TERMS OF REFERENCE for CURRENT GROUP MEDICAL INSURANCE PLAN

ANNEX B

TERMS OF REFRENCE
FOR THE PROVISION OF GROUP MEDICAL INSURANCE POLICY (GMIP)

1. INTRODUCTION

The Preparatory Commission for the Comprehensive Nuclear-Test-Ban Treaty Organization (hereinafter referred to as the "Commission" and/or "Policyholder") operates a global verification regime to monitor compliance with the Comprehensive Nuclear-Test-Ban Treaty. It provides timely data, assessments and other products and services to Signatory States of the Treaty.

The Commission wishes to establish the Group Medical Insurance Policy with an experienced organization or team of organizations (viz. insurer and broker) (hereinafter referred to as the "Insurer" and/or "Contractor" whether single insurer or team).

The Commission outlines here the Terms of Reference (ToR) that the Insurer shall use as a basis for the Provision of Group Medical Insurance Policy (hereinafter referred to as the "Services").

These Terms of Reference define the technical framework of all related activities to be performed during the Services and contain all technical requirements for the activities which shall be carried out by the Contractor.

The Contractor shall provide the Services in accordance with the requirements of this ToR and in the most cost-effective manner possible.

The Contractor must inform the Commission of the appropriate and current points of contact, including contacts for: 1) technical matters, 2) logistics matters and 3) commercial matters. If these points of contact change during any phase of the Services, the Contractor must inform the Commission immediately in writing.

2. ELIGIBILITY

2.1 The provisions of Services apply automatically to all beneficiaries declared by the Commission including but not limited to fixed-term staff and their families, and General Temporary Assistants (GTA).

2.2 A combination of insurance coverage under the GMIP with insurance coverage in the Austrian Social Security sickness scheme (Gebietskrankenkasse) (GKK), if registered through the employer, is possible. Beneficiaries who are insured with GKK are entitled to reimbursement only upon submission of the medical expenses to the Austria Social Security Sickness Scheme .

2.3 The Scope of Services also apply to non-Austrian live-in domestic Household Help residing with the staff member.

3. DEFINITIONS

The below definitions apply for the interpretation of the Contract as follows:

Accident	**Impairment of physical integrity through the sudden action of an external force**
Beneficiary	**A person who is entitled to the benefits provided herein including active staff members dependants and survivors as well as non-Austrian domestic Household Help residing in the staff member's household**
Dependents	**The spouse, unmarried children under 25 residing with or financially dependent on the staff member (in respect of disabled children there is no age limit)**
Emoluments	**The amount used for the calculation of premiums and catastrophic expenses shall consist of net base salary plus post adjustment, language allowance, and dependency allowance**
Gender	**Reference to beneficiaries and insured persons, in the masculine gender shall apply to both sexes, unless clearly inappropriate from the context**
Staff member	**A person employed in accordance with the rules and regulation of the Policyholder**
Medical treatment	**All examination or measure taken to restore health**
Policyholder	**The policyholder is the Preparatory Commission for the Comprehensive Nuclear-Test-Ban Treaty Organization (The Commission).**
Preventive Care	**Preventive care shall include (i) application of medical tests for the early recognition of disease, (ii) inoculations, vaccinations or related treatment for the prevention of diseases, and (iii) medical approved birth control devices and medicines obtained on medical prescription.**
Sickness	**A deterioration in health, confirmed by a competent medical authority.**

4. SCOPE OF SERVICES

4.1 The Commission's Requirements for Services

The Insurer shall reimburse 80% (unless otherwise specified by the Commission) of the medical costs for medical and dental consultations/examinations and for prescribed treatment, including medicines and, medical devices prescribed by doctors qualified to treat patients.

The Contractor shall make reimbursement of hospital costs, other than fees of surgeons and anaesthetists, incurred during hospitalization in semi-private or second class accommodation (two- or more bedroom, "Sonderklasse" of an Austrian public hospital) at the rate of 90%.

The Contractor shall ensure that the rate of reimbursement is 70% for hospital costs, including fees of surgeons and anaesthetists, incurred during hospitalization in private or first class accommodation (single-bedroom).

The Contractor shall reimburse the fees of surgeons and anaesthetists, incurred during hospitalization in private and semi-private accommodation at the rate of 80%.

The Contractor shall apply the rate of reimbursement of 100% for hospital costs, including fees of surgeons and anaesthetists, incurred during the hospitalization in the general ward ("Allgemeine Klasse" of an Austrian public hospital) or in the equivalent class at other hospitals with an "all in" daily charge;

When the Commission's staff is entitled to reimbursement by another source the difference between the costs actually incurred and the reimbursement obtained from other sources shall be reimbursed by the Contractor using the percentages and maximum applicable to such services.

The Contractor shall ensure that the treatment for detoxification for alcoholism or drug abuse is reimbursed as in-patient treatment in a hospital up to a maximum of two treatments in all.

The Contractor shall note that only the below mentioned types of treatment are subject to certain limitations as follows:

A. Dental and orthodontic treatment

Any kind of dental care and dental treatment such as dental consultations/examinations, gum examinations, x-rays, dental hygiene, scaling and periodontic treatment, fillings, root-treatment, tooth extraction, crown, bridges, inlays, tooth implantations, treatment of Temporo Mandibular Joint diseases, orthodontic treatment, and other dental work shall be subjected to a maximum reimbursement of 1.455,00 EUR per calendar year per person, with an unspent balance of the previous year being carried over to the following calendar year. Any reimbursement shall first be charged to the unspent balance of the previous calendar year. Any unspent balance of one calendar year shall be carried over to the next calendar year but not beyond that year.

Dental treatment also includes dental surgery, whether performed as in-patient or as out-patient, such as surgery to remove wisdom teeth, surgery in connection with dental implants, etc. Hospital costs other than fees of surgeons and anaesthetists shall be reimbursed by the Contractor without regard to the above limitations.

Provisional tooth replacement shall not be covered. The cost of orthodontic surgery required as a result of an accident shall be reimbursed by the Contractor at 80% of the cost without regard to the above limitations.

B. Hearing aids and optical lenses

The cost of hearing aids shall be reimbursed to a maximum amount of 545,00 EUR per ear (i.e. per hearing aid) in every three calendar years period per beneficiary.

The cost of optical lenses (including spectacle lenses and/or contact lenses, and frames) shall be reimbursed to a maximum of 291,00 EUR in every two calendar year period

irrespective of a prescribed change in strength. For staff members who have previously claimed optical lenses, and their two calendar year period has already commenced, the coverage of 291,00 EUR shall only apply from the commencement of a new two calendar year period which begins either on or after 01.01.2014.
Corrective optical laser treatment shall be reimbursed to a maximum of 291,00 EUR in every two calendar years.

C. Special Examinations and treatments

1. Radiological treatment

   The costs of radiological treatment shall be reimbursable only if the patient has been referred to the specialist by the doctor in attendance.

2. Psychiatric treatment

   The costs of psychiatric treatment shall only be reimbursable if such treatment is performed by a psychiatrist.

3. Psychotherapy

   The costs of psychotherapy shall only be reimbursable if the treatment has been performed by a psychiatrist for a defined therapy by a qualified provider and subject to prior approval by the Insurers.

D. Convalescence and spa cure

1. Accommodation:

   Based on prescription by a physician for a specified therapy at a registered spa institution and subject to prior approval by the Insurers, a total sum of 15,00 EUR per day shall be paid to cover the costs of accommodation.

   Convalescence in a medical facility under the care of licensed practitioners immediately following hospitalization and prescribed by the attending physician shall be reimbursed as hospitalization.

2. Therapy:

   The costs for therapy shall be reimbursed if prescribed by a physician.

E. Transportation

Ambulance transportation shall be reimbursed only in emergency cases and shall be supported by a statement of a medical practitioner.

F. Preventive care

The following costs for preventive care shall be reimbursed:

1. Physical examination: the cost of one preventive physical examination shall be reimbursed to a maximum amount of 182,00 EUR per calendar year per beneficiary.
2. Birth control devices and medicines: the cost of medically approved birth control devices and medicines, which are obtained on medical prescription, shall be reimbursed up to a maximum of 73,00 EUR per beneficiary per calendar year.
3. Vaccinations and inoculations: the cost of preventive vaccinations and inoculations shall be reimbursed at 80%.
4. The cost of an induced abortion, salpingectomy, vasectomy or electrocoagulation of the Fallopian tubes by laparoscopy shall be reimbursed at 80%, once per beneficiary.
5. Membership fees for physical fitness will be reimbursed for staff members only at the rate of 80%, up to a maximum of 363,00 EUR per calendar year, per staff member. Physical fitness is considered to be active exercise in an institutional setting, e.g. a club. Costs will be reimbursed upon receipt of proof of membership and participation in physical fitness exercises.

G. Alternative medicine

For the following types of treatment of alternative medicine, carried out by a medical doctor or prescribed by a medical doctor and carried out by recognized paramedical personal, the cost shall be reimbursed at the rate of 50%:

- Neuraltherapy
- Ozone therapy
- Chiropractical therapy

H. Maternity

Expenses incurred for maternity are covered under the same terms as any other illness. The term maternity is taken in its wider sense and includes reasonable related treatment in respect of pregnancy as well as up to three applications of conceptive methods leading to pregnancy

4.2 – Catastrophic expenses

Whenever the uncovered portion of reimbursable medical expenses incurred by the staff member and all persons included in the staff member's coverage exceeds 5 % of the annual emoluments of the staff member during a 12 month period, 100% reimbursement shall be made for that portion of the cost that exceeds 5% of the annual emoluments.

The cost of treatment above the limits established or excluded by the plan shall not be taken into consideration in calculating eligibility for reimbursement of catastrophic expenses.

Also the costs of first-class hospitalization in excess of the 70% limit shall not be taken into consideration when calculating eligibility for catastrophic expenses if the first class accommodation was the patient's free choice.

The uncovered expenses incurred by any non-Austrian domestic "Household Help" residing in the staff member's household and enrolled in the Plan, shall not be considered in the calculation of the catastrophic expenses.

4.3 - Reimbursement for General Temporary Assistants (GTAs)

For GTA Staff, the Contractor shall reimburse under the provisions of Section 4.1 with the following limitations:

A. The provisions of this contract do not apply to the GTA's spouse and/or children.

B. The coverage is limited to emergency medical care. Emergency medical care being medical treatment (by a physician, medical practitioner or specialist or during hospitalisation) that commences within 24 hours of a emergency event.

C. The overall maximum reimbursement per person per calendar year is limited at 100.000,00 EUR per staff;

D. Article 4 A. Dental and orthodontic treatment: the maximum reimbursement for dental and orthodontic treatment shall be 454,00 EUR per person per calendar year and there shall be no carry over of the unspent balance of the previous calendar year.

E. There will be no coverage for Hearing aids, Optical Lenses, Spa cures and Preventive care.

4.4 – Reimbursement procedure

The Commission shall provide the list of names for all existing staff and their eligible family members (hereinafter referred to as the "List of Names") to the Contractor within 30 days after the signature of the Contract. The Contractor shall ensure the provision of the Services in accordance with this List of Names.

The Policyholder will regularly provide the Contractor with this List of Names indicating the surnames and first names of beneficiaries whose state of health has involved expenses for which claims have been submitted; this List of Names will be accompanied by written evidence, in particular medical, surgical, pharmaceutical bills, hospital bills, etc. and by any payment slips made out by other insurers (with details of the amounts reimbursed); if these documents do not indicate exactly the sums actually paid by the beneficiary, the Commission may provide the necessary details in a statements based on his or her word of honour.

The Insurer shall pay the amounts due within maximum ten (10) working days following receipt of the List of Names with the written evidence. The Insurer shall retain the monthly List of Names indefinitely and be available to the Commission upon request.

The Policyholder accepts no financial or other responsibility regarding the accuracy of the request for reimbursement which it submits.

5. EXCLUDED RISKS AND SPECIAL RISKS

The Contractor shall note that the individual insurance coverage for staff and his/her eligible members (hereinafter referred to as the "Insurance Coverage") shall not be extended to the below mentioned items as follows:

1. The consequences of sickness or accidents resulting from wilful and intentional action on the part of the insured, such as attempted suicide or intentional mutilation;

2. Medical expenses of persons who, in time of war, are mobilized or voluntarily enter military service;

3. Rejuvenation cures and cosmetic treatment. Cosmetic surgery is covered, however, when it is necessary as the result of an accident for which medical coverage is provided;

4. Accidents resulting directly from alcoholic intoxication or the use of drugs that had not been medically prescribed;

5. Direct or indirect results of nuclear explosions and related heat release or irradiation;

6. COMMENCEMENT AND TERMINATION OF SERVICES

6. 1 Commencement and Completion of the Services

The Contractor shall commence the Services on 1 January 2013. The Services shall be provided for three years until 31 December 2015. The Commission has the option to extend the Services two (2) times for further periods of twelve (12) months each, subject to the availability of funds, under the same terms and conditions as those of this Contract. The Commission will inform the Contractor about the intention to extend the Services at least thirty (30) days prior to the completion date. The optional extensions will be implemented through a written notification to the Contractor by the Commission.

6.2 Commencement of Individual Insurance Coverage for Staff and GTA

The Contractor shall ensure that the Insurance Coverage is provided for the below mentioned staff categories as follows:

(a) ***for the Commission's Existing Staff and GTA's*****:** the Insurer shall provide the Insurance Coverage in respect of medical treatment obtained on or after the date of 1 January 2013 for the staff and dependents indicated in the List of Names provided by the Policyholder;
(b) ***for the Commission's New Staff and GTA's*****:** the Insurer shall provide the Insurance Coverage in respect of medical treatment obtained on or after the date designated in the Commission's notification to the Contractor for new staff indicated in the List of Names provided by the Policyholder;
(c) ***for new dependants of the Commission's Staff*****:** the Insurer shall provide the Insurance Coverage in respect of medical treatment obtained on or after the date

designated in the Commission's notification to the Contractor for new dependants of the Commission's staff indicated in the List of Names provided by the Policyholder;

6.3 Termination of Individual Insurance Coverage for Staff and GTA's

The Contractor shall ensure that the Insurance Coverage shall end on termination of the policy or on withdrawal from risk as indicated on the lists of names as provided by the Policyholder. No expenses incurred after the date of termination or withdrawal from risk shall be covered by the Insurers.

The Contractor shall ensure that when the Insurance Coverage under this Contract terminates, a former staff member is entitled to extend his/her Insurance Coverage and eligible family members insured with him/her at the time of separation for one or more monthly periods up to, but not exceeding 6 months, provided:

i. the staff member applies to the Policyholder for the extension before his/her normal termination date of his/her coverage ;
ii. the staff member pays the full premium due pertaining at the time of his/her separation from the organization to the Policyholder who shall remit the premiums to the Insurers.

The Contractor shall charge the same premium rates for the period of extension for Insurance Coverage under the same terms and conditions as those of this Contract.

During the period of extension of Insurance Coverage for each staff, the Contractor shall ensure that the Plan Benefits as described under Section 3 – "*Reimbursement*" and Section 4 – "*Catastrophic expenses*" is applied. For the calculation of the catastrophic expenses during a 12 month period including the period of extension, the emoluments taken into account for the period of extension shall be based on the staff member's last monthly emoluments. Coverage shall strictly end on the final day of the period of extension, even if the sickness or treatment continues beyond that date: no expenses incurred after the expiry date of the extension period shall be covered by the Insurer.

GTAs are not eligible for extension of coverage.

The Contractor shall ensure that the premiums received and the claims paid during the period of extension are added to the claims of experience of the GMIP for the calculation of next year's premium.

7. REPORTING

The contractor shall provide claims and financial reports on the plan's operation in a format and schedule mutually agreed upon with the Commission.

The Contractor shall provide Services taking into account the Commission's statistical information input and historical data; as per Attachments of this ToR.

LIST OF ATTACHMENTS OF CENSUS AND CLAIMS EXPERIENCE (2009, 2010, and 2011)

Attachment 1:	Number of regular staff and number of GTA staff as of 23 March 2012 by sex, age category, family size for premium classifications.
Attachment 2:	Number of regular and GTA staff as of 1 January 2009, 2010, 2011, and 2012
Attachment 3:	Total incurred claims for 2009, 2010, and 2011 (estimated), and number of claims.
Attachment 4:	Largest 5 single medical claims by incident in 2009, 2010, and 2011. Largest 5 claimants per entire calendar year 2009, 2010, and 2011.
Attachment 5:	Distribution of 2011 claims by country where treatment received.
Attachment 6:	2011 claims by gender and family size.
Attachment 7:	Amounts paid for Catastrophic Benefit (for those meeting the 5% of salary limit) for 2009, 2010, and 2011.