimbursed at the costs of the country of care in certain circumstances and without reimbursement for travel costs.

OOCC has two major components:

1) Regional approach to usual and customary charges:

- Staff can obtain medical care in the region with maximum limits based on the usual and customary charges for the region. There are no limits to the number of trips a member can take, with all travel costs borne fully by the member.
- Can be used for primary and/or acute care
- Not restricted to destination in the region

2) Travel Benefit:

- Available for staff who want to travel within the region but need/want some financial assistance for travel to the destination
- Medical treatment is reviewed based on medical necessity and the availability of appropriate care in the member's location. The MBP insurance administrator determines the appropriate destination for any necessary travel.

Medical care within your MBP Region

MBP participants can benefit from medical care in any country within the designated MBP region of their duty country under the following conditions:

1. The services needed are not available in the duty country.

2. If the services available are not appropriate or performed in conditions that are not appropriate.

3. If a member needs to access the services out of the duty station, the covered medical services will be reimbursed at the cost of care in the country where it is delivered. Staff are responsible for the applicable MBP co-payments, if any, and/or the cost of uncovered services as per the MBP Policy. The MBP Insurance administrator will issue a guarantee of payment to the provider at 100 percent and the co-share will be recouped through the member's payroll.

Medical care outside your MBP Region

In a country or region where services for chronic or severe ailments, specific treatments or examinations, radiology, procedures and surgeries may not be available or may not be performed in appropriate conditions as determined by the Medical Board of the MBP insurance administrator, MBP members may request authorization to receive appropriate medical care, out of the duty country, in a recommended Center of Appropriate Care. In this case, MBP members must obtain prior approval from the MBP insurance administrator before travelling.

Medical costs:

The medical costs for MBP-covered services are paid or reimbursed at the cost of the country where the services are delivered. Staff are responsible for the applicable MBP co-payments, if any, and/or the cost of uncovered services as per the MBP Policy. The MBP insurance administrator will issue a guarantee of payment to the provider at 100 percent and the co-share will be recouped through the member's payroll.

Travel costs:

Airfare for OOCC shall be via economy class/coach; or first-class rail travel, not exceeding the cost of air travel by economy class. For each trip, reimbursement will be limited to the cost of a round-trip lowest fare economy class air ticket for the most direct and cost-effective route between the duty city airport and the nearest airport to the approved location.

This cost will be covered by the MBP at 100 percent. Travel benefit for OOCC will be applicable for one trip per plan year per participant. Additional trips for recurring treatments can be authorized by the MBP insurance administrator on an exceptional basis.

Members must:

1. book their travel through http://MyTravel/ and benefit from any less than full-fare tickets available, and

2. obtain visas when visas for travelling to certain destinations are necessary. Higher class tickets will be reimbursed only up to 100 percent of the cost of the lowest economy class fare available at the time of travel.

Travel Benefits cannot be carried over to the following year and will not accumulate over multiple years.

No excess baggage, stopover, or other transport or incidental expenses will be reimbursed by the MBP.

MBP members can travel as many times as necessary to receive appropriate care for their condition when approved for out-of-country care by the MBP insurance administrator but will be reimbursed by the MBP for 100 percent of one trip. The Travel Benefit is not limited to receiving medical care for severe conditions but must be used prudently and according to policy, in case of medical necessity.

Members must receive prior approval from the MBP insurance administrator for the Travel Benefit in all cases. The decision of the MBP insurance administrator to grant or deny approval for the Travel Benefit will be made on a case-by-case basis, considering the availability and appropriateness of the medical services in the duty country.

Travel by surface transportation, including private or rental automobile, will be reimbursed on a mileage basis. This amount is specified in Administrative Manual Statement 3.10, 'Operational Travel Expense Reimbursement'. Higher class tickets will be reimbursed only up to 100 percent of the lowest economy class fare available at the time.

The MBP insurance administrator will pay for the travel expenses in full upon receipt of an invoice or receipt from the member. If the member needs advance payment for travel, they are advised to contact the MBP insurance administrator.

Hotel and MTV:

Participants are eligible for 100 percent of hotel and MTV costs, up to the maximum of the Bank Group approved per-diem rates. Participants must submit their receipts to the vendor within 60 days of completion of any OOCC event. Since per-diem may be advanced to participants, any amount due to the Bank Group after the cost evaluation by the vendor will be recuperated through payroll from the participant.

The allowance will be paid as of the first day for all approved days spent in the country of care when accommodation in the country of care is necessary. However, it will not be granted to the member for each day of hospitalization as those would be included in the hospital bill and paid by MBP.

The allowance will not be paid for an extension of the stay based on receiving other medical services not related to the initial pathology, unless prior approval has been sought and received from the MBP insurance administrator.

The allowance will not be paid for any days over and above those approved by the MBP insurance administrator for the treatment for which the travel was approved.

When the patient is:

- a minor child, a family member will be expected to accompany the child and the expenses for travel and MTV of the accompanying family member will be covered by the MBP as indicated above.
- an adult, determining the need for an accompanying family member will be based on medical necessity as decided by the Medical Board of the MBP insurance administrator.

When the patient is a minor child of:

- less than six years of age, the daily allowance will be reduced by 50 percent.
- more than six years and less than 13 years of age, the allowance will be reduced. Travel and MTV for an accompanying family member when the patient is a minor child, that is, 18 years old and below; or when deemed medically necessary by the Medical Board of the MBP insurance administrator by 25 percent.

Note: Accompanying family members must be medically insured and proof of insurance is required during the trip, if not enrolled and covered by the Bank Group Medical Insurance Plan (MIP) or MBP.

The duration of the stay will be determined by the MBP insurance administrator in relation to the case medical reports.

Request for the Travel Benefit should be made along with the approval for the out-of-country treatment by the member. The member must complete a prior approval form, provided by the MBP insurance administrator that will include an option for requesting the Travel Benefit.

Staff can make their own arrangements for short distance surface travel but must book airplane tickets and railway tickets through the country office's travel agency to benefit from any reduced rates that would be available to the Bank Group.

Visa costs:

Participants are responsible for acquiring visas to the countries of destination on their own. The cost of obtaining a visa is the responsibility of the staff member and is not covered by the MBP.

Centers of Appropriate Care (Centers of Excellence)

Centers of Appropriate Care are health care facilities that are capable of providing quality health care services that may not be available in the various Bank Group duty countries. MBP members will be eligible to access these facilities for services that are not available in their duty country/home country.

The MBP insurance administrator, in partnership with HSD, develops and maintains a list of health care facilities in all regions, covering all country offices.

Note: The list of Centers of Appropriate Care is available on the MBP insurance administrator's website. The list will change as facilities may be added or removed from the list.

For a list of countries in each region, refer to the List of MBP Regions.

Approval Process

In circumstances detailed in Medical care outside your MBP Region, MBP members must request for approval by sending a request form to the MBP insurance administrator. The MBP insurance administrator will:

- review the request in relation to the MBP guidelines and either approve or deny the request.
- select and recommend a Center of Appropriate Care for the planned procedure or treatment, if approved and
- provide guarantee of payment (GoP) according to the current inpatient or outpatient prior approval process.

For primary care and preventive services, approval for destinations other than those that are already pre-authorized can be granted by the MBP insurance administrator based on the needs of the patient and the care or treatment required.

To determine the location of the appropriate Center of Appropriate Care, the MBP insurance administrator will consider the:

- facility's record in providing the requested service.
- medical costs of the services.
- facility's proximity to the member's duty country.
- potential entry issues. *Example*: visa
- availability and costs of means of transportation.
- potential cultural and language barriers and the need for follow-up care.

No single factor shall be determinative in assessing the need for OOCC.

The MBP insurance administrator will attempt to respond to member preference for facility location. However, the primary criteria will be based on the factors listed above.

Eligibility for out-of-country care and Centers of Appropriate Care

Active staff under MBP, retiree under retiree MBP (RMBP), former enrolled staff under continuation MBP (CMBP), and their enrolled family members are eligible for coverage at the cost of the country of care in Centers of Appropriate Care.

Reimbursement of Travel Expenses

Costs for air tickets is paid for by the plan through http://MyTravel/, Staff may request for advance payments in http://mytravel/ for per diem and hotel expenses. Staff should complete their SOE when they return from their travel. Costs not accounted for will be collected from the member's payroll.

Reimbursements will be based on the WBG travel expenses guidelines.

Reimbursement of travel expenses will be subject to appropriate documentation. Staff must submit airline ticket stubs, boarding passes and invoices, railway tickets, taxi receipts, hotel bills, and any other documentation in http://MyTravel/ to support their claims. In cases where the daily allowance is provided in advance, if the total amount of the daily allowance is not supported by appropriate documentation, the non-supported amount will be collected from the member by the MBP insurance administrator.

Medical Coverage for Dependents Studying Outside the Duty Country

MBP strongly encourages staff to explore what health services are provided by the university their dependents will be attending. Almost all universities in the U.S. have their own health centers where students can freely obtain general health services. We strongly encourage that staff also consider purchasing supplemental medical insurance for their dependents from the attending university, if available, which can be more cost effective than purchasing it directly from an insurance provider, for the dependent’s routine or preventive care. By purchasing the insurance coverage, it will ensure that the dependent is fully covered while in the U.S.

In the situation when dependents are studying outside the duty country, that is not the U.S., we strongly encourage the staff member to inquire with the university about the different types of health coverage available within that country.

The insurance administrator processes the medical or dental care claim, received by the dependent outside the duty country, using the cost index of that country. This is done when the care received is not an emergency, as confirmed by the insurance administrator.

Note: Staff in the U.S. can benefit from Cigna International Health Services’ network in the U.S. by calling 1-888-301-0115 to reduce their out-of-pocket costs. Staff may also consult the provider directory on Cigna's website.

These providers have agreed to offer discounted rates for MBP members. The dependent will be responsible for co-payment at the time of service and the provider will send the invoice to Cigna for settlement.

Staff may contact these insurance providers to purchase supplemental coverage for their dependents studying in the U.S., if the university does not offer medical insurance:

- Individual Health Quotes
- Blue Cross Blue Shield
- United Health Care
- Kaiser Permanente
- Aetna

If staff choose to purchase supplemental coverage for their dependents who are studying abroad, reimbursements of medical claims will be administered under MBP's coordination of coverage policy which means that the other insurance plan becomes primary and MBP becomes secondary.

Claims must be submitted to the supplemental insurance plan and then to Cigna for further consideration. To submit a claim for further consideration, the staff member or dependent must submit a copy of the other plan's benefit statement or explanation of benefits (EOB) along with the invoice to Cigna. Cigna will review the benefit already reimbursed and take the required action.

This is an important benefit that can help with medical expenses. In case of intervention by another insurance plan, MBP will consider payments for a service made by the primary plan and apply the normal MBP rules to reimbursement. However, the coverage will be coordinated. So, it is possible for the claim to be covered 100 percent when processed by both plans.

For example, if the other insurance plan covers a treatment at 20 percent and MBP covers the same treatment at 80 percent, then MBP will cover the difference.

Addendum

Purpose of the addendum

Clarify the definition of core medical benefits and the criteria of medical necessity.

Travel Benefit

In all cases, the Travel Benefit requires prior approval by the insurance administrator and is authorized based on medical necessity.

Core medical benefits and medical necessity

OOCC may be authorized for all covered services under the MBP that are not available in a duty country. The Travel Benefit will be authorized for core medical benefits in case of medical necessity.

The core medical benefits are those benefits that constitute the fundamental medical services covered by the MBP as opposed to other services which are ancillary. *Examples*: medical preventive care/screening covered at 100 percent for curative, restorative and rehabilitative treatments, procedures, or care. The list of covered services is much broader.

Medical necessity is a service or product delivered by a particular provider which is necessary and appropriate as determined by the insurance administrator for the diagnosis, care, or treatment of the disease or injury involved. Recommendation by a doctor for a specific treatment or service does not make that treatment 'medically necessary'. *Examples*: requesting a second opinion for a well diagnosed ailment, or requesting services out-of-country when medically available in the duty station including services for normal pregnancies will not be considered medically necessary.

The decision making for the Travel Benefit by the Medical Board of the MBP insurance administrator will be governed by the definitions of core medical benefits and medical necessity, after out-of-country care has been authorized. This also clarifies the circumstances when MBP members can request the Travel Benefit.

Non-core medical benefits

The following services will not be considered core medical benefits for the Travel Benefit. OOCC may be granted when unavailable in the duty country, but services of this type will not be deemed medically necessary for purposes of the Travel Benefit:

- Acupuncture
- Alternative medicine
- Chiropractic care/spinal manipulation
- Diet/nutrition counseling
- Dental and orthodontics with exceptions determined by the insurance administrator
- Psycho-therapy, psychoanalysis, or psychiatry with exceptions for inpatient treatment determined by the insurance administrator
- Speech, occupational, or physical therapy with exceptions determined by the insurance administrator
- Speech, physical, or occupational therapy for a minor child diagnosed with developmental delays
- Infertility treatment
- Alcohol and substance abuse treatment
- Applied kinesiology
- Obesity treatment with exception for morbid obesity
- Podiatry/removal of bunions
- Vision care/eye examination with exceptions determined by the insurance administrator to treat an injury or medical condition
- Family planning medical services
- Hearing test routine
- Routine examination except for annual physical examination and preventive care services covered at 100 percent which is unavailable at the duty station

Note: Other services not listed above may also be considered as ancillary and may not be eligible for Travel Benefit. Some of the services mentioned above may become medically necessary when included in a comprehensive treatment for a medical condition. It is up to the Medical Board of the insurance administrator, who has sole authority in determining medical necessity, to assess each case and determine eligibility for the Travel Benefit for out-of-country care services.

Destinations

Travel Benefit will only be authorized for travel to the Center of Appropriate Care which delivers the required service and is recommended by the insurance administrator.

Approval for other destinations can be authorized by the insurance administrator on a case-by-case basis, taking into account the needs of the patient and the care or treatment required. In this case, transportation costs and other expenses will be limited to the travel expenses for the Center of Care initially approved by the insurance administrator.