



Guide to Global Healthcare Systems & Employee Benefits

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The information contained within this guide is intended for informational purposes only and should not be used as a substitute for professional consultation about the circumstances of any specific company or situation. This material is not intended to provide legal or tax advice. Companies should always seek professional legal, tax, and consultative advice before taking any action affecting employees and benefit plans.

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ARGENTINA

SOCIAL SECURITY

The National Health Administration (ANSSAL) supervises the entire medical structure, including hospitals affiliated with the state or with the Social Assistance programs, as well as private hospitals. The Board of Directors of ANSSAL periodically establishes what benefits must be provided and the system of social assistance programs, Obras Sociales, is generally controlled and managed by the labor unions. The social assistance programs are organized by industry and by region.

Eligibility

By law, all employees, laborers, and their primary family members are included in this system, as well as s, including a spouse, and single children under age 21 (up to age 25 if a student) . Children older than age 21 may be included if disabled and of the insured. Other s are eligible only with the payment of additional contributions. Salaried employees generally receive benefits from social assistance programs (Obras Sociales) administered by unions and financed by employer and employee contributions. Employees have the option to choose the program to which they belong according to the type of work they perform and/or the industry in which they perform said. New workers must stay in the corresponding program for a minimum of one year. Many social assistance programs carry agreements with private medical companies (or contract the service of private providers) , so employees can redirect their contributions to the health schemes towards payment of a plan provided by the private health care companies and supplement payment on a direct basis if the contribution is insufficient.

Benefit

Each social assistance program has its own coverage amounts and limits depending on their resources and any additional support they receive from unions. They are required to cover at least 40% of outpatient costs and all the benefits stipulated in *Resolución del Ministerio de Salud y Acción Social No. 247/96*, known as *Programa Médico Obligatorio* (PMO) .

MARKET PRACTICE

Companies typically provide supplemental medical benefits in the form of private prepaid plans (Sistema de Salud Prepago) . This coverage is financed by supplemental employer contributions. Coverage is typically available through a single preferred provider because employers are able to restrict supplemental contributions to a specific provider. It is rare for employees to select providers.

This supplemental benefit is typically reserved for higher-level employees (executives) , but in some cases this benefit is made available to the rest of the payroll, although different plans would be offered on a tiered basis according to job position.

Supplementary group health coverage would be comprised of medical and dental plans, including hospitalization, outpatient, and 40% prescription drug coverage. These benefits are typically arranged through private medical associations.

AUSTRALIA

BENEFITS AT A GLANCE

Australia has a government-regulated, mandatory retirement savings program called “superannuation,” a system that requires employers to contribute a percentage of workers’ annual base salary to a fund of the employees’ choice. Recognizing that Australians are not saving enough for retirement, the government has proposed to increase the amount from 9% to 12% over the coming years; that increase is still awaiting approval by the Australian Parliament. All superannuation funds have an investment component, and the government is also making it easier for employees to choose the superannuation fund in which they want to put their money. Any discussion of employee benefits in Australia must consider how non-medical based insurance coverage is delivered. Most superannuation funds also have, either on a voluntary or mandatory basis, an insurance component for products including term life, disability and income protection. While American-style, employer sponsored corporate or group insurance is available in the Australian market, most employees obtain their insurance coverage through the superannuation relationship. Such coverage is contracted between the trustees of the superannuation fund and local insurance providers. While many employers choose a particular superannuation fund in which they fund employees’ superannuation contributions, employees can choose to have their dollars directed to a superannuation fund of their choice. It is common for employees to have dollars invested in multiple superannuation funds, although consolidation is being emphasized. Employees may purchase additional insurance benefits if offered, and costs are deducted from their investment account. There is government-provided national health insurance but private supplemental health insurance is available and frequently obtained. 9%

SOCIAL SECURITY

There are both public and private hospitals in Australia. Private hospitals treat about 40% of all patients admitted to Australian hospitals, representing about one-third of all days of hospitalization.

Eligibility

Basic health coverage is furnished through Medicare, the government's national health plan, for all permanent Australian residents.

Benefit

Medicare provides the following hospital and medical benefits:

- ▶ 100% of the cost of hospitalization in a public hospital and treatment by a doctor chosen by the hospital.
- ▶ 75% reimbursement of the Medicare Benefits Schedule (MBS) for treatment by the patient’s own doctor while he or she is hospitalized.
- ▶ For out-of-hospital treatment, 100% reimbursement of a general practitioner’s MBS fee and 85% reimbursement of a specialist’s MBS fee (100% if the doctor bills Medicare directly). The portion of expenses that is not paid by Medicare is referred to as the “Medicare gap”. The patient must pay these expenses; private insurance is not permitted to do so. The Medicare gap is limited to AUD 383.90 per year from 1 January 2009 for either an individual or a family; thus, medical and surgical charges in excess of that amount, up to the MBS level, are reimbursed in full. In addition, there is an Extended Medicare Safety Net threshold of AUD 1,111.60 per year. Medicare pays 80% of the out-of-pocket costs for services provided outside a hospital after this threshold is reached. Families who are eligible for the Family Tax Benefit Part A or who have Concession cards have a threshold of AUD 555.70 per year, after which 80% of out-of-pocket costs for services outside a hospital are paid. A doctor is permitted to charge more than the fee listed on the MBS. In such a case, the excess amount is the responsibility of the patient — or of his or her insurance company, if there is private insurance coverage. Medicare does not cover most ancillary services or ambulance services.

All Australians also are covered for prescription drugs through the Pharmaceutical Benefit Scheme (PBS). Most drugs require a patient co-payment of AUD 32.90 per prescription from 1 January 2009. Low-income persons who hold a Concession Card pay AUD 5.30 per prescription.

MANDATORY

As of 14 September 2009, applicants for a Long-stay Temporary Business Visa (Subclass 457 Visa) and subsequent renewals are subject to Visa Condition 8051, which requires that applicants provide evidence that they have obtained adequate health insurance. Coverage must be maintained for the visa holder and his or her accompanying family members during the duration of stay in Australia. The coverage may be provided by an

Australian or foreign insurance company. The minimum health insurance policy standards that must be satisfied include the following:

- ▶ Public hospital. The benefit must be equal to the state and territory health authority rates for ineligible patients. The coverage must be for in-patient, out-patient, emergency and post-operative services.
- ▶ Surgically implanted prostheses. The benefit must be at least 100% of the minimum benefit under the Private Health Insurance (Prostheses) Rules 2007.
- ▶ Pharmacy. The benefit must be equal to the Pharmacy Benefits Schedule listed price in excess of the patient contribution.
- ▶ Medical services. The benefit is equal to 100% of the Medicare Benefits Schedule fee (or less, if the charge to the patient is lower).
- ▶ Ambulance services. The benefit must be 100% of the charge, to the extent that it is not covered under other arrangements.
- ▶ Pre-existing conditions. The coverage may have a waiting period of no more than 12 months for pregnancy related conditions and other pre-existing conditions. The maximum waiting period for psychiatric, rehabilitative and palliative care is 2 months.
- ▶ Maximum. The maximum benefit per person per annum must be at least AUD 1 million.

This requirement applies to nationals of all countries except those with which Australia has a reciprocal health agreement—currently Ireland, New Zealand, the United Kingdom, Sweden, the Netherlands, Belgium, Finland, Norway, Malta, and Italy.

MARKET PRACTICE

Employer funding of medical coverage is not common. Some companies have fitness centers, wellness programs, and company doctors for their employees. Corporate employers wishing to encourage employees to maintain private health cover will typically either arrange coverage through a large private insurer like Medibank Private or refund employees for their own individual policies.

Policy premiums are more or less standard across insurers. Another alternative would be to establish a corporate membership with a large private insurer.

Employees are encouraged to take out private health insurance policies in order to be able to pay for private treatment. As of 2008, slightly more than 50% of the Australian population has some form of private health coverage. To encourage private health insurance coverage, the federal government provides a 30% rebate deducted either from premiums or when the tax return is filed to those who purchase private health insurance coverage from an approved insurer. All Australians are eligible, regardless of income. The rebate is 35% for persons age 65 to 69 and 40% for persons aged 70 or over.

The government has imposed a number of requirements on private health insurers that are intended to make coverage available to all. Among these is a requirement for a modified community rating system.

AUSTRIA

SOCIAL SECURITY

The Austrian national health insurance system also falls under the social insurance system. The various provincial municipalities are responsible for the daily operations of the system, while employees/residents are required to enroll in a fund for coverage and administration. There are 22 funds in Austria that manage the national healthcare administration. The funds are organized around specific industries, trades, or provinces.

Eligibility

Health insurance is offered to all Austrian residents. Employees and their s are covered upon the beginning of their employment. The employee usually does not choose their associated fund, as it is commonly chosen by the employer via the location or industry that enrolls them. Pensioners and the unemployed are commonly insured through the fund of the province in which they live. Insured individuals in Austria are free to choose any physician who has an agreement with the insurance fund of which they are members. The majority of local physicians are members of the local funds.

Benefit

Services are paid for through healthcare checks or “e-cards” with credited entitlements that pay for the services. Healthcare costs covered by the national plan for services within the contract network of the insured’s healthcare fund include all physician visits for ailments plus one preventative visit per year for adults over 19 years of age and all hospitalization with a co-payment for employees and for s for the first 28 days and 100% thereafter. Hospitalization for s is covered at 90% for four weeks and at 100% thereafter, as well as four weeks of home care. There is a co-payment per prescription for drugs and a co-payment of up to 33% of dental care depending on type of service and fund. There is also a co-payment of EUR 80.40 or 10% of the cost for vision care, whichever is higher, with free vision for children under 15 years old. Covered costs can slightly vary by fund, but must meet statutory guidelines as above. If an insured decides to use a physician outside of his/her fund’s contracted network, a co-payment of 20% applies for all services.

Long-Term Care Insurance

In 1993 the Austrian government passed the Federal Act Governing Long-term Care Benefits in order to harmonize long-term nursing care. This act introduced categorized long-term care benefits, regardless of income, property ownership or reason for long-term care. The benefits for long-term care are funded from general tax revenues and are categorized into seven levels. The benefits are paid 12 times a year.

MARKET PRACTICE

Private health insurance plans in Austria, when offered, are typically provided by large international companies. Less than 1/3 of workers purchase private health insurance, which provides a supplementary role to the national health insurance system. Few companies offer private medical coverage to their employees. The benefit usually requires a contribution from employees. Private medical insurance coverage typically includes better hospital accommodations and free choice of physicians not covered under contract with the insured’s national health insurance fund.

BELGIUM

SOCIAL SECURITY

Eligibility

All employees active or retired (white or blue collar), spouses and children, disabled employees, the unemployed, and expectant mothers are eligible for medical care benefits provided that the employee has worked 120 days during a period of six months. Also, a minimum amount of contributions, fixed by Royal Decree, must have been paid to a Mutualité. A Mutualité is a health insurance fund that is either a mutual insurance fund or a regional service of the Auxiliary fund for sickness and invalidity insurance. All persons and employees must register with one of these funds as a condition of eligibility. All persons must pay the full cost of medical treatment when provided and obtain a medical receipt. The person's health insurance fund then reimburses the costs according to prescribed schedules.

Benefit

Generally, 75% of the agreed upon fees for current medical expenses, such as home visits general and specialized practitioners, dental care, and therapists or nursing care are reimbursed. The remaining 25% is the patient fee. There is also a scheme of higher reimbursement, commonly known as the "preferential scheme" for health benefits for:

- ▶ Widows, disabled persons, pensioners and orphans
- ▶ Persons who are awarded support from the Public Centre for Social Welfare
- ▶ Beneficiaries to an income guarantee for the elderly
- ▶ Beneficiaries of a disability benefit
- ▶ People entitled to higher family benefits
- ▶ Persons of at least 50 years old with at least one year of full unemployment
- ▶ The s of the above categories

MARKET PRACTICE

Employers typically provide supplemental medical and hospitalization benefits. Private health insurance in Belgium provides coverage for treatments and medical equipment that are not covered in the national health insurance plan, i.e., single-bed hospital rooms and co-payments. Private and employer group insurance can be purchased from the Mutualités or insurance companies. Most plans provide coverage up to 2x the social security coverage in addition to the social security benefits with a deductible. Some medical costs for serious illness can be covered up to 3x the social security benefit. Many plans additionally cover 100% of expenses for critical illness and certain "dreaded diseases" where there are state plan limitations. These plans usually cover emergency medical and hospitalization abroad when a person is traveling. Benefit plans are typically 100% employer paid premiums, with low deductibles around EUR 75, and if there are dependents, the employee pays 100% of the premium.

BOTSWANA

SOCIAL SECURITY

Botswana does not have a mandatory national health insurance system.

MARKET PRACTICE (MEDICAL BENEFITS)

A national health service exists in several major cities, and a number of medical care societies provide healthcare coverage. Larger employers sponsor a group medical plan. Expatriate employees generally have private health insurance.

BRAZIL

BENEFITS AT A GLANCE

Government pension is available for men after 35 years' contribution and for women after 30 years. It is also possible to apply for the pension benefit by age — the pension is available for men older than 65 and for women older than 60. Rural workers can apply for the benefit five years earlier. They must have contributed for at least 180 months. It is financed through mandatory payroll taxes, shared by the employer and the employee, revenues from sales taxes and federal transfers that cover shortfalls of the system. This federal system also covers survivor and disability pensions. For people who do not meet the contribution and age criteria, the government applies an adjustment factor to arrive at a pension amount. The maximum value for the pension is R\$ 3689.66 (US\$: 2,341.16) , but this amount changes according to some conditions, including amount of contribution during the employee life, the amount of time contributed and age at retirement. As in other countries, private sector employees would not be able to meet their financial needs in an extended retirement with just the state pension. But workers in the public sector are in a different situation in Brazil. When they retire, they receive their full salary. Health care in Brazil is provided by both private and government institutions. Primary health care remains the responsibility of the federal government; some elements of the system, such as the operation of hospitals, are overseen by individual states. Public health care is provided to all Brazilian permanent residents and is free at the point of need (being paid for from general taxation) .

SOCIAL SECURITY

Health services are provided on a (very decentralized) regional and local basis with coordination by the unified health system (SUS) . Adequate health care is guaranteed in the Constitution. About 3/4 of the population receives their health care from the public system. The quality of care is generally considered poor in rural areas, where health care services (and accessibility to such services) are inadequate. In urban areas, the quality of care is adequate in most cases. In many cases there are long waiting periods for some forms of medical attention, such as routine examinations and non-emergency medical treatment.

Eligibility

Brazil's state medical program provides free medical coverage to employees making contributions to the INSS and their dependents. Those who are employed receive benefits for themselves and their s for up to 12 months after they stop making contributions to INSS.

Benefit

State medical coverage includes medical care, hospitalization in ward facilities, outpatient care, maternity benefits, and some vision and dental care. Prescription drugs are also covered. There is no limit on the duration of care. The benefits are available in state owned facilities or in facilities contracted by the national health system; however, about 2/3 of all hospital beds are in private hospitals.

MANDATORY

Employers must transfer an employee's supplemental healthcare provider if requested. The new plan selected must have equal or cheaper premiums than the previous plan.

Premium Rate Adjustments

Effective 15 October 2009, health insurance premium rates may only be adjusted once a year per National Private Health Agency (ANS) Resolution 195 (14 July 2009) . This regulation is intended to prevent abusive tactics by insurers (such as sudden premium increases for new members) , but it may also have an effect on employers' premium rate negotiations with insurers.

Family Planning Coverage

Effective 12 May 2009, private health insurance policies must mandatorily cover family planning according to Law 11,935. Though some elements of family planning were already mandatorily covered, this law expands the scope of this legal requirement for private health insurance policies.

MARKET PRACTICE

ANS is the governmental body that establishes the standard or minimum supplementary health insurance

coverage every health insurance carrier must offer to the individuals covered by their policies. As a result, coverage provided by every carrier is very similar if not equal. The difference among carriers lies in their overall medical networks and in their out-of-network usage reimbursements. Services are provided through a public facility, a private clinic/hospital, and private doctors, working alone or as a group. It is important to point out that it would be highly unusual for management employees to use public healthcare facilities. Also, one of the primary reasons why companies offer private health insurance is to reduce the time employees are off work waiting for treatment. Large companies in the private sector provide health plans for all levels of employees. Some companies have opted for the same plan for all employees, though it is more common to provide different levels of coverage for the various employee groups. Many of the plans are not insured.

The private medical care market in Brazil is one of the most sophisticated in the world. Direct service arrangements with private clinics and hospitals—like health maintenance organizations (HMOs) in the US—and networks of healthcare providers, such as preferred provider organizations (PPOs), are quite common in Brazil.

There are basically three methods of providing care. All of them involve prepayment.

► At one time, clinics (HMOs) were very popular: the employer pays a monthly or annual premium, and the patient receives the necessary services. In some cases, the services would only be those provided by the clinic; in others, the clinic doctors could refer the patient to an outside specialist. The clinics began to lose attractiveness when they acquired more patients than they could handle, resulting in long waits for service; thus, they created the same problems that the public sector faced, and which had led to the initial creation of clinics.

► Networks of “approved” doctors (generally compiled by an insurer or health plan administrator), participating doctors, and other providers have agreed to provide services to members of a health plan at a reduced fee or charge. These preferred provider organizations are normally administered by an insurer or third party administrator.

► A fee-for-service arrangement, whereby the insurer or administrator pays the doctor/clinic/hospital their charges (within specific limits). The first arrangement (the clinic) operates like an insurance company, in that it sets the premiums it will charge for the services the employees can receive, and it sets reserves just like any other insurer. In the other two arrangements, the plan can be insured or self-insured (possibly with a cap or stop-loss on the liability of the employer). If the plan is self-insured, which is quite common, the plan can be internally administered or, more likely, administered by an administrator. It would be rare for an employer to administer its own PPO. Typically companies offer a basic dental plan (i.e. no coverage for prosthetic devices and orthodontics) and pay 80% of the cost approved services for the employee and 50% of the cost approved services for s. The plan is customarily designed using a PPO approach. The “in-network” dentist will be given a higher reimbursement than an “out-of-network” dentist. While most plans cover on a local/regional basis, there are countrywide plans.

Vaccine Coverage

Brazilian health plans do not currently cover vaccines according to local legislation. Companies that are looking to provide an additional benefit linked to health insurance typically provide vaccine shots. The cost of vaccine shots range from BRL 219 to BRL 3,570.

Executive Check-ups

Executive check-ups are very common in Brazil for managers and higher-level positions. These check-ups process are divided in two steps: one 5 hour session with an average 20 types of exams (blood samples, urine samples, electrocardiograms, mammography, etc.) and one return visit to discuss results.

Insurance Transfers

Effective 2 April 2009, the rules for employees who wish to transfer their individuals and family supplemental health plans changed. Individuals with health plans contracted after 1 January 1999, are permitted to change their healthcare provider without being subject to long waiting periods. Employees must have a minimum of 2 years in their current health plan in order to benefit from these new regulations; employees with preexisting diseases or injuries must have a minimum of 3 years in their current health plan in order to qualify. Previously, an employee that wanted to switch healthcare providers had to meet certain deadlines in order to qualify for full coverage under a new plan. Especially if more sophisticated tests and surgeries are required, employees sometimes faced long waiting periods if they wanted to receive the benefits under a new health plan. Now, with the new rules regulating healthcare transfers, if an employee is not satisfied with the current care they receive, they will have an easier time changing plans.

BULGARIA

SOCIAL SECURITY

Bulgaria has a mandatory health insurance system administered by the National Health Insurance Fund (NHIF).

Eligibility

All citizens and permanent residents are eligible for medical benefits through NHIF.

Benefit

Covered medical benefits include emergency care, inpatient care, outpatient care, maternity care, dental care, prescription medication, transportation, and medical appliances. Co-payments are applicable at rates of 1% of the minimum wage for a doctor's visit and 2% of the minimum wage for a hospital stay (maximum 10 days a year).

MARKET PRACTICE

Medical insurance may be provided through voluntary health insurance funds. Group medical insurance has proven of limited interest to many companies.

CANADA

SOCIAL SECURITY

Each province in Canada has its own provincial health insurance program that must conform to the federal standards specified in the Canada Health Act to receive federal subsidies. The federal standards are comprehensiveness, universality, portability, accessibility and public administration. Physicians generally work on a fee-for-service basis with the schedule of fees negotiated between the province and its medical association. Hospitals are operated by municipalities, community boards of trustees or voluntary organizations.

Federally-Regulated Industries

Employees of federally-regulated industries are covered under the provincial health insurance plan in the province where they reside.

Ontario – Ontario Health Insurance Plan (OHIP)

Eligibility

Canadian citizens or persons with legal residence status, who make their permanent and principal home in Ontario and are physically present in Ontario for 153 days in any 12-month period, are eligible to participate in the Ontario Health Insurance Plan. New residents of Ontario, including immigrants from other countries and returning Canadian citizens who have been resident outside of Ontario, have a three-month waiting period after becoming a resident before becoming eligible for OHIP. Visitors from outside of Canada are not covered by OHIP. Visitors to Ontario from other provinces are covered by their province of residence.

Benefits

OHIP covers all medically necessary services, such as:

- ▶ Visits to physicians' offices and home visits by physicians, including maternity care, surgical procedures, immunizations, diagnostic tests, etc.
- ▶ Outpatient services provided in a hospital, including laboratory services, X-rays, etc.
- ▶ In-patient hospital care and services including room and meals at standard ward level, physicians' services, surgery, nursing care, laboratory and diagnostic tests, X-rays, medical supplies, prescription drugs administered in the hospital, anesthesia, childbirth, physiotherapy, etc.,
- ▶ Dental surgery only if done in a hospital,
- ▶ Eye exams once a year for persons under age 20 and seniors age 65 and over, plus for persons of any age who have medical conditions requiring regular eye exams; ophthalmology services are covered for persons of any age,
- ▶ Outpatient physiotherapy is covered for persons age 19 and under, seniors age 65 and over, nursing home residents, and all persons needing physiotherapy in their home or after being hospitalized,
- ▶ Prescription drugs for persons age 65 and over and other residents of long-term care homes with a CAD 2 copay per prescription,
- ▶ Limited home care (visits from nurses or housekeeping workers) if authorized by a physician; does not include 24-hour home care,
- ▶ Community mental health services,
- ▶ Medical services in a long-term care (nursing) home; does not include room and board,
- ▶ Chronic care patients in a hospital with a co-pay; normally these are patients waiting for placement in a long term care facility, and
- ▶ Ambulance services with a co-pay, usually CAD 45, although there are exemptions under various circumstances such as transfers between medical facilities.

There are generally no co-pays for covered services, except as indicated above. Services not covered by OHIP include: chiropractic care, private or semi-private hospital rooms (unless medically necessary such as for terminally ill patients), prescription drugs for persons under age 65, glasses and contact lenses for persons age 20 to 64, and regular dental care for all persons. Some dental care for children and seniors may be covered in cases of financial hardship.

OHIP members traveling to other provinces are usually covered for physician and hospital services, but not for other services. Out of province providers can choose whether to bill OHIP directly, or whether the patient must pay for

services and claim reimbursement from OHIP personally. For OHIP members traveling outside of Canada, OHIP reimburses the member only for emergency medical services at its prescribed rates, not including ambulance service.

Ontario – Trillium Drug Program

Ontario has a separate Trillium Drug Program that provides reimbursements after a deductible for OHIP members who have high prescription drug costs and no or only partial prescription drug insurance. The reimbursement is scaled by income and the amount paid for prescription drugs in a calendar quarter. Any reimbursements paid from a private or group insurance plan must be subtracted from the cost of the drugs. For a single person with an annual income of CAD 14,000, the cost of prescription drugs is reimbursed in excess of a deductible of CAD 108 per quarter; the person pays a CAD 2 co-pay for each prescription after the deductible is met for the quarter. For a single person with CAD 100,000 annual income, the cost of prescription drugs is reimbursed in excess of a deductible of CAD 1,022 per quarter with the same CAD 2 co-pay per prescription. Families have lower deductibles. The reimbursement can be paid even at higher income levels if the person is registered with the program and the prescription drug costs are high enough.

Ontario – Assistive Devices Program

A separate Assistive Devices Program provides partial payments for OHIP members for walkers, wheelchairs, home oxygen, artificial limbs, hearing aids, communication and visual aids. The patient must be determined to have a medical need for the specific device and be approved in advance.

Quebec - Régie de l'Assurance Maladie du Québec (RAMQ)

Eligibility

Canadian citizens or persons with legal residence status, who make their permanent and principal home in Quebec, and are physically present in Quebec for 153 days in any 12-month period are eligible to participate in the Régie de l'assurance maladie du Québec. New residents of Quebec, including immigrants from other countries, Canadian citizens or former Quebec residents, who have been resident outside of Quebec, have a three-month waiting period after registration before becoming eligible for RAMQ. Certain services such as maternity care, childbirth, care for infectious diseases, and care for persons suffering from domestic violence or sexual assault are covered during the three month waiting period for persons who have registered with RAMQ. Temporary workers, students and expatriates sent by their employer, and their s, who are in Quebec temporarily from countries with which Quebec has signed a social security agreement providing for healthcare coverage (Denmark, Finland, France, Greece (not students or expatriates), Luxembourg, Norway, Portugal and Sweden) are exempt from the three month waiting period. New residents in Quebec from other Canadian provinces are generally covered by their former province's health care system during the three month waiting period. Visitors to Quebec from other provinces are covered by their province of residence. Generally, members of RAMQ cannot leave Quebec for more than 183 days in a calendar year and remain covered. However, there are exceptions for students, government employees posted outside of Quebec, persons with a temporary contract outside of Quebec, international aid employees, employees of company with headquarters in Quebec who are posted outside of Quebec. Persons who lose their coverage because of an absence of more than 183 days in a calendar year lose their coverage for the entire calendar year including for time in Quebec before or after the absence. They may be required to reimburse RAMQ for services provided before the absence. Members who remain covered by RAMQ while temporarily in other provinces are covered for most of the same medical services as in Quebec. The physician may choose to accept or not accept the RAMQ card. If the physician accepts it, RAMQ reimburses them directly at RAMQ rates. If the provider does not accept the RAMQ card, the patient must pay for services and claim reimbursement from RAMQ; reimbursement will be at RAMQ rates. Hospital services in other provinces are covered directly by RAMQ under an interprovincial agreement. Ambulance costs in other provinces or the cost of transporting a patient back to Quebec are not covered. Prescription drugs are not covered outside of Quebec. Members who remain covered by RAMQ while temporarily outside of Canada are covered for emergency physicians and hospital services only. The patient must pay for services and claim reimbursement from RAMQ. RAMQ reimburses a maximum of CAD 100 per day for hospitalization and up to CAD 50 per day for hospital outpatient services.

Benefits

RAMQ covers all medically necessary services, such as:

► Physicians' services in the office, home or hospital,

- ▶ Hospital room and board in ward accommodation; hospitals are permitted to charge fixed fees for semiprivate or private rooms,
- ▶ Nursing care, diagnostics services, prescription drugs, surgery, X-rays, anesthesia, physiotherapy, emergency care,
- ▶ Psychiatric care,
- ▶ Most laboratory services, ultrasound, CAT scans, MRIs only when performed by a hospital,
- ▶ Oral surgery,
- ▶ Dental care, except for cleaning, for children under age 10, by dentists who participate in RAMQ (not all dentists participate in RAMQ),
- ▶ Optometric services for persons under age 18 and age 65 or over, plus certain other persons with serious visual impairment or low income,
- ▶ Hearing aids if the person has specific levels of hearing loss which vary by age,
- ▶ Medical services in long term care homes (not including room and board), and
- ▶ Prescription drugs for persons age 65 and over who do not have private health insurance.

There are no co-pays for covered services.

Services which are not covered include: cosmetic surgery, acupuncture, psychoanalysis conducted outside a facility authorized by the Minister of Health and Social Services, consultations by fax, email or correspondence, appointments solely to have a prescription renewed, most laboratory services (unless performed in a hospital). Physicians' examinations for insurance purposes, employment, obtaining a passport or visa, school or camp are not covered. Prescription drugs or anesthesia administered in a physician's office are not covered. Most physicians in Quebec participate in RAMQ. Some physicians have withdrawn from RAMQ, and require their patients to pay them directly and then request reimbursement from RAMQ. A separate category of physicians, known as non-participants, require their patients to pay them directly, but RAMQ does not reimburse for their services. Physicians must inform patients of their status.

Quebec – Public Prescription Drug Program

All Quebec residents must be covered by a prescription drug plan. If a person under age 65 is eligible for a private drug plan, such as a plan offered by an employer or union, or could participate in a plan covering a parent or spouse, he or she must join that plan. All other residents must join the public prescription drug program offered by RAMQ. Residents are prohibited from registering for both the public and a private plan.

Persons who turn 65 are automatically registered for the public prescription drug plan. However, if they have been covered by a private drug plan which offers coverage after age 65, they may choose to participate in one of:

- ▶ Public plan only,
- ▶ Public plan (first payer) and a private plan offering supplemental coverage (second payer), or
- ▶ Only a private plan, providing it offers benefits at least as generous as the public plan. Members of the public plan pay a deductible and co-pay for their prescriptions. The maximum amount that the member is required to pay for prescription drugs is CAD 927 for the period from July 1, 2008 to June 30, 2009.

British Columbia – Health Insurance BC – Medical Services Plan (MSP)

Eligibility

Health Insurance BC is the agency that administers the medical services plan (MSP) under the Medicare Protection Act. Canadian citizens and persons with legal residence status, who make their home in British Columbia, and are physically present in British Columbia for at least six months in a calendar year, and their s, who are resident in British Columbia, are eligible to participate in the medical services plan. Residents can be covered with Health Insurance BC either under a self-administered medical services plan or a group medical services plan offered by an employer, union or pension plan. New residents of British Columbia and returning residents have a waiting period after application and before coverage; the waiting period is the month of arrival plus two months.

Benefits

In British Columbia, the medical services plan includes the following medically necessary services:

- ▶ Physicians' services providing the physician is enrolled with the medical services plan,
- ▶ Maternity care,

- ▶ Medically required eye examinations by an optometrist or ophthalmologist when required because of eye disease, trauma or medical conditions such as diabetes; routine eye examinations are only covered for children age 18 and under or for seniors age 65 and over,
- ▶ Diagnostic services, X-rays, laboratory service, which provided at an approved facility and requested by an enrolled medical services provider,
- ▶ Dental surgery when performed in a hospital, and
- ▶ Surgical podiatry services.

Services not covered by the medical services plan include ambulance services (see British Columbia Ambulance Services below), cosmetic surgery, routine dental care, routine eye examinations for members age 19 to 64, eyeglasses, hearing aids and other appliances, prescription drugs (see PharmaCare below), services of counselors and psychologists, routine annual physical examinations, medical examinations required for driving, employment, insurance, school, sport or immigration purposes. Services from a chiropractor, massage therapist, naturopath, physical therapist or podiatrist for non-surgical procedures are not covered, except for 10 visits per year for low income patients. Patients are permitted to be charged fees for limited types of services such as allergy or cortisone shots, extensive burn dressings, crutches, etc.

Physicians enrolled with the medical services plan may choose to be "opted-in" or "opted-out". Opted-in physicians are paid directly by MSP for their services. A physician who is opted-in to MSP may not charge a patient for an insured benefit. Opted-out physicians bill patients directly for their services, then the patients may claim reimbursement from MSP. By law, an opted-out physician may not charge a patient more for an insured benefit than the prescribed MSP amount. A physician who is not enrolled with MSP may not charge patients more than the MSP rate, unless the service is provided at a facility other than a hospital or community care facility. Un-enrolled physicians will not be reimbursed by MSP. Some physicians choose to charge their patients an annual, enrollment, or registration fee. Patients cannot be denied service for choosing not to pay these fees. An annual fee is generally meant to cover uninsured services over the course of a year. Patients must be given the option to pay for these uninsured services through an annual fee or individually as they occur. If a physician charges an annual fee, a record detailing what the fee includes must

be provided to the patient. Members of the medical services plan must be physically present in British Columbia for at least six months in a calendar year to retain coverage. Once in five years, a member may be eligible to receive approval for an absence of up to 24 months while retaining coverage. For members traveling temporarily to other provinces, or outside Canada, the medical services plan will reimburse for most necessary medical and hospital services, but only at the medical services plan rates. Ambulance services outside British Columbia are not covered. Members moving to other provinces may retain coverage with the medical services plan for the balance of the month of leaving plus two months. Coverage may be extended for up to three additional months, if travel requires it. If moving outside Canada, coverage is retained only for the month of leaving.

British Columbia - Hospital Insurance Act and its Regulations

Hospital services for residents of British Columbia are specified under the British Columbia Hospital Insurance Act and its Regulations as covering the same beneficiaries as the medical services plan. Hospitals are paid for by the British Columbia government. Hospital services include:

- ▶ In-patient hospital care and services including room and meals at the standard ward rate, nursing care, laboratory and diagnostic services, X-rays, prescription drugs administered in the hospital, surgery, anesthesia, surgical supplies, and physiotherapy,
- ▶ Out-patient emergency services or minor surgical procedures at a hospital,
- ▶ Treatment at a rehabilitation hospital,
- ▶ Skilled nursing care in an extended care facility,
- ▶ Out-patient services such as psychiatric care, rehabilitation, diabetic day care, dietetic counseling, dialysis, MRIs, etc.

Services not covered include cosmetic surgery, reversal of sterilization, among others. Patients over age 19 in an extended care facility are required to pay partial costs depending on income.

British Columbia – British Columbia Ambulance Services

Ambulance services (land and air) are provided by British Columbia Ambulance Services. Fees from 1 October 2007 are CAD 80 for either land or air transport for medical services plan members. There is no fee for transportation between hospitals. If ambulance is called to a workplace when an employee is injured at work, the

employer pays CAD 530 for land service, CAD 2,746 per hour for helicopter service, or CAD 7 per mile for airplane service. Visitors to British Columbia and other non-members of the medical services plan pay the same fees as employers. There is a CAD 50 fee for an ambulance responding when services are later declined or not required.

British Columbia - PharmaCare

All members of the medical services plan are encouraged, but not required, to register for the Fair PharmaCare program for prescription drugs. Participants must have filed an income tax return two years prior to the coverage year. Fair PharmaCare reimburses the patient for the cost of drugs in excess of a deductible which varies by income. After the deductible is met, Fair PharmaCare pays 70% of the costs for the remainder of the year until the family maximum is met. After reaching the family maximum, PharmaCare pays for 100% of prescription drug costs. For example, a family with income of CAD 15,000 per year has no deductible, and the family maximum is CAD 300 (2% of income). A family with income of over CAD 30,000 has a deductible of 3% of income, and a family maximum of 4% of income. There are special PharmaCare programs for persons born in 1939 and earlier, residents of residential facilities, social assistance recipients, and persons with particular medical conditions (e.g., cystic fibrosis, psychiatric illnesses, HIV/AIDS etc.) which provide more generous benefits.

Alberta – Alberta Health Care Insurance Plan (AHCIP)

Eligibility

Canadian citizens and persons with legal residence status who make their home in Alberta, who are physically present in Alberta for at least 183 days in a 12 month period, and their s, are eligible to participate in the Alberta Health Care Insurance Plan. Individuals must not be claiming residency or obtaining health care benefits from another province. New residents of Alberta from another province are eligible for coverage on the first day of the third month following the arrival date. New residents or returning residents from outside Canada may be eligible on the date of arrival. Visitors to Alberta are not eligible for coverage.

All residents of Alberta must register with AHCIP, but some choose to formally opt-out after registration.

Contributions may be paid by the member monthly or quarterly or contributions may be submitted by an employer or union as part of a group plan.

Benefits of AHCIP include medically required health care services such as:

- ▶ Physicians' services at their office, patient's home, or in the hospital,
- ▶ Dental surgery, although the patient may need to pay for dental X-rays,
- ▶ Chiropractic care and X-rays are covered up to CAD 200 per person per year; chiropractors are permitted to charge the patient more than the amount reimbursed by AHCIP,
- ▶ Podiatry services are covered up to CAD 250 per person per year; podiatrists are permitted to charge the patient more than the amount reimbursed by AHCIP, and
- ▶ Optometry services are limited to one complete exam, one partial exam, and one diagnostic procedure per year for children under 19 years of age or for seniors age 65 and over; optometrists are not permitted to charge the patient any excess amount over the AHCIP reimbursement rate for covered services.

Services that are not covered include routine dental care, cosmetic surgery, experimental procedures, transportation costs, medical advice by telephone, routine eye exams for persons age 19 to 64, eyeglasses, hearing aids, psychologists, prescription drugs (see Alberta Blue Cross below) , immunizations; services of an acupuncturist, massage therapist, midwife, homeopath, social worker or nutritionist; chiropractic services for minor injuries from traffic accidents, medical exams needed for employment, sports, insurance, and for driver's licenses for persons under age 74 ½. Optical and dental assistance for seniors is available through a separate program from Seniors and Community Supports. Members of AHCIP must maintain their membership if they are absent temporarily from Alberta in another province and intend to return within 12 months. Claims for medically required physician and hospital services are usually billed directly to AHCIP and paid at the established rate for the province in which services were provided. Members of AHCIP must maintain their membership if they temporarily leave Canada and intend to return to Alberta within six months. However, the maximum amount reimbursed for inpatient hospital care outside of Canada is CAD 100 per day, not including the day of discharge. The maximum amount paid for outpatient hospital visits including any X-rays or tests is CAD 50 per day. Residents intending to be away from Alberta for longer periods, but then return, may apply for an extension of coverage for up to 24 or 48 months, depending on the reason. of AHCIP who move to another province may continue coverage for the balance of the month they leave and the next two months providing premiums are paid in advance. An extra month of travel time

may be paid for if necessary. Members of AHCIP who move outside of Canada permanently can arrange for AHCIP coverage for up to three months from the date of departure providing premiums are paid in advance.

Alberta – Hospital Care -- Alberta Health and Wellness

The Alberta Ministry of Health and Wellness provides funding to regional health authorities to provide medically necessary inpatient and outpatient hospital services, including diagnostic, laboratory, nursing services, and prescription drugs provided in the hospital. There are no fees or co-pays for Alberta residents for hospital care for ward accommodation. Hospitals may bill patients for semi-private or private rooms.

Alberta – Prescription Drugs & Supplementary Health Services – Alberta Blue Cross The Alberta Ministry of Health and Wellness subsidizes non-group supplementary health care plans managed by Alberta Blue Cross. Participation is voluntary and requires the payment of premiums by the participant. There are three different plans:

► **Alberta Blue Cross Non-Group Coverage:**

Available to residents under age 65 upon payment of premiums. Covers the following benefits with some restrictions or maximum limits: prescription drugs, ambulance services, clinical psychologist services, home nursing care, prosthetic and related devices, and hospital accommodation in a private or semi-private room.

► **Alberta Blue Cross for Seniors:**

Covers seniors age 65 and over and their s for similar benefits as above. No premiums are charged.

► **Alberta Blue Cross Palliative Care Drug Coverage:**

Available to residents who are diagnosed as needing palliative care at home, with no premiums.

MARKET PRACTICE

In Canada, private medical insurance is restricted to those medical services not covered by the provincial health insurance plans, and does not replace the provincial health care plans. Competitive employers offer supplemental extended healthcare coverage for medical and vision services that are not covered under the provincial government healthcare plan. All regular full-time employees are eligible upon commencement of employment. Generally, there is no deductible payable by the employee on these services. The plan covers 80% of prescription costs, and 80% of other eligible medical expenses. Competitive employers offer a plan similar to the following:

Deductible: None

Reimbursement: 80% prescription drugs; 80% all other eligible expenses

Overall Benefit Max: None

Eligible Expenses: Semi-private hospital, prescription drugs, paramedical practitioners (CAD 500/practitioner/year) , medical supplies, orthopedic shoes and inserts (CAD 300/year) , hearing aids (CAD 500/5 years) , private duty nursing (CAD 10,000/year) , outside Canada - emergency treatment, global medical assistance

Competitive employers pay the full premium cost for this benefit. All provincial medical plans encourage members to have travel health insurance when leaving Canada, as the amount reimbursed by the plan may be insignificant compared to expenses. Competitive employers offer dental insurance with no deductible for single or family members.

Competitive employers generally provide:

Deductible: None

Reimbursement: 100% of eligible expenses for basic coverage, preventative and restorative (endodontics, periodontics) , 50% of major services (caps, crowns, bridgework, dentures) .

Maximum: CAD 2,000 per year.

Fee Guide: Standard provincial current fee schedules.

Eligible Expenses: Exams, x-ray, test, lab, consultations, preventative services, restorative services, endodontics, adjunctive, periodontal, denture, and oral surgery.

Orthodontics: 50% of expenses with a CAD 2,000 lifetime maximum.

Vision plans are typically provided in medium-to-large-sized companies. Amounts are generally kept around CAD 150 to CAD 250 every 24 months for frames and lenses or contact lenses. Any premiums for provincial medical plans that are considered employers' premiums are not taxable benefits for the employees. However, if the employer pays the employee's portion of the provincial premiums, the premium is taxable income to the employee; this may occur in British Columbia and Alberta in particular. Employer-paid premiums to a private health care plan are not taxable income. Employee-paid premiums to a private health care plan are considered qualifying medical expenses for which a partial tax credit is permitted on the employee's tax return. However, if an employer pays medical expenses directly, or gives the employee an allowance for medical expenses, it is taxable income.

CHILE

SOCIAL SECURITY

Chile has a mixed system, and the Constitution recognizes a person's right to choose between the public and private systems for health care. Basic health care covers 100% of the population, since there are no barriers to access in public facilities, and acute care in the public facilities is guaranteed for both emergency care and complex conditions (GES plan) . This guarantee covers participants in both public and private health plans.

Medical benefits are funded and payable by either the FONASA (National Health Fund) or the employee's chosen

ISAPRE (Private Health Care Institution) .

Eligibility

At least six months of coverage with at least 3 months or 1 month of contributions in the preceding six months depending on whether the employee is under a fixed-term contract or a temporary one respectively.

Benefit

Employees who are insured by the FONASA have free access to public medical facilities and professionals, except for emergency care and complex conditions included in the GES Plan, for which they pay a copayment of 10% to 20% of the FONASA-determined cost. The copayment varies according to each individual's income level, to reach 0% for incomes within or under the national poverty line. Senior citizens do not pay copayments in the public system. All children under age 15 (age 18 if a student, any age if disabled) receive free outpatient medical and surgical care, as well as partial cost of hospitalization. Additionally, under FONASA, the insured may choose private medical facilities and professionals but will be imposed certain ceilings and higher copayments. Individuals with incomes within or under the national poverty level and seniors may not exercise this option. FONASA benefits cover prescription drugs, medical and hospital fees and expenses for inpatient and outpatient care, dental care, psychiatric care, and other basic medical care.

MARKET PRACTICE

Employees may choose private individual or family health coverage through plans administered by government regulated private funds called ISAPREs (Instituciones de Salud Previsional) . These plans are contracted for a premium and while they provide broader medical services coverage, they typically cover up to 80% of their cost. Moreover, individuals applying to the plans may be refused coverage unilaterally.

Premiums for Isapres' plans vary depending on factors such as the network of health services they provide, and the age and general health of the covered individual. The plans are contributory but only for the employee, although it is the employer's obligation to transfer the employee's contributions to the employee's chosen Isapre. Employees must comply with the statutory health contribution of 7% of their monthly wages, and must make a voluntary contribution equal to the difference between the statutory contribution and the Isapre plan premium, which may not exceed 5% of the employees' monthly wages. Both these contributions go to the Isapre plan. Also, for conditions included in the GES Plan, covered individuals are charged an additional contribution of 0.07% of their monthly salaries. Benefits typically include enhanced medical services coverage, dental treatments, cancer treatments, outpatient and in-patient care, and prescription drugs.

CHINA

Medical Reform Plan

In January 2009, the State Council approved a medical reform plan pledging CNY 850 billion (approximately USD 123 billion) over the next three years to broaden and strengthen the reach of the country's healthcare system. The plan includes 5 core measures: basic medical insurance coverage for at least 90% of the populations by 2011, basic medicine system including government control and supervision of the production and distribution of medicines, improved grassroots medical services in remote locations, equal and standardized medical services in rural and urban areas, and a pilot program to reform public hospitals.

This initiative comes as a response to challenges the Chinese public medical system has faced since initial steps were taken in the late 1990s to provide universal access to affordable healthcare on an insurance-based model. Subsidies to hospitals were cut back and prices for advanced procedures and pharmaceuticals rose significantly. With rapid modernization, population movements to urban centers, and the expansion of multinational business, pressures on the system have become acutely visible.

Health Insurance Transfers

Health insurance transfers between provinces will be possible from 1 July 2010 according to a policy published by the Ministry of Human Resources and Social Security (MHRSS) in January 2010. The policy ("Interim Measures for Basic Health Insurance Transfer for Migrant Workers") will allow internal migrant labors to transfer their health care coverage when moving from one province to another. Currently, the "Hukou" (household registration) system makes it difficult for internal migrant workers to enroll in a local health insurance system of the province or municipality if they just moved from another location. Written transfer forms must be attained from the local agency then completed and filed within 3 months of the individual's move to a new location. The MHRSS will work with the Ministry of Health to issue unified insurance certificates for the Urban Employees' Basic Health Insurance and the updated Rural Area Cooperative Health Insurance. The unified certificate will help facilitate the portability of the health insurance. The MHRSS has indicated that the ID number on the certificate will be the same as that on the State ID number. The MHRSS has not yet issued further details on this certificate. The MHRSS will be in charge of the design of the certificate and the local agencies will take care of producing the certificates.

In addition to being transferrable between provinces, health care coverage will also be transferrable amongst the different program types including Urban Employees' Basic Health Insurance, Urban Residents' Basic Health Insurance, and the updated Rural Area Cooperative Health Insurance.

SOCIAL SECURITY

Beijing - Basic Medical Insurance

The Beijing Municipal People's Government launched a pilot health insurance program in 1994. In December 1998, the central government introduced guidelines for a system of medical insurance coverage, which Beijing integrated with its existing program in 2001 (Decree No. 68, amended by 2005 Order No. 158). All state-owned and foreign-invested enterprises are required to contribute to the system of medical insurance coverage. The Health Insurance Fund consists of a social fund with a pooled account and an individual account as well as a supplementary fund.

The categories of social security coverage are as follows:

Social Fund Pooled Account

A pooled fund, covering all social security participants, provides coverage for expenses incurred in connection with hospitalization and serious acute illness. Employers are required to contribute 10.0% of covered earnings to the social fund, with different percentages of this amount allocated to the individual's account according to an age-based formula, as described below. Covered earnings are actual earnings up to 3x the average earnings in Beijing in the previous year. The minimum contribution basis is 60% of one month's average earnings in Beijing in the previous year.

Social Fund Individual Account

A medical savings account is established for each social security member. These are similar to the mandatory Medisave accounts in Singapore and the voluntary Health Savings Accounts in the United States. The individual account is financed by an employee contribution equal to 2% of the employee's contributable average earnings in the previous year. The employer contribution to the employee's individual, which is account allocated from the

10.0% total contribution, is 0.8% if the employee is younger than age 35, 1.0% if he/she is age 35 to 44, and 2.0% for an employee aged 45 or older. The balance of the employer contribution is allocated to the pooled fund, making a total employer contribution of 10% for these two funds, regardless of age.

Supplementary Fund

The supplementary fund is used to top up the individual account in cases where an individual incurs exceptional health expenses. It also is used to finance specific catastrophic health expenses such as cancer. The program is financed by an employer contribution of 1% of the employee's contributable average monthly earnings in the previous year, which is part of the total 10% employer contribution. Employees contribute CNY 3 per month.

Coverage

The fund pays part of the hospitalization costs of the individual, subject to a deductible that is determined according to the classification of the hospital. In general, 85% to 97% of costs are paid, up to a maximum of 4x the annual earnings in Beijing in the previous year. Different coverage rates apply according to hospital classification. The individual account can be used to pay eligible outpatient and emergency health expenses. It is also used to pay the deductible and the employee's share of the coinsurance that applies (typically 15%) .

If the individual account is exhausted, the employee must pay for the medical services in cash; however, if the out-of-pocket expenses are greater than CNY 1,800, up to 50% of the excess is paid from the supplementary fund. The annual ceiling on all disbursements from the fund is CNY 20,000 for outpatient emergency care and CNY 100,000 for inpatient care. Basic medical insurance does not cover medical treatment resulting from attempted suicide, self-inflicted injury, assault, drug and alcohol abuse, and vehicular accidents. Basic medical insurance does not cover services rendered in non-designated hospitals, clinics, and pharmacies.

Prescription Medication

Domestically produced prescription medications are typically covered at 90% and imported medications at 80%, with the employee responsible for the difference.

Guangzhou - Basic Medical Insurance

The Guangzhou Municipal People's Government launched the city's basic medical insurance program in 2001 (Order No. 17, amended in 2006 and 2008) , according to the guidelines introduced by the central government in December 1998. All state-owned and foreign-invested enterprises are required to contribute to the system of medical insurance coverage. The Health Insurance Fund consists of a social fund with a pooled account and an individual account.

The categories of social security coverage are as follows:

Social Fund Pooled Account hospitalization and serious acute illness. Employers are required to contribute 8.0% of covered earnings to the social fund, with different percentages of this amount allocated to the individual's account according to an age-based formula, as described below. Covered earnings are actual earnings up to 3x the average earnings in Guangzhou in the previous year. The minimum contribution basis is 60% of one month's average earnings in Guangzhou in the previous year.

Social Fund Individual Account

A medical savings account is established for each social security member. These are similar to the mandatory Medisave accounts in Singapore and the voluntary Health Savings Accounts in the United States. The individual account is financed by an employee contribution equal to 2% of the employee's contributable average earnings in the previous year. The employer contribution to the employee's individual, which is account allocated from the 8.0% total contribution, is 1.0% if the employee is younger than age 35, 2.0% if he/she is age 35 to 44, and 2.8% for an employee aged 45 or older. The balance of the 8% is allocated to the pooled fund, making a total employer contribution of 8% for these two funds, regardless of age.

Coverage

The fund pays part of the hospitalization costs of the individual, subject to a deductible that is determined according to the classification of the hospital. In general, 80% to 90% of costs are paid, up to a maximum of 4x the annual earnings in Guangzhou in the previous year. Different coverage rates apply according to hospital classification. The individual account can be used to pay eligible outpatient and emergency health expenses. It is also used to pay the deductible and the employee's share of the coinsurance that applies (typically 10% to 20%). If the individual

account is exhausted, the employee must pay for the medical services in cash; however, if the out-of-pocket expenses are greater than CNY 2,000, up to 50% of the excess is paid from the supplementary fund. The annual ceiling on all disbursements from the fund is CNY 60,000.

Basic medical insurance does not cover medical treatment resulting from attempted suicide, self-inflicted injury, assault, drug and alcohol abuse, and vehicular accidents. Basic medical insurance does not cover services rendered in non-designated hospitals, clinics, and pharmacies.

Prescription Medication

Domestically produced prescription medications are typically covered at 90% and imported medications at 80%, with the employee responsible for the difference.

Shanghai Basic Medical Insurance

In December 1998, the central government introduced guidelines for a system of medical insurance coverage. The system in Shanghai established in October 2000 is patterned after the central government guidelines and is administered by the Shanghai Municipal Medical Insurance Bureau. All state-owned and foreign-invested enterprises are required to contribute to the system of medical insurance coverage. The Health Insurance Fund consists of a social fund with a pooled account and an individual account as well as a supplementary fund.

The categories of social security coverage are as follows:

Social Fund Pooled Account

A pooled fund, covering all social security participants, provides coverage for expenses incurred in connection with hospitalization and serious acute illness. Employers are required to contribute 10.0% of covered earnings to the social fund, with different percentages of this amount allocated to the individual's account according to an age-based formula, as described below. Covered earnings are actual earnings up to 3x the average earnings in Shanghai in the previous year. The minimum contribution basis is 60% of one month's average earnings in Shanghai in the previous year.

Social Fund Individual Account

A medical savings account is established for each social security member. These are similar to the mandatory Medisave accounts in Singapore and the voluntary Health Savings Accounts in the United States. The individual account is financed by an employee contribution equal to 2% of the employee's contributable average earnings in the previous year. The employer contribution to the employee's individual account allocated from the 10.0% total contribution is 0.5% if the employee is younger than age 35, 1.0% if he/she is age 35 to 44, and 1.5% for an employee aged 45 or older. The balance of the 10% is allocated to the pooled fund, making a total employer contribution of 10% for these two funds, regardless of age.

Supplementary Fund The supplementary fund is used to top up the individual account in cases where an individual incurs exceptional health expenses. It also is used to finance specific catastrophic health expenses such as cancer. The program is financed by an employer contribution of 2% of the employee's contributable average monthly earnings in the previous year, which is part of the total 10% employer contribution.

Coverage The fund pays part of the hospitalization costs of the individual, subject to a deductible that is determined according to the classification of the hospital. In general, 85% of costs are paid, up to a maximum of 4x the annual earnings in Shanghai in the previous year. Different coverage rates apply according to hospital classification. The individual account can be used to pay eligible outpatient and emergency health expenses. It is also used to pay the deductible and the employee's share of the coinsurance that applies (typically 15%). If the individual account is exhausted, the employee must pay for the medical services in cash; however, if the out-of-pocket expenses are greater than CNY 1,500, up to 50% of the excess is paid from the supplementary fund. The annual ceiling on all disbursements from the fund is CNY 70,000.

Basic medical insurance does not cover medical treatment resulting from attempted suicide, self-inflicted injury, assault, drug and alcohol abuse, and vehicular accidents. Basic medical insurance does not cover services rendered in non-designated hospitals, clinics, and pharmacies.

Prescription Medication

Domestically produced prescription medications are typically covered at 90% and imported medications at 80%, with the employee responsible for the difference.

MARKET PRACTICE

China still has an insufficient number of health facilities and medical costs that far exceed the amounts paid under the social security programs. Out of pocket expenses can be considerable and statutory basic medical insurance does not cover many healthcare needs. Nor does basic medical insurance cover services in non-designated facilities. For these reasons, employer-sponsored health insurance plans are commonly offered by multinational companies in China, particularly among multinationals that are experiencing high turnover among skilled and technical employees. Recent studies indicate that more than 80% of multinational companies in China offer some form of supplemental health benefit. The number of local and international insurers in the market is growing at a steady pace.

There are two types of health insurance programs.

Indemnity plan:

This type of plan pays a fixed sum (for example, CNY 150 per day) for each day the patient is hospitalized, regardless of expenses actually incurred. These plans are normally available as a rider to a life insurance contract.

Supplementary medical plan:

Most employer-sponsored health insurance plans provide coverage that pays some of the expenses that are not covered under the social security programs.

These programs normally cover three categories of expenses. The amount insured varies, depending upon the company; frequently, several benefit scales will be used, based on the job classification of the employee.

Following is the description of an executive-level plan.

► Hospitalization: Expenses incurred while hospitalized. For example, the plan might pay up to CNY 300 per day of hospitalization for expenses not paid by social security, subject to a maximum of CNY 60,000 per year.

► Clinic and outpatient: Expenses for treatment out of the hospital. For example, the plan might pay up to CNY 15,000 per year for expenses not paid under social security. Normally, deductibles and/or coinsurance factors are applied.

► Critical illness: Expenses incurred in connection with stroke, heart attack, chronic kidney failure, cancer, major organ transplant, paralysis and other major illnesses. The plan might pay up to CNY 300,000 of such expenses (not including those paid by social security).

Annual physical checkups are highly common.

Dental and vision are not common.

Employers normally pay the full cost of the coverage for the employee, and part of the cost for s of the employee.

Some employers pay the full cost of a reduced coverage package; in some cases, the employee can pay an additional premium to enhance the coverage. Plans often are insured; however, there is growing interest in noninsured plans, especially with the recent development of third-party administration service providers.

COLOMBIA

SOCIAL SECURITY

Contributory System Medical Coverage

Medical Benefits in Colombia under the contributory scheme are provided through a system of health insurance funds called *Entidades Promotoras de Salud* (EPSs). EPSs contract with medical services providers (IPSS) to provide medical coverage to those they insure. At the mandatory basic coverage level or *Plan obligatorio de salud* (POS), all EPSs provide the same benefits. EPSs then differ in terms of type and quality of the additional coverage they provide. Employees have a choice of which EPS they select to join, and may change EPSs after 24 months of contributions. No employee can be refused membership from an EPS because of any pre-existing conditions.

Eligibility

All employees are eligible to emergency medical benefits from the date of employment. After 26 weeks of contributions, the insured has full access to the services under POS, but must make copayments and may be subject to a deductible (*cuotas moderadoras*). The employee is entitled to full coverage of high cost medical treatments (e.g. renal transplant) he or she reaches 100 weeks of contributions for coverage.

Coverage includes the employee, the employee's s, a spouse, a permanent companion of two or more years, and children under age 18 (25 if students; no age limit if disabled).

Benefit

The mandatory basic coverage level includes the following:

- ▶ Preventive medicine including family planning, children's developmental controls, women's health and immunization through vaccination;
- ▶ Maternity care, covering the pregnancy, delivery, lactation and the initial child medical care;
- ▶ General and specialized medical treatments, including optometry and psychology;
- ▶ Diagnostic services, such as lab tests, radiology, ultrasounds, nuclear medicine, electromagnetic resonance and scans;
- ▶ Prescription drugs;
- ▶ Rehabilitation and physical therapy, including occupational, language and respiratory therapy;
- ▶ Hospitalization and surgery;
- ▶ Basic dental care.

Deductibles and copayments are set by the National Health Council for Social Security (CNSSS) and they vary depending on the service provided and income level of the insured and his or her family unit. Deductibles are paid by both the insured and his or her s, while copayments are paid by the insured's s only.

Non-Contributory System Medical Coverage

A mandatory subsidiary medical coverage is also available to individuals who do not fall under the contributory scheme. This is a subsidiary arrangement funded by the state and services are provided through Entidades Promotoras de Salud del Rgimen Subsidiado (ESP-Ss) , which function in the same way as those pertaining to the contributory system but they mostly contract with public medical service providers. Under this subsidiary coverage, the mandatory basic coverage level (POS) must be provided by all EPS-Ss.

MARKET PRACTICE

Most companies do not provide medical benefits for their employees and s through private health carriers because the state sponsored programs provide a relatively thorough coverage. However, the health cost impact can be significant for specialized and complex treatments, so employers are increasingly leaning towards providing supplementary health plans to their employees. In fact, extra coverage in addition to the one provided by EPSs is typically easy to obtain. In order to be eligible for private health insurance, an individual must provide documentation that he/she has medical coverage from an EPS. Typically, supplemental private health insurance plans have co-insurance and deductibles of 10% to 20% of the total cost of the medical services provided, depending on the type of plan and the insurance carrier. Copayments also apply, and they vary depending on the type of health coverage and insurance carrier as well.

COSTA RICA

SOCIAL SECURITY

The national health system offers all citizens and legal residents of Costa Rica coverage for medical benefits through the CCSS. For employees or those under 55, coverage is compulsory. The rest of eligible individuals adhere to the system voluntarily through the Voluntary Health Care Insurance of the CCSS. Individuals under with scarce resources are automatically covered by the system. Typically, medical benefits are provided through the medical facilities of the CCSS or by private medical centers contracted by the CCSS. The national health systems covers about 90% of the entire population in Costa Rica.

Eligibility

The insured must be a citizen or legal resident of Costa Rica. Covered individuals include:

- ▶ All individuals actively employed in the private and public sectors;
- ▶ Individuals receiving old age and disability pensions;
- ▶ All individuals under the Voluntary Health Insurance system;
- ▶ All in workers who contribute to the CCSS;
- ▶ The insured family, including the unemployed or disabled spouse or life partner, children under the age of 18 (25 if students, no age limit if disabled), dependents, parents and siblings.
- ▶ Individuals with scarce economic resources.

Benefit

The medical benefits covered by the CCSS include:

- ▶ Specialized medical and surgical care;
- ▶ Out-patient and in-patient care;
- ▶ Subsidized prescription drugs plan;
- ▶ X-rays and lab tests;
- ▶ Dental and vision care;
- ▶ Preventive care and rehabilitation;
- ▶ Maternity care;
- ▶ Subsidized prosthetics and other medical aids.

There is no annual limit on benefits.

MARKET PRACTICE

The health system in Costa Rica is practically a State monopoly. Starting 2011, however, private insurance providers are expected to break into the market as the 2008 Regulatory Law for the Insurance Market (Ley Reguladora de Seguros) comes into effect. As of date, the National Insurance Institute (INS) is the only insurance provider of medical coverage to top off CCSS' benefits. INS' medical coverage plans available for employers are of two types: Cobertura A and Cobertura B. Premiums for this additional insurance vary depending on the insured's age, sex and overall health, and on whether the coverage is for the individual or for the individual and his/her family group. Better rates are offered for collective plans with a minimum of 10 covered individuals. At the discretion of the employer, premiums may be paid by both the company and the employee, by the employee only or by the company only. Typically, large or international companies provide this coverage to management and executive employees. Covered amounts may be either CRC 5,000,000 or CRC 10,000,000.

Coverage includes:

- ▶ Cobertura A: basic top-off coverage for outpatient care, prescription drugs, lab tests and diagnostic tests. Excludes pregnancy and maternity related services. Copayment for the insured is 20% of the total cost for in network services, and 30% for out-of-network services. The maximum sum per person the insurance covers is 10% of the insured amount (CRC 500,000 or CRC 1,000,000).
- ▶ Cobertura B: top-off benefits for hospitalization, surgical care, outpatient care, lab and diagnostic tests, prescription drugs, dental care, at-home nurse care, rehabilitation, prosthetics and medical aids, ambulance service, specific therapy and medical exams (e.g. chemotherapy), and pregnancy and maternity care. Copayment for the insured is 25% of the total cost for in-network services, and 30% for out-of-network services. The maximum sum per person the insurance covers is 90% of the insured amount (CRC 4,500,000 or CRC 9,000,000).

For maternity the limits per person are CRC 500,000 for a CRC 5 million policy and CRC 700,000 for a CRC 10 million policy.

INS collective medical insurance monthly premiums for a CRC 5,000,000 policy range from CRC 10,180 to CRC 247,500 for men, and from CRC 34,966 to CRC 165,000 for women, depending on their age and overall health. For a CRC 10,000,000 policy, the monthly premiums range from CRC 13,973 to CRC 415,800 for men, and from CRC 51,997 to CRC 257,400 for women, depending on their age and overall health.

There are also a few private hospitals and clinics (CIMA, La Católica, Bíblica and Jerusalén among them) that offer private subscriptions by which, for a premium, the subscriber has access to their medical and subsidized pharmaceutical services. These types of plans are the best choice for foreign nationals working in Costa Rica since foreign insurance is typically not accepted in the country, and insurance through the INS may not be available to them. In some cases on-site medical care is provided.

CZECH REPUBLIC

SOCIAL SECURITY

The General Health Insurance Act established mandatory health insurance for all residents of the Czech Republic as well as persons working for an employer located in the Czech Republic. Diplomats, or employees working under a foreign contract, are exempted. The Ministry of Health oversees the Czech Republic's national medical care system. This agency manages nine health insurance companies, the largest of which is the General Health Insurance Company (VZP) which covers about 70% of the population. The other eight companies are employer-sponsored and overseen by The Ministry of Labor and Social Affairs. These health insurance companies cover in-patient and out-patient medical care, accident, emergency and rescue services, preventative care, prescriptions, spa treatments, basic dental care, and medical equipment.

The government manages most hospitals. Some private hospitals exist as either for-profit or not-for-profit organizations, the former primarily serving foreign nationals. Most primary care physicians and dentists work in the private sector under contracts with the health insurance companies. They primarily treat patients enrolled with those companies. Healthcare in contract facilities (clinics, hospitals, doctor's offices) is financed by public funds and there is no patient copayment.

Copayments

As of January 2008, four types of copayments were introduced into the VZP scheme. Health and medical services require small copayments of CZK 30 for outpatient visits, CZK 60 per day of hospitalization, CZK 90 for emergency services and CZK 30 for prescription drugs. There is an annual cap of CZK 5,000 on copayment fees. In October 2010, the new coalition government agreed to increase the patient copayment for hospital stays from CZK 60 to CZK 100 per day, and will replace the copayment for prescription drugs (currently CZK 30 per prescription) with a single annual deductible. As of 2009, patients younger than age 18 and older than age 65, and those confined to homes for the elderly and other health care institutions, no longer are required to pay a co-payment for medical and hospital services, and the maximum out-of-pocket expenditure has been reduced from CZK 5,000 to CZK 2,500 per year. This change, part of a law that took effect in February 2009, does not change the legal status of co-payments for other patients. Though these patients are legally required to make co-payments for medical and hospital services, all 13 regional governments have agreed to waive these fees as a "gift" to patients.

MANDATORY

Mandatory Health Insurance for Foreign National Employees

Effective 1 April 2010, foreigners who are in the Czech Republic on a long-term (Type D) visa will be required to show evidence of health insurance when the visa is renewed or modified. This health insurance coverage must be from a health insurer registered with the Czech National Bank, and is subject to certain minimum requirements. This requirement is now in effect for all new applicants for the long-term visa.

The long-term visa is required for those who will remain in the Czech Republic for a period of 90 to 365 days. The requirement does not apply in the following circumstances:

It does not apply if the foreigner is an European Union country national. It does not apply if the individual is employed by a company registered in the Czech Republic and if he or she is covered under the Czech social security health insurance system or a health plan that is covered under a social security treaty between the Czech Republic and the home country. It does not apply if the foreigner is travelling on a short-term (Type C) visa. Long-term visa applicants must submit a health insurance voucher that is issued by an insurer that is authorized to provide this insurance in the Czech Republic; proof of payment also must be submitted. The health insurance must provide coverage of costs incurred as a result of injury or sudden illness, and the cost of medical repatriation to the individual's home country. Though a limit on covered expenses may be imposed, it cannot be less than EUR 30,000. In general, the plan cannot have deductibles or other copayments.

MARKET PRACTICE

Supplemental benefits are typically not provided.

DENMARK

SOCIAL SECURITY

Eligibility

All residents are entitled to medical benefits. If the person is moving from another country, there is a six-week qualifying period after residency is obtained.

Benefits

The great majority of Danish residents are covered under a program that pays the following benefits:

- ▶ 100% of the cost of hospitalization, treatment by doctors and specialists (in the home, office of the doctor, or hospital), emergency treatment, and X-rays and laboratory services in the hospital
- ▶ Partial reimbursement for transportation to a doctor's office (paid in full if the patient is transported in an ambulance)
- ▶ Partial reimbursement for dental care (full reimbursement for children)
- ▶ Partial reimbursement for physiotherapy, chiropractic treatment, psychological treatment, and podiatry
- ▶ Reimbursement for prescription drugs and medicines based on the total amount of drugs purchased in a benefits year, starting on the date the first drugs are purchased (no reimbursement for the first DKK 820; 50% of the charge is reimbursed when the total in a benefits year is from DKK 820 to DKK 1,340, rising to 75% from DKK 1,340 to DKK 2,885, and 85% when the total exceeds DKK 2,885)
- ▶ Coverage for up to three months if the employee is on temporary work assignment in another European Union country

The patient must sign up with a general practitioner whose office is within 10 km of the patient's home (5 km in Copenhagen) . The services of a medical specialist are reimbursed only if there is a referral from the general practitioner. A small number of Danish residents—probably about 2%—have elected to be covered under a different program. It permits the patient to use any general practitioner, regardless of location, and to visit a specialist without referral. The physician or specialist is permitted to charge an amount in excess of the standard fee schedule, which is the responsibility of the patient. With these exceptions, the coverage is essentially the same as that under the standard program.

MARKET PRACTICE

Most Danes are very satisfied with the level of care received under the national health program. However, availability of services can be a problem, resulting in waiting lists for non-urgent treatment. Thus, in recent years, several private hospitals have opened, providing services to patients who need (or wish) to avoid lengthy delays in treatment. Data from the Danish Insurance Association shows that about 600,000 individuals—approximately 20% of all fulltime employees in Denmark—had private health insurance coverage in 2006, compared with 150,000 individuals in 2001. Most Danes have a health insurance contract in relation to their employment, with 90% of the contracts paid for by the employer, according to the Association. Most of the employer-sponsored coverage is provided through a medical savings account that is part of the retirement plan. The employee is permitted to withdraw from the account to pay specified medical expenses. At the time of retirement, any money left in the account is paid out as a retirement benefit.

DOMINICAN REPUBLIC

SOCIAL SECURITY

Established by Law 87-01, the SDSS' Family Health Insurance, *Seguro Familiar de Salud*, (SFS) became fully functional in 2007. The new system provides universal access to healthcare through a "Basic Health Plan," *Plan Básico de Salud* (PBS), available to all citizens and permanent residents of the Dominican Republic.

Under the contributory system, employee and employer contributions are paid to their chosen Health Risk Administrator (ARS) which contracts with a network of health care providers or *Proveedoras de Servicios de Salud* (PSS). Under the subsidiary system, the State finances the contract with the ARSs. ARSs and PSSs may be public, private or semi-private. In terms of the medical benefits provided by the PBS, they are the same for contributors and for subsidized individuals. However, contributors are entitled to social security disability and maternity benefits under the SFS (see Short-term disability, Long-term disability and Maternity), while non-contributors are not. It should be noted that while the system aims to be comprehensive, public services are generally of a low standard.

Eligibility

Access to the Basic Health Plan is available to all citizens and permanent residents. Additional benefits are available to salaried employees participating in the contributory system with minimum contributions of 12 continuous months or 18 discontinuous months required.

Benefit

The Family Health Insurance (SFS) system guarantees minimum medical benefits as described in the Basic Health Plan (PBS). Medical benefits include:

- ▶ Preventive care
- ▶ Outpatient visits
- ▶ Emergency services
- ▶ Prescription drugs (co-payment of 30% for insured individuals under the contributory and contributory subsidized regimes)
- ▶ Prenatal and maternity care
- ▶ Surgery
- ▶ Hospital/clinic care
- ▶ Physiotherapy and rehabilitation
- ▶ Prosthetics and other aids
- ▶ Diagnostic and laboratory tests
- ▶ High cost diagnostic and therapeutic procedures (MRI, Cardiac Catheterization, etc.)
- ▶ Treatment of cancer and other diseases □ Basic dental services
- ▶ Childcare services (up to age 5)

Co-payments are generally not necessary for services in a public health institution. Co-payments may be applicable for employees enrolled with a private healthcare administrator (ARS) .

MARKET PRACTICE

Many employers provide supplemental medical benefits through an "iguala." These medical insurance plans are similar to an HMO or managed care arrangement. Monthly payments are made to a clinic, which agrees to provide all the medical services needed at no additional cost, with certain limitations. For instance, it may be possible that a certain type of specialist is not available at a particular clinic and in effect the employee will have no coverage under this scheme. Employer-sponsored group insurance plans provide broader coverage but are somewhat less common. These plans typically work on a reimbursement and/or a co-payment basis, and they can be set up as HMO or PPO plans. A typical plan might reimburse most medical expenses to include prescription drugs. Employee co-payments may be as high as 20% of the total medical cost and fix-rate copayments typically apply for physician visits and lab tests and x-rays.

Foreign insurance companies offer insurance plans that include coverage abroad. Employers whose group health insurance covers all employees may deduct the expense from its taxes and are not liable for fringe benefit taxes on the premiums. When the plan covers only certain employees (e.g. executives) employers must pay a non-deductible 30% fringe benefits tax. The premiums are not considered taxable income to the employees.

EGYPT

SOCIAL SECURITY

Health Insurance Organization (HIO)

The Health Insurance Organization (HIO) serves as the administrator of all public health facilities. Employers may opt out of this system if they provide equal or better medical coverage to their employees.

Eligibility

To be eligible for medical benefits, employees must be at least age 18 and have made contributions in all of the past 3 months or for at least 6 months total. Only employees are eligible, not their s.

Benefit

Medical benefits include general care, specialist care, hospitalization, surgery, maternity, lab work, rehabilitation, dental care, and medication. Co-payments may be applicable. Medical benefits are not subject to a maximum benefit period.

MANDATORY

Employers with at least 50 employees are required to have an on-site nurse and to cover the cost of on-site medical treatment and medication. Employers with at least 300 employees are required to provide free medical coverage to all employees. All private sector companies in Egypt are required to provide free health care for their Egyptian employees either through the Medical Insurance Plan of the Ministry of Social Insurance or privately. Large companies may maintain a comprehensive insurance plan.

MARKET PRACTICE

Employers typically provide a private medical plan to their employees, with reimbursement coverage (subject to expense caps) for employees and their s. It is common for there to be little or no deductible or co-payments for employees.

FIJI

SOCIAL SECURITY

There is no system of national health insurance per se; however, a member of the Fiji National Provident Fund is permitted to withdraw up to 1/3 of his/her account balance to pay for treatment of unforeseen medical conditions that require urgent attention. The treatment can be received either locally or abroad.

Most health care services are provided through public hospitals and clinics throughout Fiji. The public system primarily is financed from general tax revenue. The total health expenditure as a percentage of GDP is one of the lowest among Pacific region nations.

MARKET PRACTICE

At least two local insurance companies specialize in private medical coverage. Most higher-income persons have private coverage, frequently in connection with their employment. Premiums paid by the employer, as well as any employer-paid reimbursement for medical services (including prescription drugs), are considered to be taxable income to the employee. The medical insurance is geared toward the use of private treatment at the Suva Private Hospital, which provides Western-style medical care, and overseas treatment. A typical plan would pay 80% of medical, surgical and hospital expenses incurred at Suva Private Hospital, up to a maximum of FJD 100,000 per year per condition; no copayment would be charged after FJD 2,000 of out-of-pocket expenses were incurred. The plan would pay the full cost of treatment in a public hospital, up to FJD 10,000 per year per condition. Treatment outside of Fiji would be covered, subject to an 80%/20% copayment—or 100% reimbursement from a preferred provider. 80% of the cost of maternity charges, up to a maximum of FJD 3,500, also would be payable. A rider to this basic coverage provides for the payment of the full cost of outpatient treatment from a preferred provider. Premiums for the basic coverage are based on age and family status; for an individual age 35 to 39, the premium would be FJD 729 for a single person and FJD 1,608 for an individual and his or her family.

FINLAND

About 60% of all primary health care services in Finland are provided through health centers operated by hundreds of municipalities. Private medical doctors account for about 25% of the health services, with the remaining 35% provided through occupational health service programs that are established by employers (see Workers' Compensation) . Medical services from private doctors tend to be most prevalent among higher-income persons and those living in urban areas. More than 10% of Finnish doctors only have a private practice; about one-third have a private practice and also work in a hospital or health center. The health centers, and the general hospitals with which they are affiliated, provide medical, surgical and emergency care, rehabilitation, and home health care services. It is estimated that about 5% of the patients require specialist care. This is provided by hospitals in one of 20 hospital districts. Each municipality belongs to a hospital district. The largest district is in the Helsinki-Uusimaa region, with 32 hospitals covering about 1/4 of the Finnish population. The services provided by the health centers and public hospitals are primarily financed by the municipalities and the national government through the tax system.

SOCIAL SECURITY

The national health program is administered by the Social Insurance Institution (KELA) . Copayments generally are required for public services, but these are not reimbursed by KELA. KELA will reimburse private physician, dental, examination, treatment, and qualified travel fees up to a percentage of the schedule fee established by the Ministry of Social Affairs and Health. The KELA insurance plan does not provide reimbursement for hospital inpatient and outpatient charges, administrative fees, preventive care (except dental care) , or periods of treatment in a public hospital or institutions. Copayment amounts vary from one municipality to another. A visit to a medical center, including laboratory work and x-rays will typically require a copayment between EUR 11.60 and 22.80 in 2010. Outpatient examinations and treatments require a copayment of EUR 13.46. Treatment and accommodation in an in-patient ward requires a copayment of EUR 30.30 per day of hospitalization, EUR 25.60 for outpatient emergency care, and EUR 83.90 for outpatient surgery. The total annual charge for public sector health care services is capped at EUR 590 per calendar year and out of pocket costs for medicines are capped at EUR 672.70, after which reimbursement is at 100% and no further copayments apply.

Eligibility

Every person in Finland has the right to health care. Permanent residents are issued a KELA Card to prove that they have KELA health insurance; the card also can contain other information, such as codes indicating eligibility for special reimbursement rates for medicines. It may be noted that the European Health Insurance Card is not accepted as a KELA Card.

Benefit

The health insurance program covers some of the fees paid by patients to private doctors and dentists. It also covers prescription drugs and transportation costs that are related to the illness. Reimbursement of medical and dental expenses is calculated on the basis of a fee schedule that is negotiated between KELA and the medical or dental profession. The patient is reimbursed for medical services according to the fee schedule; however, the doctor or dentist is free to charge a higher fee, with the patient (or private insurance company) paying the excess.

Following are the principal services that are reimbursed:

Doctors in private practice: Consultation

The reimbursement is equal to 60% of the scheduled fee for a consultation. A copayment does not apply.

Doctors in private practice: Examination or treatment

Reimbursement is subject to a patient copayment of EUR 13.46 per visit for examinations (including laboratory and radiology tests) or treatments. A prescribed series of treatments is treated as a single treatment, except in the case of physical therapy (where each treatment is subject to a copayment) . Reimbursement of charges in excess of the copayment is at a rate of 75% of the scheduled fee.

Private dental services

The reimbursement rate is 60% of the scheduled fee for an oral or dental examination (limited to one exam per year) ; a copayment does not apply. The reimbursement rate is 75% of the scheduled fee for laboratory and radiology tests; a single copayment is assessed for all tests prescribed at a single time. The services of a dental technician are not covered; prosthetic and orthodontic procedures also are not covered.

Prescription drugs

Reimbursement is based on the price that is set by the Pharmaceuticals Pricing Board. The basic reimbursement is 42% of the price. However, for special drugs that are used for the treatment of severe and long-term diseases (as defined by the government), KELA reimburses either (a) 72% of the cost or (b) 100% of the cost minus a copayment of EUR 3 per medication. If the patient's out-of-pocket expenses for pharmaceutical drugs reach EUR 672.70 in 2010, all drug costs are fully reimbursed, subject only to a copayment of EUR 1.50 per prescription.

Transportation

Expenses incurred in connection with receiving medical or dental treatment are reimbursed, subject to a patient copayment of EUR 9.25 (one way); the maximum copayment in a calendar year is EUR 157.25. Expenses in excess of the copayment are reimbursed on the basis of the most inexpensive way of reaching the private or public doctor or rehabilitation therapist. Reimbursement at a rate of EUR 0.20 per kilometer applies if a personal car is used. Up to EUR 20.18 per night is reimbursed for accommodation expenses.

MARKET PRACTICE

An increasing number of employers are providing additional medical care for their employees through their Occupational Health Services program (discussed in the section on Workers' Compensation in this manual) or through a company-operated clinic. Some companies provide a major medical insurance plan to management employees and their families; some companies make coverage available for all salaried employees and their families. The plan typically will cover all expenses not covered under the statutory arrangement, subject to a lifetime limit on the amount paid—for example, EUR 50,000. The plan may assess a percentage copayment (e.g. 20%) or a fixed copayment (e.g. EUR 30) per treatment or service. Most plans have a minimal (EUR 30) or no annual deductible.

Supplemental dental plans are not common. The public system provides partial reimbursement for dental expenses.

The cost of the plan for employees normally is fully paid by the employer. Some companies ask the employees to share the cost of coverage for their s.

FRANCE

French law does not allow for medical policies that supplant or take the place of the coverage provided by the state, for which all citizens and legal residents with more than 90 days of residence in the country are eligible.

Participation in the state system is funded through employment contributions or in some cases paid directly by the individual household through the universal medical coverage program (CMU) at a rate of 8% of the combined net income above a threshold revised quarterly (EUR 9,020 through 30 September 2010, and EUR 9,029 from 1 October 2010 until 30 September 2011). Since the state system generally covers only 70% of normal medical charges, supplemental insurance purchased through a "mutuelle" is commonly used to cover the balance and other costs not covered by the state system. Retired EU residents are typically exempt of contributions to the state system, but often elect to purchase supplemental coverage.

SOCIAL SECURITY

Social Security Health Care (Assurance Maladie)

Eligibility

To qualify for healthcare benefits, employed persons must have worked at least 60 hours in the preceding 30 days, or 120 hours in the preceding 3 months, or 1,200 hours in the preceding 12 months. Cash benefits require the employee to have worked at least 200 hours in the preceding 3 months. The beneficiary must have been insured for at least one year to receive cash benefits beyond six months. The s of an insured employee are covered provided they are not covered by another social security scheme. All old-age pensioners, disability pensioners, workers' compensation pensioners with a disability rating of at least 66.66%, and unemployed people are covered, as are their s.

Benefit

Medical expenses for doctors' fees and prescribed medicines are normally paid first by the insured and then reimbursed by social security. Social security typically reimburses 70% of nationally negotiated tariffs, reimbursing lower rates if the patient does not seek referrals from the primary treating physician. The non-reimbursed amount, called the "ticket modérateur," is paid by the insured. Patients must choose a primary treating physician ("médecin traitant") who will refer them for specialist consultations and hospital procedures as necessary. The treating physician is also responsible for maintaining the patient's complete medical record. Patient's who coordinate their treatment through treating physician referrals are reimbursed at a higher rate than those who consult another physician without referral. Emergency care, gynecological, ophthalmological, and psychiatric care does not require a referral to secure better reimbursement rates.

The reimbursement of doctors and hospital fees by social security is controlled by different tariff rates and national agreements with doctors and medical care providers. Providers may participate in the negotiated scheme, or they may choose not to participate and set their own rates, which results in lower social security reimbursement (from 70% to 60%) and requires higher patient participation in costs.

Providers fall into three categories:

- ▶ Sector 1 doctors ("médecins conventionnés") have agreed to charge the official rates negotiated with social security tariffs.
- ▶ Sector 2 doctors ("médecins conventionnés à honoraires libres") participate in the national agreement with social security when they receive referrals from a primary treating physician but are also allowed to charge above the agreed rates for other self-referred patients.
- ▶ Sector 3 doctors ("médecins non-conventionnés") have not agreed to participate in the social security national agreement and are free to set their own fee schedule. Care provided by a private physician is reimbursed by social security at the lowest rate, which is often less than 10% of the nationally agreed reimbursement rate.

For example, whereas the reimbursement for an outpatient consultation costing EUR 20 according to the agreed tariff would be reimbursed at EUR 13, the reimbursement for the same consultation by a private doctor would be reimbursed at EUR 0.49. Patients seeking care from private physicians typically have private supplemental insurance that covers a portion or all of their fees. Medicine prescribed by private doctors is however reimbursed by social security at normal rates.

Social security reimbursement rates for professional and technical fees as a percentage of the social security tariff amount. Actual fees may be higher than the tariff amount.

Procedure	Social Security Reimbursement Rate for: France	Alsace-Moselle
Physician fees (including midwives)	70%	90%
Auxiliary professional fees (nurses, therapists, etc.)	60%	90%
Laboratory fees	60% to 70%	90%
Infectious disease screening	100%	100%
Medications (white label)	65%	90%
Medications (blue label)	35%	80%
Medications (vital and expensive)	100%	100%
Extemporaneous mixtures	35% to 65%	80% to 100%
Optical	65%	90%
Hearing aides	65%	90%
Bandages and dressings	65%	90%
Orthopedic devices	65%	90%
Prosthetics and mobility devices	100%	100%
Transportation fees	65%	100%
Thermal cures, hydrotherapy, lodging and transport	65% to 70%	65% to 90%
Thermal cures with hospitalization	80%	100%
Hospital transfer fees	100%	100%

Outpatient Care

Fees for care provided by sector 1 doctors at nationally agreed tariffs are reimbursed at 70% by social security. Medical and surgical procedures that cost more than EUR 91 require a flat-rate copayment of EUR 18. Since 1 January 2005, an additional patient participation charge of EUR 1 has been added to the copayment ("ticket modérateur") for consultations, procedures, and exams. Since 1 January 2008, new additional flat-rate charges apply for out patient procedures performed by medical auxiliary staff and for travel expenses incurred for medical purposes. Patients are responsible for EUR 0.50 per medicinal item and procedure and for EUR 2 of reimbursed medically necessary travel. These fees are capped at EUR 2 per day for procedures and EUR 4 for travel. All flat-rate charges are capped at EUR 50 per year. Minors under 18 years of age, women who are more than 6 months pregnant and patients who benefit from supplemental CMU coverage are exempt from all fees.

None of these fees are covered by supplemental private insurance.

Inpatient Care

Social security contributes to the costs associated with hospital care, including the daily rate for accommodation and clinical fees. Hospital costs are covered at 80%. In cases of prolonged inpatient treatment, reimbursement may be at 100%. There is an additional flat-rate fee for inpatient care of EUR 16 per day and EUR 12 per day for inpatient psychiatric care. The flat-rate fee of EUR 18 for procedures costing more than EUR 91 only applies once per hospital stay, even if multiple procedures are performed. The local health fund directly pays the hospital or clinic for inpatient fees. The patient is only responsible for paying any applicable copayments and daily fees. If a patient chooses to be admitted to a private hospital whose rates are higher than the closest public or private non-profit hospital, the local health fund will reimburse services at the rate of the closest public hospital.

Travel Expenses

Medically necessary travel expenses are reimbursed if the means of travel is prescribed by the physician or if the patient is required to travel to receive medical treatment or examination. The patient is responsible for 35% of the travel expense, plus the added charge of EUR 2 per trip up to a maximum of EUR 4 per day.

Universal Medical Coverage

Eligibility

All citizens and legal residents of France who do not have access to social healthcare benefits can participate in the system through the universal medical coverage program (CMU). To qualify, individuals must have been residents in France for at least 3 months, but certain exceptions apply. Participants must pay a contribution equal to 8% of their earnings above a minimum ceiling established annually by the government (EUR 9,020 through 30 September 2010, and EUR 9,029 from 1 October 2010 until 30 September 2011) and up to 5x the social security ceiling (EUR 173,100 as of 1 January 2010). The contribution is assessed quarterly and covers the period from 1 October through 30 September. Low-income earners may be eligible to receive CMU coverage at no charge; they may also be eligible to receive supplemental CMU, which also covers co-payments and daily fees for hospitalization. Persons

with income at or below the following thresholds are eligible for supplementary health care coverage through CMU at no cost and pay no premium as of 1 July 2010:

Size of Household	Monthly Income Threshold (EUR)	Threshold for Previous 12 Months' Income (EUR)
Single person	761.67	9,134
2 persons	1,141.67	13,700
3 persons	1,360.08	16,441
4 persons	1,598.42	19,181
Increase per additional person	304.45	3,653

Benefit

The benefits under the CMU coverage are the same as those of the Assurance Maladie.

MARKET PRACTICE

Social security reimbursements are often considerably less than expenses actually incurred, especially dental fees, vision expenses, and fees for sector 3 private doctors ("médecins non-conventionnés") and services. It is highly common for companies, both local French companies and multinationals, to offer a medical plan to cover costs not paid by social security. Coverage normally is provided to executives and non-executives alike (although at different benefit levels) and, in most cases, to their spouse and children. It is common for the employer to require employee participation of between 40% and 50% for supplemental medical coverage.

Plans typically reimburse between 100% and 300% of the social security tariff for physician fees and offer supplemental benefits to maternity, vision and dental in coordination with social security. Medical coverage is normally provided by the employer through an insurance company or "mutuelle." The coverage frequently is underwritten in connection with group life coverage, thereby producing a more favorable premium rate than would be found if the programs were separately rated. The medical coverage often is administered by an administration firm (rather than by the insurer); many of these firms are affiliated with employee benefit brokers. Any company sponsored plan must be applied collectively and equally to all employees of a recognized employee group and participation in the plan must be obligatory for all employees of that group.

GERMANY

Reform of the German healthcare insurance system was enacted on 1 April 2007, making coverage mandatory for all citizens and residents through either the state statutory system (*Gesetzliche Krankenversicherung* or GKV) or the private insurance market (Private Krankenversicherung or PKV). The reform imposes changes on the private health funds that will make them look more like the statutory funds, and it removes some restrictions and protections from the statutory funds so that they can more effectively compete with the private funds.

The German statutory system has two separate programs relating to health care:

- ▶ Medical care, cash sickness benefits, and maternity benefits are provided by government-supervised sickness funds. (Cash sickness and maternity benefits are discussed elsewhere.)
- ▶ Long-term care benefits, paying benefits to disabled persons who require personal assistance, are discussed below under “Long-Term Care.”

Statutory Funds

All employed persons who have annual earnings of less than EUR 48,600 (as of 2009) are required to be members of a statutory health fund (*Krankenkassen*). There are approximately 250 funds covering about 88% of the population. The funds are non-profit entities, offering members free choice of doctors and dentists who are contracted with the fund. Coverage under a statutory fund is voluntarily provided to employees earning in excess of EUR 48,600 for 3 consecutive years and if they were covered at one time under the statutory health fund and they maintain coverage by payment of voluntary contributions to the fund. Adults must share in the cost of services; children under age 18 are not required to make co-payments. Members are required to pay a co-payment of EUR 10 once each quarter to the first doctor and dentist consulted.

A copayment of EUR 10 is assessed for every day of hospitalization and for each visit to a medical specialist. There also are co-payments for prescription drugs, and dental and general practitioner visits. Limits on the co-payments apply, based on income and family composition of the household. There is generally no coverage for private doctors or surgeons, a private room in the hospital, alternative/homeopathic medical care, dental implants, and vision products for adults and there is no coverage outside of Europe.

Non-working spouses of statutory fund members automatically are covered at the same level of coverage at no additional cost.

The health insurance reform law calls for the statutory funds to be financed through a central health fund, beginning in 2009. Employer and employee contributions will be paid directly to the central fund. The statutory fund will receive a fixed amount for each member from the central fund; the fund will have the ability to charge members an additional fee (no more than 1% of a member's income).

The reform law brings the statutory funds under a single regulatory agency and introduces measures that make it possible to impose reimbursement limits.

Private Insurance

Employees with earnings in excess of EUR 49,950 per year for the past three years have the option of being a member of a private health insurance fund. About 9% of the population is covered by private insurance. There are approximately 50 providers in the German private health insurance market.

Premiums for private health insurance are calculated on the basis of age, gender, health status, and coverage, among other factors. Premiums may be lower than those of statutory funds, especially for those who are younger, in good health, and with no pre-existing conditions. Private health fund premiums do not automatically include coverage, which generally requires additional premiums for each insured. The reform law requires all private insurers to offer a basic coverage (*Basistarif*) comparable to that of the statutory system by 1 January 2009. This coverage must be made available to anyone eligible to be privately insured and at the same cost as the premiums charged by the statutory funds. Eligibility for basic coverage and its benefit provisions cannot be restricted because of the individual's health status or pre-existing conditions.

Benefits are provided to patients by doctors, dentists, hospitals, and pharmacists under contract with sickness funds. Services include comprehensive medical and dental care, preventive examinations and treatment, laboratory tests, maternity care, hospitalization, out-patient treatment, surgery, appliances, and prescribed medicines.

Employers are obliged to pay half the monthly cost of private health insurance up to the maximum level they would have paid for the government insured employee, presently EUR 280 per month. This applies if the employee purchases a private medical insurance plan from a German health insurance company that provides a certificate recognized by the German government (*Arbeitgeberbescheinigung*).

A law effective 1 January 2010 grants a full tax exemption for private basic health insurance coverage premiums. Previously, up to EUR 1,500 was deductible for the privately insured who received subsidies, such as employer provided benefits. The deductible amount for insured who bore the total cost was EUR 2,500.

Long-Term Care

Long-term care insurance provides payments for those who have been sick or disabled for at least 6 months and who need assistance in carrying out daily living functions such as dressing, getting up from and going to bed, bathing, housekeeping, and preparation and/or eating of food.

The program covers all members of sickness funds who have been insured for at least 5 of the last 10 years.

Employees who opt for private health insurance are required to include private coverage for long-term care.

Services may be provided by paid caregivers, nurses, and other home health service providers.

The benefit entitlement varies, depending upon the extent to which help is needed. The maximum benefit in 2009 is EUR 1,510 per month for most cases; however, if the patient requires around-the-clock care, the maximum is higher.

MARKET PRACTICE

Employer-sponsored medical, dental, and long-term care plans are rare. However, for more highly compensated employees, supplemental medical coverage is available under a group contract.

Individual employees often choose to purchase a supplemental policy from a private insurer to have additional benefits such as reimbursement for a private hospital room, higher dental coverage, or homeopathy and alternative treatments. Supplemental policies require a 3-year commitment and cannot be cancelled even if premiums increase.

GHANA

SOCIAL SECURITY

National Health Insurance Scheme (NHIS)

Eligibility

Employees are covered under the National Health Insurance Scheme (NHIS) through SSNIT (2.5% of the SSNIT contribution is redirected to the NHIS fund).

Benefit

NHIS covers emergency care, outpatient care, inpatient care, maternity care, dental care, specialist care (that is not specifically excluded and accompanied by a referral from a primary physician), and medication on the approved drug list. There are no copayments, deductibles, or cap on covered costs.

NHIS does not cover HIV/AIDS, most cancers (it does cover cervical and breast cancer), dialysis for chronic renal failure, and public services provided to the public (such as family planning and immunization).

Covered care is provided at NHIS accredited facilities. Also, NHIS coverage is portable, so patients may seek care anywhere in the country.

MARKET PRACTICE

Private sector health insurance companies and medical centers operate in Ghana.

Medical benefits are tax exempt if an employer provides this benefit on an equal basis to all full-time employees; this exemption applies to reimbursements for medical or dental costs, or the cost of health insurance.

For comparison, the U.S. government provides medical reimbursement to local Ghanaian employees and their s up to GHS 1,500 a year, and GHS 5,000 a year for major medical (including medical evacuation).

GREECE

SOCIAL SECURITY

Eligibility

To be eligible for medical coverage, the employee must have at least 50 days of contributions in the last 12 months (including or excluding the last quarter). Contribution requirements are halved if medical need is due to non-work accidents. s are covered.

Benefit

Public hospitals provide free emergency care, maternity care, and prescription drugs; non-emergency services incur a nominal fee. Social security (IKA-ETAM) covers medical care (including dental) at contracted or IKA-ETAMowned facilities; co-payments of 25% are applicable for outpatient drugs (10% for cancer and tuberculosis and no co-payments for chronic medications).

Patients may elect to have a higher level of medical accommodations. Higher-level benefits, such as rooms with single beds, are granted (for a maximum of 6 months) based on the patient's prior contributions to social security; an additional cost is also applied of 10% of the cost difference for the first month of hospitalization.

MARKET PRACTICE

State medical benefits are inadequate. It is highly common for employers to provide group health plans covering major medical plus basic or limited outpatient benefits with annual plan coverage caps. Typically, plans reimburse both private and public facilities and physicians and cover services not covered by social security health programs. They have deductibles, typically under EUR 100, and require 80/20 coinsurance payments. Employee coverage is generally not contributory, but employees may be required to contribute for coverage.

It is common among larger companies to have a company doctor or nurse and to offer annual health check-ups. Dental insurance is less commonly offered, with approximately 25 percent of multinationals offering coverage.

GUATEMALA

SOCIAL SECURITY

Medical benefits are available to all citizens and legal residents of Guatemala through the public network of healthcare centers managed by the Ministry of Public Health and Social Assistance (MSPAS), and through other health managed by not-for-profit foundation or associations such as Mercy Corps, the Institute for Social Cooperation and the Association for Eastern Sustainable Development among others.

In the contributory social security system, medical benefits are provided through the Guatemala Social Security Institute's (IGSS) healthcare network, composed of IGSS and private health care centers.

IGSS Medical Benefits

Eligibility

There are no qualifying requirements to access medical benefits under the IGSS program. Eligible insured include the actively employed and their s, and to IGSS' pensioners and their s.

The unemployed who meet certain eligibility requirements may also qualify to IGSS medical benefits.

Benefit

Medical benefits include the following:

- ▶ General and specialist care;
- ▶ Surgery and hospitalization;
- ▶ Dental care;
- ▶ Prescription drugs;
- ▶ Rehabilitation treatments, orthopedics and prosthetics;
- ▶ Maternity care (prenatal and postnatal);
- ▶ X-rays, lab tests and other diagnostic tests;
- ▶ Social services;
- ▶ Transportation from/to healthcare centers.

MARKET PRACTICE

The private medical sector has some 2,000 establishments but covers only about 10 % of the population. It consists of non-profit healthcare centers managed by non-governmental agencies (NGOs), and of private for-profit hospitals, clinics, laboratories, and pharmacies authorized by the MSPAS. Some of these hospitals and clinics offer medical services directly to employee groups for a monthly premium. Insurance companies also offer collective hospital and medical expenses insurance for employers with at least 5 employees. These policies are basically reimbursement plans for medical services provided by private health centers. Monthly premiums, deductibles and coinsurance for health insurance coverage vary.

Employer-sponsored group medical coverage is not typical except in large companies located in populous cities.

HONG KONG

Hong Kong does not have a compulsory national health insurance program. Medical care is provided in both public and private facilities, though most emergency and hospitalization care is provided in public facilities and a majority of primary care physicians are in the private sector. Medical care is financed almost equally by both public (primarily general tax revenues) and private (out-of-pocket payments) resources.

The cost of care varies based on whether the patient receives care in a public facility (where the government sets fees) or in a private hospital. The government-set fees for public facilities are differentiated between those who are “eligible” (Hong Kong Identity Card holders under the Registration of Persons Ordinance) and those who are “non-eligible.” “Eligible” patients pay lower set fees.

For example, the following is the cost difference for general outpatient care (routine visit):

- ▶ Public facility (“eligible” patient): HKD 45
- ▶ Public facility (“non-eligible” patient): HKD 215
- ▶ Private facility: Varies, but in the range of HKD 300 to HKD 600 (which includes prescription medicine)

Healthcare System Reform

On 29 September 2010, the legislature passed the second round of the proposal review for the voluntary health insurance system. The system is expected to take effect no sooner than 2013.

According to the current draft, the government will provide all individuals with a subsidy of 30% of the cost for the first year of coverage. The government is considering providing additional financial assistance to retirees and those who have chronic illnesses.

The premium rates will be established according to age groups. It will increase every 5 years. The average monthly premium for a man aged 20 could be as low as HKD 120 a month. For a man aged 65, the monthly premium would be around HKD 450 a month. Those who have higher risk of health problems may be likely to have a 2x higher premium rates than normal patients.

The new insurance plan will not cover the full medical expenses. The government is still working on the ratio between insurance coverage and individual co-payments.

MARKET PRACTICE

It is fairly common practice for Hong Kong companies to provide private medical benefits to employees and their families. The plan may be insured or self-insured. Many insured plans use a Preferred Provider approach, whereby benefits are paid in full if they are provided by a doctor who is on the “approved” list of the insurer.

Frequently, an employer will offer two or three levels of benefits – one for executives, providing care in a private hospital room; another level for managers; and a third, lower level for other employees (providing care in a hospital ward) .

Insurers also offer dollar indemnity plans (paying a specified amount for each day in the hospital, regardless of actual expenses) , maternity benefit riders, and dental coverage.

Normal exclusions from coverage include nervous and mental disorders, AIDS and HIV-related conditions in the first five years of membership, cosmetic surgery, maternity expenses (unless covered under a rider) , and general physical examinations.

Many employers pay the full cost of coverage for employees; they pay half of the cost for coverage.

Employer- and employee-paid premiums are tax deductible. Benefits are paid free of tax.

HUNGARY

The Hungarian health system—and, by extension, the system of health insurance benefits—is in a state of flux. Recent attempts to reform the way in which health services are provided have failed, in spite of rising costs and deteriorating service. A system of personal copayments for services, introduced in 2007, was withdrawn in mid-2008 following rejection in a public referendum. Further consideration of health reforms has been side-lined by the need for the government to deal with its worsening financial situation.

Currently, each local government is responsible for the health care system in its area; many of the hospitals are owned by the governments. Experts consider that there is a surplus of hospital beds, but a serious lack of professionals in medical departments. In most areas, hospital facilities and equipment have not been kept up to date, primarily due to inadequate financing. Mandatory basic health insurance is provided by the Health Insurance Fund (HIF) , a social security agency. There has been a steady growth in voluntary private health insurance coverage, primarily to enable individuals to receive private treatment, thereby avoiding the continuing problems with the health system. Employers are required to provide a yearly medical exam for all employees. An increasing number of employers are providing additional coverage through voluntary mutual health funds.

SOCIAL SECURITY

Eligibility

The HIF coverage is provided to all social security contributors and their s, as well as those receiving old age, survivors' and disability pensions; unemployment and cash sickness benefits; and maternity and child care allowances. There is no length of coverage requirement.

Benefit

Under the Hungarian system, each patient is entitled to select his or her primary physician; if the physician agrees, the patient is entered on the doctor's list of patients (which is the basis of the government's payment to the doctor) . The individual may change his or her primary physician once a year.

Virtually all services of the primary physician are provided without charge to the patient. There is no charge for the services of a specialist, provided the patient has been referred by the primary physician. There also is no charge for outpatient treatment that has been received following the referral of the primary physician or on an emergency basis. Most transportation costs to visit a specialist or an outpatient clinic are reimbursed.

The government subsidizes part of the cost of prescription drugs. The use of generic equivalents is being strongly encouraged. Dental services may be received without a referral. Full basic treatment is provided at no charge to children under 18, pregnant women (until the 90th day following the birth of the child) , and those older than age 60. Other adults may receive urgent dental treatment at no cost; copayments are assessed for other dental services.

MARKET PRACTICE

Private health care has developed because of the inadequacies of the public system. Thus, senior management employees often will be given private health insurance coverage. Supplemental benefits may be provided for other salaried employees, as well.

Some companies provide services at private health clinics to their employees. The services would include an annual medical exam, which is legally required for all employees. The services also may include extensive outpatient care, day surgery, X-rays, and diagnostic tests.

Medical insurance may be provided by insurance companies. There are several types of policies. One program reimburses the patient for the cost of a surgical operation, paying a scheduled amount that is intended to cover most of the cost of the operation (including the gratuity—a "tip" of up to 20% of the fee—that is customarily paid to the doctor and the medical staff) . Another program pays a specified amount, without regard to the actual expenses incurred, if the insured has a cerebral stroke, chronic kidney failure or a similar critical illness. Insurance companies also may offer an income replacement benefit as a rider to the standard group life insurance contract; under this arrangement, a fixed amount is paid for each day of confinement in a hospital, regardless of the diagnosis or cost of the treatment.

Voluntary Mutual Health Funds

It is becoming increasingly common for above-average income individuals to join a voluntary mutual health fund (VMHF) , a tax-effective non-profit entity that has similarities to the voluntary pension fund. The funds are mutual organizations that are regulated by the Financial Services Authority. Currently, there are 37 funds; 6 of them have at

least 50,000 members. Most VMHFs are marketed and operated by banks, insurance companies and similar organizations.

Typically a VMHF provides a health care spending account that is financed by membership fees paid by the individual and/or his or her employer. The individual draws from the account in order to pay for specified services offered by private doctors and clinics. Some VMHFs have negotiated member discounts for specified services—including services not covered by the VMHF (for example, a discount card for use in specified stores or a reduced fee for banking at the bank affiliated with the VMHF).

Some employers have entered into a contractual arrangement with a VMHF to make contributions on behalf of their members. To be tax-favored, the employer contribution to the program must be on a uniform basis for all employees, and must cover all employees with more than 6 months' service; thus, the contribution must be the same forint amount, or the same percentage of salary. The contribution is tax-free up to HUF 20,700 per person per month in 2008 (that is, 30% of the legal minimum wage).

INDIA

BENEFITS AT A GLANCE

Retirement benefits are dominated by a government-mandated employer benefit called the Gratuity, by which every employee, upon leaving his or her employer after more than five years of service, collects 15 days of last drawn salary for each year of service. Workers may also save for retirement with a tax favored vehicle called a Public Provident Fund, to which some employers also contribute. The life insurance market is dominated by the government-owned Life Insurance Corporation of India, but private insurers continue to enter the Indian market, as joint venture partners or minority stakeholders in firms. The Pension Fund Regulatory and Development Authority is expected to pave the way for more modern financial products. In its current form, it offers the cheapest accumulation vehicle for building a retirement nest egg. However, it has seen limited success since the distributors' benefit in offering this as a solution is limited. Post offices have been offering monthly income products which give a guaranteed payout and are widely accepted as an effective tool to derive an income. Life insurance companies have been offering annuity products. However such products contribute only about 2% of the product mix for the industry.

SOCIAL SECURITY

Employees' State Insurance Scheme (ESIS)

The Employees' State Insurance Scheme provides full medical care in the form of medical attendance, treatment, drugs and injections, specialist consultation and hospitalization to insured persons and members of their families. State governments arrange medical services; therefore, services vary somewhat by State. Services can be provided through federal hospitals and dispensaries, State government facilities, or private doctors under contract.

Eligibility

The Employees' State Insurance Scheme (ESIS) is administered by the Employees' State Insurance Corporation (ESIC) and applies to employees of factories with 10 or more employees and to shops, hotels, restaurants, cinemas, road transport undertakings, newspaper establishments, and factories not using electricity, employing 20 or more persons.

Since 1 May 2010, all workers who earn less than INR 15,000 per month and their s are covered for medical and hospital care. Retired or disabled persons and their spouses may participate in the ESIS medical care program, providing the insured person was in covered employment for at least five years prior to retirement or disability, and upon payment of a contribution of INR 120 per year.

Benefit

The entire cost is paid from the ESIS contributions for employees. There are no co-payments by patients, except as noted above for retired or disabled persons. ESI benefits include outpatient medical treatment, diagnostic services, hospital care, surgery, specialist care, maternity care, transportation, preventive care, appliances, and pharmaceuticals. The level of services varies by State. The duration of medical care is three months to one year, depending on the employee's contribution record.

Government Facilities

For those not covered by the Employees' State Insurance Scheme, medical care is still provided free or at low cost in government facilities.

MARKET PRACTICE

Medical benefits are generally provided to all employees and their s.

Outpatient Treatment

A company can reimburse each employee directly for medical expenses up to INR 15,000 per year on a tax-free basis. The coverage is normally offered to the employee and his or her immediate family (spouse and typically a maximum of two children) ; however, some employers cover all children and some parents as well. All expenses for minor ailments, doctor's visits, and the purchase of over-the-counter drugs are reimbursed up to INR 15,000 per year. The cost of this coverage usually is considered to be part of the total remuneration paid to the employee.

Hospitalization

Group health insurance policies are available for hospitalization expenses up to an amount set by the employer. All employees and their immediate family members are usually covered. The employee is reimbursed for part of the expenses incurred in a hospital for room and board, surgery, specialist's fees, and medicines. Typical practice for hospitalization coverage is to bear all expenses (with an upper limit) that are incurred during the hospitalization of the employee for all cases that require hospitalization of 24 hours or more. No separate limits are set for room rent or medication, etc.; only a single annual upper limit is set for each employee.

There are four state-owned insurance companies and four private insurance companies that offer health insurance policies at present. It now is mandatory for all insurance companies to use third-party administrators. Coverage per employee typically ranges between INR 100,000 to INR 700,000 per year, and may differ by employee category. Most organizations also include spouses, children, and parents in the coverage; in such cases, the cost per employee is significantly higher. Parental coverage in particular has led to increasingly high claims experience and subsequently higher premiums. Many companies have begun introducing a copayment for parental claims or an insured sum sub-limit, and in some cases have been eliminating parental coverage.

INDONESIA

SOCIAL SECURITY

In Indonesia, the Jamsostek health care system covers employees and their s for hospitalization, physicians' services, and prescription drugs. The current social security reform legislation includes a provision for universal health insurance to be phased in from 2010 to 2014.

Eligibility

Employees and their s are enrolled on their hire date. s are limited to one spouse and up to 3 children under age 21. Children are normally covered by the father's employer, which pays the family contribution rate (6%) and if the mother is employed, her employer pays the single contribution rate (3%). If there is no father, the children may be covered by the mother's employer.

Benefit

The basic health services provided through Jamsostek include:

- ▶ Primary care
- ▶ Additional outpatient treatment
- ▶ Inpatient hospital care
- ▶ Maternity care (prenatal care and delivery)
- ▶ Diagnostic support
- ▶ Vision care (including glasses)
- ▶ Dental care (not including teeth cleaning and orthodontics)
- ▶ Other special treatment such as hearing aids orthopedic prostheses
- ▶ Emergency treatment

MARKET PRACTICE

The amount of medical benefits that companies provide is very broad. Most companies self-insure and will reimburse 100% of all medical expenses up to an annual maximum of 1x to 2x monthly salary. Other companies pay a flat monthly allowance to employees whether or not the employees incur any medical expenses. Large companies and multinational companies usually provide some type of medical benefits. Companies with insured plans will provide basic hospitalization, possibly with supplemental major medical benefits.

Basic hospitalization (per disability) might typically include:

- ▶ Room and board (maximum of 31 days): IDR 300,000
- ▶ Surgical: IDR 10,000,000
- ▶ Doctor's visits: IDR 150,000

Supplemental Major Medical might typically include:

- ▶ Coinsurance: 10% to 20%
- ▶ Maximum amount: IDR 1,000,000 to IDR 10,000,000

Typically, the level of benefits will differ within a plan depending on job classification.

IRELAND

SOCIAL SECURITY

The Health Service Executive (HSE) is in charge of Ireland's public health services. All Irish residents and some visitors are eligible for free maintenance and treatment at public hospitals (Health Service Executive or voluntary public hospitals). Some charges may be applicable if the patient does not have a medical card, which entitles the card holder to some free health services.

Medical Card

There are different ways to qualify for a medical card. Some people qualify for medical cards based on receiving no other income than a maximum rate of a means-tested social assistance payment or meeting a weekly income limit. In this case, adults and children up to age 18 or age 22 if a student is also covered. Irish residents that are at least 70 years old qualify for medical cards, but their spouses are not covered. A medical card enables the recipient to receive free family doctor services, some prescription drugs, in-patient public hospital services, out-patient services, maternity and infant care services, medical appliances, and dental and vision care services.

Additional Programs

Those without a medical card are required to pay part of the cost for medical services (except for maintenance and treatment in a public hospital); however, they might be eligible for the following programs: a General Practitioner (GP) visit card, drugs payment scheme, long-term illness scheme, or the Hepatitis C scheme.

The GP visit card weekly income test has thresholds approximately 50% higher than the medical card limits. This card enables the holder to receive free visits to a family doctor selected by the patient from a panel of participating physicians.

A drugs payment scheme is available to all residents who do not have a medical card. By using this card, an individual or family only has to pay a maximum of EUR 85 a month for approved prescription drugs and medicines, and specified appliances. The 2010 austerity budget affects drug payments. Participants in the drug payment scheme (available to all residents without a medical card) will have qualified drug expenses reimbursed if they exceed EUR 120 per month per family; the current threshold is EUR 100 per month.

The 2010 austerity budget also introduces a prescription drug charge, effective from 1 April 2010, for those with medical cards (low income persons and residents age 70 or older). Medical card holders will have to pay EUR 0.50 for each prescription, up to a maximum of EUR 10.00 per family per month.

Those with a long-term illness or disability may qualify for a long-term illness scheme. Free drugs, medicines, and medical appliances are available to those who have been certified by their doctor as suffering from one of a list of qualifying long-term illnesses or disabilities.

MARKET PRACTICE

Approximately 50% of the population has private health insurance that covers treatment in a private hospital (private or semi-private room), and reduces the long waiting periods that can occur for non-urgent procedures under the public system.

It is relatively common for a company to provide private health insurance for employees. Premiums for employer sponsored groups are about 10% lower than for individual coverage without employer involvement.

The three private health insurers in Ireland are increasing their premiums for 2010, reflecting medical inflation and an increase in the health insurance levy that they must pay. The largest health insurer, VHI, announced an increase ranging from 6.0% to 9.5%, depending upon the type of contract, effective for contracts renewed on or after 1 February 2010. The other two insurers also are increasing premiums; Quinn Healthcare is increasing premiums by an average of 12%, whereas Hibernian Aviva Health is calling for an average increase of 15%.

Part of the increase is due to a higher health insurance levy that must be paid by all health insurers, from EUR 165 to EUR 180 for each adult subscriber, and from EUR 53 to EUR 55 for each subscriber younger than age 18. The levy, which is used to subsidize health insurance costs for subscribers age 50 or older, was introduced last year when the Irish Supreme Court invalidated the Risk Equalization Scheme that had been introduced to achieve the objectives of community rating.

The Voluntary Health Insurance Board (VHI) is the largest provider of voluntary private health insurance. It is a statutory body whose board is appointed by the Minister for Health and Children. BUPA is the second largest provider of voluntary private health insurance in Ireland; however, in December 2006, BUPA announced its decision to leave the Irish health insurance market. BUPA's members will be covered for the duration of their existing contracts. Those unable to renew their cover with BUPA are entitled, under open enrolment regulations, to move to

another insurer without penalty for an equivalent level of cover to that held at present. The insured would not be subject to additional waiting periods before cover would take effect. Vivas are the third voluntary private health insurance provider in Ireland. There are a number of long-established health insurance providers that deal solely with specific groups of employees—membership is confined to employees and retired employees and their dependants. These schemes are known as restricted membership schemes (e.g. the Gardai, prison officers and ESB employees). Vivas are the third voluntary private health insurance provider in Ireland. There are a number of long-established health insurance providers that deal solely with specific groups of employees—membership is confined to employees and retired employees and their s. These schemes are known as restricted membership schemes (e.g. the Gardai, prison officers and ESB employees).

ISRAEL

SOCIAL SECURITY

Israel has highly developed healthcare infrastructure and an extensive network of hospitals and clinics. All Israel residents are compulsorily covered by health insurance. Residents may choose from one of four funds (Clalit, Maccabi, Meuhedet, and Leumit). All health insurance funds are subject to a minimum basic benefits package and may not bar applicants on any grounds, including age and state of health.

Basic benefits required by law of all health funds include:

- ▶ Medical diagnosis and treatment
- ▶ Preventive medicine and health education
- ▶ Hospitalization (general, maternity, psychiatric and chronic)
- ▶ Surgery and transplants. If medical treatment is not available in Israel, treatment abroad will be covered.
- ▶ Preventive dental care for children
- ▶ First aid and transportation to a hospital or clinic
- ▶ Medical services at the workplace
- ▶ Medical treatment for drug abuse and alcoholism
- ▶ Medical equipment and appliances
- ▶ Obstetrics and fertility treatment
- ▶ Treatment of injuries caused by violence
- ▶ Medication, in accordance with an order issued by the Ministry of Health
- ▶ Treatment of chronic diseases
- ▶ Paramedical services (physical therapy, occupational therapy, etc.)

Co-payments may vary by fund and plan, though a common co-payment is a flat-rate first visit co-payment applicable each quarter.

MARKET PRACTICE

While primary healthcare in Israel is provided under the National Health Insurance plan through the four health funds, the majority of health fund members purchase supplemental insurance from their fund at additional expense. Group private health insurance is becoming increasingly common in certain sectors, and especially among foreign owned multinationals. These plans typically cover services and medications not included in the basic benefits required by law of the national health funds. They may also offer full refund (no copayment or excess) on inpatient and day clinic services, including hospital charges, professional fees, laboratory fees, maternity, and outpatient procedures. Private health insurance gives employees immediate access to appointments with specialists, private laboratory services and tests that would otherwise require pre-approval from the health fund.

Private hospitals may have a special service for patients with private health insurance.

Employer-sponsored plans typically cover all employees and their family members.

Premiums run approximately \$100 per month per employee and family.

Basic dental plans have become somewhat more popular among foreign-owned larger companies and some smaller high-tech companies. Dental plans are not common among Israeli companies.

ITALY

SOCIAL SECURITY

National Health Service

The National Health Service (Servizio Sanitario Nazionale or SSN) provides universal health care coverage for all residents of Italy. The SSN health coverage is not financed through employer and employee contributions, but through a corporate tax called IRAP (typically 4.25% of corporate gross profit).

The National Health Service system is constantly under review as are the services it offers and its deductibles and co-payments (known as tickets).

Eligibility

Medical care is provided to all citizens and foreign workers in Italy.

Benefit

Currently, the benefits are:

- ▶ General practitioner and specialist treatment, including dental treatment
- ▶ Ambulatory care
- ▶ Hospitalization care
- ▶ Pediatric care (up to age 12)
- ▶ Maternity care
- ▶ Specialist care (including dental care) in public out-patient departments
- ▶ Some prescription drugs (some like are available free of charge to all persons, some require a copayment, and some are covered if provided in a hospital) Health benefits can be provided directly, free of charge, through the local health center or doctor, or indirectly where the patient pays the costs and is reimbursed. When applicable, copayments (called ticket sanitary) are based on age, earnings, and treatment; they are typically waived for children, the elderly, the chronically ill, and low-income persons.

Medical services that typically require copayments include outpatient specialist care, rehabilitation treatments not offered at state hospitals, thermal waters treatments and certain diagnostic tests

Medical Care for Dirigenti (Executives and Senior Managers)

Dirigenti (executives and senior managers) are covered for expenses beyond those covered by the general National Health Service coverage. The main supplementary programs are F.A.S.I. (Fondo Assistenza Sanitaria Integrativa) for dirigenti in industry and F.A.S.D.A.C. (Fondo Assistenza Sanitaria Dirigenti Aziende Commerciali, better known as Fondo Mario Besusso) for dirigenti in commerce.

F.A.S.I.

F.A.S.I. is integrated with the National Health Service and covers dirigenti in industry that do not receive employersponsored supplement (SSN) al health coverage. The program is financed through employer and employee contributions as stipulated in industry collective bargaining agreements (CCNLs).

F.A.S.I. coverage is extended to the dirigente's spouse and children under age 18 (26 if university student, no age limit if disabled). The program provides partial and full reimbursement of costs not covered by the National Health Service in the areas of:

- ▶ Specialist care
- ▶ Stomatological and dental care
- ▶ Intensive care and surgery (inclusive of medicines and other supplies)
- ▶ Diagnostic tests
- ▶ Rehabilitation and therapy
- ▶ Home nurse care
- ▶ Thermal waters treatments

F.A.S.D.A.C. (Fondo Mario Besusso)

Unlike F.A.S.I., F.A.S.D.A.C., is not only integrated with the National Health Service (SSN) but it also offers its insured (dirigenti in commerce and their families) medical benefits through their own network of health care facilities subject to coinsurance. If the insured chooses to make use of health care facilities and services outside the F.A.S.D.A.C. network, within Italy or abroad, the program provides reimbursement for certain services up to

predetermined limits which vary according to the medical service for which reimbursement is sought. F.A.S.D.A.C. reimburses costs only for the following:

- ▶ Specialist care
- ▶ Obstetrical care
- ▶ Hospitalization and surgery (inclusive of medicines and other supplies)
- ▶ Dental care (inclusive of dental implants and dentures)
- ▶ Prosthetics and hearing aids
- ▶ Home nurse care
- ▶ Funeral expenses (for the insured only: dependants are excluded from this coverage)

Within the F.A.S.D.A.C. network, most routine medical services (check-ups, non-complex diagnostic tests) and physiotherapy are typically free of charge for the insured. The coinsurance rates are as follows:

- ▶ Hospitalization services and inpatient care: 15%
- ▶ Outpatient specialist care: 20%
- ▶ Dental care: 30%

MARKET PRACTICE

Typically, large and multinational companies supplement the dirigenti CCNL mandatory plans through employer sponsored health care plans generally implemented through a multiemployer health fund. The current trend is for these plans to be extended to non-managerial employees as well, since the SSN health system is rapidly deteriorating.

Typical employer-sponsored health care plans are entirely financed by the employer and include coverage for hospitalization, outpatient care, dental care and vision care. The annual coverage cost per employee range from EUR 600 to EUR 2,000 depending on the comprehensiveness of the plan.

There are generally two types of private plans: major medical and indemnity. The typical major medical plan reimburses 100% of hospital costs up to a certain limit and 80% of expenses for outpatient medical, dental and vision care. Deductibles, co-payments and annual limits vary from plan to plan. Dependant coverage is an option typically provided in these plans and is generally financed by the employee.

Indemnity plans are not as common as major medical plans and vary in the flat amount they cover for the different types of health care services they cover.

JAMAICA

SOCIAL SECURITY

The government of Jamaica, through the Ministry of Health, provides a wide range of healthcare services to the public at the primary, secondary, and tertiary levels. National Health Services (NHS) is managed through four semiautonomous regional health authorities through the country. National Health Services are financed through general tax revenue.

Eligibility

All Jamaican residents.

Benefit

Subsidies are provided for all persons for specified pharmaceuticals used in the treatment and management of defined chronic illnesses. This includes the Jamaica Drugs for the Elderly Program (JADEP) that provides drugs free of cost for persons 60 years and over (a fee of up to JMD 40 per item may be charged by the pharmacist for dispensing a month's supply).

MARKET PRACTICE (MEDICAL BENEFITS)

Many larger employers offer private medical insurance (PMI) as an employee benefit.

Economic sources suggest that less than 20% of the population have access to PMI schemes. Blue Cross and Life of Jamaica are the sole providers of PMI group plans in Jamaica.

It is common for employers to pay 100% of the premium for PMI plans, which is tax deductible for the employer. PMI plans generally follow the US major medical plan approach, with coverage provided subject to a maximum lifetime limit. Coverage is available for physician consultation and prescription medicines, and extensions are available to provide optical and/or dental treatment. Deductibles and co-insurance are commonly used.

Typical plan limitation or exclusions include cosmetic procedures, alcoholism or drug addiction, and nervous or mental disorders.

JAPAN

SOCIAL SECURITY

Social Security Health Insurance Plans

Under Japanese law, all residents of Japan—including foreigners—must be covered under one of the two social security health insurance plans:

▶ Employed persons who work more than 20 hours per week for a company with more than 5 employees must be covered under the Employees' Health Insurance (EHI) plan. s also are covered. A company is permitted to contract out of the EHI and establish a plan that meets the requirements of a Health Insurance Society (many medium- and large-sized companies do so). s of these employees also are covered. The cost of the EHI coverage is shared equally by employer and employee.

▶ Individuals who are employed in small companies, as well as self-employed and non-employed persons, must be covered under a National Health Insurance (NHI) program. The individual pays the full cost. The NHI covers individuals younger than age 75 who are not eligible for participation in an EHI, Health Insurance Society, or one of the health insurance programs for special categories of workers (seamen, private school employees, and government employees). NHI coverage is administered by the municipality where the insured lives. It is financed by the municipality, with subsidies from the central government.

Contracting out of the NHI program is not permitted.

Expatriates

Employers are obligated to enroll employees and their s in the social security health insurance plan, but this policy has been loosely enforced by the Ministry of Health, Labour and Welfare. As a result, the Immigration Bureau had planned to require that expatriates working in Japan furnish proof that they are covered under the statutory health insurance plan in Japan in order to obtain a renewal of their visa. The Immigration Bureau has decided not to pursue this policy.

In an announcement on 3 March 2010, the Immigration Bureau said that officials will continue to ask non-permanent residents to present an insurance card when they renew or modify their visas but, according to the guidelines, "renewal applications or change of visa status applications will not be rejected for failing to present the card."

Additional Programs

The Long-Term Insurance program provides additional coverage for those aged 40 to 75 who require long-term care or assistance, or who must be confined to a medical facility for a prolonged period.

A special program to provide coverage for those who are age 75 or older took effect from 1 April 2008. The program is financed separately from the programs for those who are younger than age 75; this was done because, with a rapidly growing elderly population, it was felt necessary to keep the EHI and NHI programs from being directly affected by the higher medical costs experienced by the elderly.

Nationwide hospital, medical and surgical reimbursement rates are set by the government following negotiations with the providers. A majority of hospitals and clinics are privately operated on a for-profit basis. About 90% of the doctors have a private for-profit practice.

Employees' Health Insurance

Eligibility

Coverage is compulsory for full-time employees of companies with 5 or more employees. Part-time workers are covered if their work days and their work hours both are greater than 75% of the average working time of a fulltime employee—that is, generally if they work more than 30 hours per week. Coverage is extended to s (spouse, children, grandchildren, younger brothers and sisters, parents, grandparents, and great-grandparents) .

The coverage ceases at age 75, when a separate program for the elderly takes effect.

An individual who was covered under the EHI system for at least two months may voluntarily continue coverage for up to two years if he or she retires or resigns from employment. The contribution is equal to the combined employer-employee contribution for EHI (currently 8.1%) .

Benefits

The EHI covers medical expenses incurred by the employee and s in connection with non-occupational related sickness or injury. It excludes cosmetic surgery, health check-ups and immunizations, normal delivery of a child,

and abortion for non-medical reasons. The plan pays for transportation expenses when the insured cannot walk due to sickness or injury. It also pays reasonable charges for transportation to the hospital or clinic.

The EHI pays 70% of the cost of care; it pays 80% of treatment of a child younger than age 3. The plan pays 90% of the cost of care for a person aged 70 through 74 (70% for higher income elderly persons) .

In the event of hospitalization, the patient is required to pay a fixed charge of JPY 260 per meal.

If the payments made by a patient for a hospital or clinic exceed a certain sum in any given month, 100% of the excess will be reimbursed by the EHI for outpatient service, inpatient service, medical service or dental service are calculated individually.

If the employee or his/her s have received the reimbursement for three months out of a year, the total excess over the payment limit will be reimbursed beginning with the fourth month.

If two or more members of the household have paid more than JPY 21,000 of co-payments each, the total medical care expenses less the sum of individual payments limit will be reimbursed

National Health Insurance

As noted, the National Health Insurance program covers those who are not participants of the EHI, a Health Insurance Society, or one of the other health insurance programs for special work categories. The NHI also covers retired persons who had been covered under the EHI or a Health Insurance Society when they were working. The health cost for these individuals are financed by a transfer from the individual's former insurer.

The NHI provides comprehensive health care services in case of sickness, and non-occupational injury. The following are excluded: cosmetic surgery, health check-ups, immunizations, normal delivery of a child, abortion for non-medical reasons, and injuries or illnesses from a brawl or drunkenness. The program covers 70% of most medical costs (80% for children younger than age 3, and 80% or 90% for those aged 70 through 74) . Patients who are hospitalized must pay a daily charge for meals: JPY 650 per day for each of the first 90 days, and JPY 500 per day thereafter.

The NHI program has stop-loss features that are similar to those in the EHI system, but the limits are different. For example, an individual younger than age 70 who is in the general category will have a stop-loss equal to JPY 72,300 + (Medical care expenses - JPY 241,000) x 1%.

The program also provides death benefits to insured workers and their s.

MARKET PRACTICE

An employer or group of employers may contract out of the government-administered Employees' Health Insurance program by establishing a health insurance society (also known as society-based health insurance or association-managed health insurance) . A great majority of eligible companies participate in a health insurance society, primarily because of the potential cost savings and the element of favorable employee relations. There were 1,584 health insurance societies in Japan, covering a total of some 30,199,000 members (about 46% of all EHI and health insurance society members) in 2006. Almost all are established and administered by companies with over 1,000 employees. By law, there must be at least 700 employees in the health insurance society, but in practice most groups have at least 1,000 employees. A smaller company is permitted to participate in a multi-employer health insurance society if the company has at least 300 employees, and the aggregate number of covered employees of all companies in the HIS is at least 3,000.

The benefits paid must be at least equal to those under Employees' Health Insurance Law.

As of 1 April 2008, all health insurance societies are required to offer metabolic screening to employees aged 40 and older. Companies are expected to introduce wellness programs—in particular, nutritional guidance, exercise programs, and weight loss and smoking cessation programs. Beginning in 2013, the government subsidy to a health insurance society will be increased or decreased, reflecting the degree of success that the companies have had in improving the health of employees.

SOUTH KOREA

South Korea has a compulsory national medical system, the National Health Insurance (NHI) program, which is funded by both employer and employee contributions. The NHI program is a fee-for-service program in which patients pay co-payments and the NHI program administrator (the National Health Insurance Corporation) pays doctors and medical facilities set fees for services.

People in South Korea primarily utilize private health care resources – 90% of all medical facilities are private clinics and hospitals. NHI coverage is applicable to services at these private facilities.

SOCIAL SECURITY

Coverage under the National Health Insurance (NHI) program is compulsory for all employees. Foreign employees may opt out of the NHI program if they have equivalent coverage through foreign medical insurance.

Eligibility

All employees are required to be covered under the NHI program, excluding foreign employees with equivalent coverage through foreign medical insurance.

Benefit

The NHI program primarily covers medical services, subject to patient co-payments, but the NHI program will also provide cash benefits in some cases (such as payment of a funeral benefit or reimbursement of excessive copayments) . Covered medical services include diagnosis, tests, drugs, medical appliances, treatments, surgery, preventive care, rehabilitation, hospitalization, nursing, transportation, and health screenings (once every 2 years for an insured or over 40) .

The Ministry of Health, Welfare and Family Affairs announced a number of changes for 2009, including changes to the copayments. Copayment limits will now be based on income level tiers. The bottom 50% of the insured group will have a copayment cap of KRW 2 million, the 50% to 80% group will have a cap of KRW 3 million, and the top 20% will have a cap of KRW 4 million.

Generally, patients are responsible for a 20% co-payment for inpatient care, between 30% to 50% for outpatient care (based on the type of facility and the total service cost) , and 30% for prescription drugs. The recent ministry announcement included copayment reductions for rare diseases (now 10%) and for cancer treatment (now 5%) . In the case of the death of an insured or covered under the NHI program, the NHI program administrator (the National Health Insurance Corporation) will pay a maximum funeral grant of KRW 250,000 to the person in charge of the funeral ceremony.

MARKET PRACTICE

Typically, there isn't much scope for private health insurance companies to provide comprehensive coverage, because a large share of the medical facilities is in the private sector and they accept National Health Insurance (NHI) . However, other forms of private insurance, such as life insurance, can include medical coverage. The health insurance is typically a rider to the private life insurance and usually covers the co-payment of the national health insurance plan. Dental plans are uncommon in South Korea. Some dental coverage (major operations, not maintenance/cavities, cosmetic procedures) is provided under the NHI program.

LUXEMBOURG

SOCIAL SECURITY

Social security medical coverage for employees is mandatory and is financed through employer and employee contributions. The benefits are managed by the National Health Fund (Caisse Nationale de Santé or CNS) through which authorized health institutions medical services are provided. Mandatory CNS membership also applies for those receiving any type of social security pension, indemnity or allowance. Voluntary CNS membership is available subject to fulfillment of applicable eligibility requirements.

Eligibility

All active employees and their qualifying s are covered by the CNS medical insurance. No qualifying period applies. Qualifying s include the insured's spouse or partner, and the insured's children under the age of 18 (27 if full-time student). Parents and other direct relatives may be covered whenever they have no access to other medical coverage. Individuals who have no access to health coverage may choose to be insured under the CNS. A three-month waiting period applies. In addition, the co-insured age 18 or more who loses eligibility for coverage may request an extension of insurance. A six-month waiting period applies. These individuals pay monthly premiums for the coverage.

Benefit

Medical benefits include general and specialist care, hospitalization, laboratory and diagnostic tests, maternity care, dental care, prosthetics and other medical devices, medicines, transportation, and rehabilitation. Medical services are provided by doctors and hospitals within the CNS network according to established tariffs.

The patient shares in the cost through co-payments, which vary depending on the service but that typically ranges from 5% to 20% of the cost.

The CNS coverage usually reimburses for emergency medical treatment provided to the insured while travelling outside of Luxembourg.

Long-Term Care Insurance

Luxembourg is one of the few countries to provide long-term care coverage under its social security program. The benefits are provided to employees and their s by the sickness funds. There is no waiting period. To be eligible for benefits, the person must have a physical, psychological or mental illness that requires him or her to be in need of assistance from a third-party in order to accomplish activities of daily living. The UCM oversees an assessment of each patient's requirements and the development of a care plan. The objective is to enable persons to remain in their own homes as long as possible. The emphasis is on long-term care; thus, at least 3-1/2 hours of care per week must be needed, and the assistance must be required for at least six months. The program pays for assistance in personal hygiene, food preparation and eating, dressing and undressing, and entering and leaving the house. It also pays for domestic tasks such as house clearing, laundry and grocery shopping.

Funeral Grant

In the event an insured or one of his or her s a funeral grant of EUR 1,229.01 (as of 1 July 2010) is provided to the surviving relatives. If the deceased is a co-insured of less than 6 years of age or a stillborn child, the grant is reduced by 50% or by 80% respectively.

MARKET PRACTICE

Employers typically provide supplementary or top-off medical coverage, particularly to their executive and management employees. The coverage may be obtained from a non-profit insurance company (mutuelle). Employers typically pay the entire premium for individual coverage and the employee typically pays any additional premium for family coverage. No deductibles or copayments apply. A supplementary or top-off medical coverage normally covers the following:

- ▶ All copayments required under the social security system
- ▶ Fees for a private hospital room and additional beds for an accompanying family member
- ▶ Reimbursement of television and telephone fees while hospitalized
- ▶ Higher dental and orthodontic reimbursements
- ▶ Higher coverage for optical frames and contact lenses
- ▶ Homeopathy

- ▶ Midwife services
- ▶ Funeral allowance
- ▶ Birth allowance

Stand-alone dental and vision plans are extremely rare.

MALAYSIA

SOCIAL SECURITY

Malaysia does not have a national health insurance program and there are no statutory medical benefits. A national health insurance plan that was announced in 2002 did not materialize and implementation remains uncertain. The public health care system charges fees at subsidized rates with copayment amounts reflective of what patients can afford to pay. Though health care services are subsidized at public hospitals and clinics, there usually is a long waiting list to receive treatment, and private sector employees prefer to use private hospitals and clinics.

Employees Provident Fund (EPF) Withdrawals for Critical Illness

In some cases, Employees Provident Fund (EPF) savings may be withdrawn from the Account II/Housing and Medical Account for medical costs. An employee must retain savings in this account. The withdrawal must be only to cover critical illnesses approved by the EPF board, which currently includes the following:

- ▶ Major organ transplant
- ▶ Coronary bypass surgery
- ▶ Heart valve replacement
- ▶ Surgery to aorta
- ▶ Multiple sclerosis
- ▶ Stroke
- ▶ Meningitis and encephalitis
- ▶ Coma
- ▶ Cancer and benign brain tumor
- ▶ Serious accident injuries
- ▶ Congenital heart disease
- ▶ Congestive heart failure
- ▶ Chronic renal failure including hemodialysis and kidney transplant

MARKET PRACTICE

A survey conducted by the Malaysian Employers' Federation shows that 98% of private companies provide medical treatment to executives and 57% provide hospitalization coverage.

Coverage usually is provided only to full-time employees and often only to higher-level employees. Coverage also is provided. Typically, a multinational company will pay the full cost of employee coverage and part of the cost of coverage, often 50%. Many employers pay directly for outpatient expenses for employees and s.

Though out-of-hospital coverage is not insured by most employers, it sometimes is provided under a program that is administered by an insurance company. Some multinational companies are now insuring the out-of-hospital coverage as part of their hospital-medical-surgical plan.

Many multinational employers purchase group insurance coverage that pays for most medical, surgical, and hospital expenses while the patient is hospitalized. The plan usually will specify a maximum duration for hospital confinement, such as 120 days, and a maximum payment that the plan will make for all expenses to be paid in a calendar or plan year.

A lifetime maximum may apply for cancer treatment and for kidney dialysis. Payment for most services is based on a reimbursement schedule that shows the maximum payment (internal limit) for a specified doctor's treatment or hospital service. Many employers will have several schedules. An abridged schedule of benefits for three levels of employees is shown below. In addition to the coverage shown, a typical plan will cover diagnostic services and a consultation with a specialist prior to hospitalization.

Usually the plan will also cover the charge for an ambulance, outpatient treatment within 24 hours of an accident, operating room charges, prescription drugs while hospitalized, outpatient surgery, and accommodation for a parent who is accompanying a hospitalized child.

Union Employees	Managers and Administrative	Executives and Senior Management
Overall annual limit (all benefits)		
MYR 25,000	MYR 50,000	MYR 80,000
Hospital room and board, per day (maximum 120 days)		
100	200	300
Intensive care, per day (maximum 60 days)		
200	400	450
Hospital ancillary charges	No internal limit	No internal limit
12,000	25,000	42,000
Maximum anesthesiologist charge		
4,000	7,500	12,500
Medical visit in hospital, per visit (maximum 60 days)		
No internal limit	No internal limit	No internal limit
Radiology and chemotherapy (per disability)		
3,000	4,000	4,700
Cash allowance if confined in public hospital, per day (maximum 120 days)		
40	50	50

In recent years, managed care plans, known as medical care schemes, have become quite popular in Malaysia. The plans are offered by many of the major insurance companies. Coverage is provided at participating private hospitals and clinics that have contracted with the managed care organization. The patient presents his or her medical card at the time of hospitalization; an advance payment upon admission is not required. The managed care organization pays the provider directly; the patient is responsible only for excess charges.

MEXICO

BENEFITS AT A GLANCE

A mandatory retirement savings system is paid for by employers, at 2% of wages, and managed in individual investment accounts by registered organizations known as Afores. In 2009, the government adopted reforms allowing the Afores, which manage about \$100 billion in assets, to gain access to local private equity funds. Mexico has a decentralized national health system, but employees who can afford private care tend to use it and buy insurance for it.

The health system in Mexico encompasses three principal providers: the Health Secretariat (SSA), the Social Security Institute (IMSS) and the private sector (private insurance companies/HMOs). The segmentation of the service providers results in unequal access to quality health services as well as in financing difficulties.

SSA and IMSS health services are provided through public health centers and clinic, public general hospitals and public regional hospital of high specialization. Private sector health services are provided through private health services providers (clinics and hospitals).

For all citizens with no access to social security health benefits due to unemployment or self-employment, Mexico's SSA created in 2003 the Seguro Popular de Salud (General Citizenry Health Insurance), a public insurance scheme. Premiums depend on the income bracket the citizen and his/her family falls under, ranging from no charge for brackets I to II, to up to MXN 11,378.86 for bracket X, the highest of the brackets.

Health services provided through the SSA include medical, surgical, pharmaceutical and hospital services.

SOCIAL SECURITY

IMSS-sponsored health services are available for the subscriber, his/her spouse and children under the age of 16 or 25 if they're students (no age limit for disabled children). Ascendants that don't qualify for any other coverage may also be included in the family plan.

Eligibility

To access the health services provided by the IMSS, the subscriber must be employed and actively contributing to the system.

Benefit

Benefits include general and specialist care, surgery, hospitalization or care in a convalescence home, medicines, dental care, prosthetic devices and laboratory services.

MARKET PRACTICE

Due to the long lines and limited care available under the government medical care system, a medical plan is commonly offered for salaried employees. The typical medical plan is similar to traditional indemnity plans in the USA, with a deductible, coinsurance, and maximum sum insured. Some insurance companies have introduced agreements with various hospitals and physicians in order to offer cheaper services and direct payment by the insurer. It is common for a medical policy for executives to include provisions allowing the individual to be covered for expenses for treatment in the USA.

Companies provide a medical plan similar to the following:

- ▶ Insured Sum: 500x to 800x monthly minimum wage (MMW) per event (senior executive plans may go up to 1,500x MMW)
- ▶ Deductible: 3x MMW per event
- ▶ Coinsurance: 10% employee up to MXN 100,000
- ▶ Accidents: Waive deductible and coinsurance
- ▶ Non-contributory for employees Family coverage paid for 50% by company
- ▶ Emergency overseas: 20% coinsurance with a USD 50 deductible and insured sum of USD 50,000 Dental and vision coverage is rare. Expenses may be reimbursed under the flexible compensation (social welfare benefits) plan.

NETHERLANDS

The health insurance system in The Netherlands was reformed in 2006. The new system is a private health insurance with social conditions. The system is operated by private health insurance companies; the insurers are obliged to accept every resident in their area of activity. A system of risk equalization enables the acceptance obligation and prevents direct or indirect risk selection.

All employees are required to be covered under 2 types of insurance: basic health insurance coverage for all employees according to the Health Insurance Act (ZVW) (employer contributions and employee-paid insurer fee) and exceptional health insurance coverage according to the General Act on Exceptional Medical Expenses (AWBZ) (only employee contributions). Employees may also be covered under voluntary health insurance, which covers care (such as non-specialist dental care) that is not included in the required forms of insurance.

Employers may establish a group plan with an insurer, which employees can join, often at better rates than through individual coverage.

ZVW Basic Health Insurance

All employees are required to take out basic private health insurance. Employers are required to cover the 6.9% contribution on the employee's salary up to EUR 32,396 (employers withhold this amount from the employee's paycheck and reimburse the employee). Employees contribute a nominal fee charged by the insurer, typically under EUR 100 per month. An annual deductible of EUR 155 per person applies in 2009 towards medical charges for certain types of care. Higher deductibles are available from insurers for coverage at lower premium rates. The government finances the nominal insurer fees for children under age 18.

ZVW benefits cover: medical care, hospitalization up to 1 year (365 days), ambulatory/transportation costs, specialist care, pharmaceuticals, maternity and postnatal care, some rehabilitation services, and dental care (for those younger than 18 and specialist dental care and dentures for adults).

AWBZ Exceptional Medical Care Insurance

Employees contribute 12.15% of salary up to EUR 32,427 for AWBZ exceptional medical care insurance which covers medical care that is not covered under the ZVW basic health insurance or in the event that private coverage is exhausted.

AWBZ benefits include, but are not limited to: hospital care, treatment in rehabilitation institutions, treatment in mental institutions, nursing care, and out-patient care.

MARKET PRACTICE

Many employers offer plans that replace (as long as benefits provided are equal to or greater than those required by law) or supplement the basic plan required by law.

A typical medical plan covers more or less the same benefits required by the state. They are:

- ▶ 100% of doctors' fees
- ▶ 100% of in-hospital care up to 12 months
- ▶ Fees for specialists
- ▶ Prescription drugs

Competitive companies contribute 50% of the premium for the group medical plan with the employee paying the balance. The premium rates are not government-controlled and vary by age and group size.

Group plans are eligible for a discount of up to 10%, which make them attractive to employees.

NEW ZEALAND

SOCIAL SECURITY

Eligibility

Basic health coverage is furnished through the Ministry of Health for the following persons: New Zealand citizens or permanent residents, work permit holders, children under the age of 18 in the care of eligible persons.

Benefit

Subsidies are provided for those using health care. Free services include:

- ▶ Free public hospital treatment
- ▶ Free treatment at public hospital 24-hour accident and emergency (A&E) clinics
- ▶ Subsidies on prescription items
- ▶ Subsidized fees for visits by family members to general practitioners (GPs)
- ▶ Subsidized fees for visits to physiotherapists, chiropractors and osteopaths when referred by a GP for an accident case
- ▶ Free or subsidized health care for those suffering from acute or chronic medical conditions
- ▶ No charge for most laboratory tests and x-rays, except at privately operated clinics
- ▶ No charge for health care during pregnancy and childbirth, unless provided by the private medical sector
- ▶ No charge for GP referrals to a public hospital for treatment
- ▶ Subsidies for children under six for visits to the doctor and for prescriptions
- ▶ Free breast screening for women aged between 45 and 69.

Government Subsidies

Certain categories of patient (low-income families and those who need intensive medical care) have access to Community Services Cards and High Use Health Cards, providing government subsidies.

MARKET PRACTICE

Approximately 35% of the population maintains private health insurance in order to cover co-payments, shorter waiting periods for surgery, and supplementary services. There are several types of private healthcare plans (also called "sustainable access") available to fully or partially subsidize costs not covered by government programs.

They tend to fall into one of four categories: surgical and medical, specialists and tests, dental and optical, and general medical. One common practice is a mutual association of companies setting up a "friendly society" for providing insurance-type benefits for its members in order to negotiate cost advantages.

Most doctors are private practitioners and can set their own fees. The standard adult consultation charges are between NZD 35 and NZD 50. Most eligible adults pay the full cost of visiting the doctor. Visits to the doctor are generally free for eligible children under six years old, although some doctors do charge a small surcharge (usually NZD 5-10). Older children (generally aged 6 – 17 years) are charged about NZD 20 if they are eligible for publicly funded healthcare.

NORWAY

SOCIAL SECURITY

All employees and their s are eligible for healthcare coverage with the National Insurance Scheme. Accommodation, treatment, and medication received in hospitals do not require co-payments. There are copayments (known as the cost share) for benefits outside of a hospital.

The cost sharing amount for treatment by a general practitioner is NOK 132 for each consultation and NOK 295 for specialists. The cost share for prescription drugs during long-term illness is 36% (maximum of NOK 520 per prescription) for adults.

There are two cost-sharing ceilings for other medical expenses. Ceiling 1 pertains to expenses related to treatment by physicians and psychologists, important drugs, and transportation expenses that are related to examination and treatment; this ceiling is fixed at NOK 1,840 per year for 2010. Ceiling 2 includes physical therapy, dental treatment, as well as expenses pertaining to accommodations at rehabilitation centers, and treatments abroad; this ceiling is fixed at NOK 2,560 per year for 2010.

There are exemptions from the cost sharing provisions for special diseases and groups of people. Cost sharing is not applicable for children under the age of 12 for treatment given by physicians, physiotherapists, certain medicines, and medical travel expenses. Cost sharing is not applicable for children under the age of 18 for psychotherapy and dental treatment.

MARKET PRACTICE

Norway has a well-developed, high quality healthcare system. Public funding covers about 85% of the cost of medical care while 15% come from co-payments according to a 2006 report by the European Observatory on Health Systems and Policies (a partnership between the World Health Organization, European governments, and other partners).

The National Insurance Scheme benefits are largely considered adequate. Additional coverage is not typical, with the exception of travel coverage abroad. Some employers pay for annual check-ups at private clinics used by the company.

PAKISTAN

SOCIAL SECURITY

Provincial Social Security

The provincial social security program provides medical benefits to lower-income employees (those who earn up to PKR 10,000 a month) and their s through a series of provincial social security facilities. Eligible s include sons (under age 21 and unmarried), daughters (unmarried), and parents.

Medical benefits include hospitalization, general care, specialist care, outpatient care, maternity care, medication, and transportation (subject to limits). Medical benefits for s are more limited.

MARKET PRACTICE

Most companies provide medical benefits for their employees and s through medical plans that are closely regulated by the Medical Schemes Act, which must cover 300 illnesses and 25 chronic conditions that are mandated by it. Because healthcare is inexpensive in Pakistan, competitive companies provide full coverage for all employees, spouses and children under age 21, with the benefits limited by employment category (i.e., the clinic or hospital that may be used and whether they are entitled to a private room, semi-private room, general ward, etc.). The medical plan is generally self-insured, with probable annual costs ranging from PKR 6,000 to PKR 20,000 per year per employee.

Some companies hire an in-house medic to provide in-house medical consultation, scrutinize all medical claims and refer employees and s to specialists, clinics, etc. Smaller payments may be made directly to employees.

Large amounts are paid directly to hospitals by the department handling salaries.

It is not common practice for employers to provide dental or optical coverage.

Some employers have plans covering pensioners for medical expenses. These plans have rolling limits.

PANAMA

SOCIAL SECURITY

Panamanians are guaranteed health care under the constitution, and the primary objective of national health care policy is to provide “universal access to comprehensive health programs and to improve the quality of service.” The primary government agencies responsible for health care are the Ministry of Health (MINSa) and the Social Security Fund (CSS).

The CSS manages health care services and delivery for the social security system. Approximately 66% of the population receives its health care through the CSS, where 27% of the population are paying participants and 40.5% are insured.

Eligibility

All employees and CSS pensioners as well as their families are eligible for CSS health coverage. Individuals and their s not covered by the CSS are eligible for health care provided by the MINSa system.

Benefit

Both the CSS and MINSa provide preventive and curative medical services through a system of sponsored health facilities or through private facilities. Medical care received in the latter required authorization from the CSS or the MINSa.

Medical benefits include:

- ▶ Outpatient general and specialist care;
- ▶ Inpatient care and hospitalization;
- ▶ Surgery;
- ▶ Diagnostic and other medical tests;
- ▶ Dental care;
- ▶ Maternity care;
- ▶ Medical and rehabilitation treatments as necessary.

Retirees are entitled to subsidies for glasses and dental prosthesis. The subsidy for glasses is 50% of the cost of the glasses (up to PAB 125). A retiree may apply for the subsidy once every two years. The subsidy for a dental prosthesis is 50% of the cost (up to PAB 100). A retiree may apply for the subsidy once every five years.

MARKET PRACTICE

In order to provide access to private medical care facilities, employers typically provide group hospitalization, surgical, and medical reimbursement benefits for their salaried employees and their dependants.

Group health plans with national and international coverage typically present a maximum benefit of USD 1 million for individuals under the age of 60, and of USD 500,000 for those over age 60. Deductibles for these plans start at USD 1,000 for most companies and may go up to USD 10,000. There also group health plans with a co-payment configuration, with maximum benefits of USD 300,000 or USD 500,000, and deductibles of USD 1,000, USD 500 or USD 200.

Most plans are contributory.

PERU

Employers may select to provide medical coverage to their employees through the national health insurance system (EsSalud) , or, since private health insurance schemes are complementary to the national scheme, through both EsSalud and private health insurance entities (EPS) .

In cases where employers choose to complement the national health insurance coverage with a private one, 25% of their statutory social security contributions to EsSalud may be applied against private health insurance premiums. EPS' premiums vary according to the level of coverage that is contracted, however the minimum EPS contribution is 2.25% of the employee salary. EPSs can offer coverage over and above that offered by the government-run system as long as it also provides the same basic benefits that the government program provides. Employees may not individually transfer among EPS coverage. If at least 51% of the employees request a different health care provider, the employer must hold a new election for employees to select a new EPS.

Medical care for those individuals that do fall within the contributory EsSalud scheme is provided through a state health insurance scheme called Seguro Integral de Salud (SIS) . The insured pay a nominal fee to access public medical services. Free or subsidized health coverage is available for individuals under the line of poverty.

In 2009, Peru passed a health insurance law intended to provide universal healthcare coverage. This system is to be contributory (though non-contributory for the poor population) , but is initially only to be effective in the poorer regions (starting with the Andean departments of Apurimac, Huancavelica, Ayacucho) . By 1 September 2010, the system was progressively being implemented in the departments of Lima and Callao.

SOCIAL SECURITY

Contributory System (EsSalud)

Serious, catastrophic, and long-term illnesses as well as cash sickness and maternity benefits are covered by the EsSalud, whether or not a company chooses to provide complementary coverage through an EPS.

Eligibility

An individual and their s are eligible for medical benefits if they have made three consecutive monthly contributions or four nonconsecutive monthly contributions in the six calendar months prior to the date of illness. There's no qualifying period for a medical condition resulting from an accident.

Benefit

Medical coverage is divided into simple care (capa simple) , which covers normal diseases of high frequency, and complex care (capa compleja) , which covers complex diseases of lesser frequency.

The basic medical coverage under both the EsSalud and EPSs schemes include:

Preventive care and health promotion activities such as health education, evaluation and control of health risks and immunizations; Health recovery services including inpatient and outpatient care, prescription drugs and other medical supplies, and prosthetics and orthopedic gear; Rehabilitation and occupational rehabilitation services; and Maternity and infant medical care and services.

MARKET PRACTICE

Companies typically supplement EsSalud coverage with a private EPS. An EPS' basic coverage must be the same as that of EsSalud, and complementary health services vary according to the health plan chosen.

EPS' health plans usually expand the basic health coverage to include dental and vision care, mental health services and oncological care. However, most plans exclude elective surgery, cosmetic surgery, and orthodontics and periodontics.

For most EPS health services there is a copayment. Copayments vary depending on the health plan. However, copayments may not exceed 2% of the insured's monthly salary for outpatient care or 10% of said salary for outpatient care. It is prohibited to request copayment for health prevention and promotion services, emergency services and maternity care.

PHILLIPINES

SOCIAL SECURITY

The Philippines Health Insurance Corporation (PhilHealth) administers the national health insurance program, a program that covers all employees enrolled with social security, eligible spouses, and pensioners. Eligible spouses include spouses that are not NHIP members, children under age 21 (or any age if disabled) who are unemployed and unmarried, and parents who are at least 60 years old.

Eligibility

To be eligible for most PhilHealth benefits, an employee must have at least 3 months of contributions in the past 6 months. Beginning with claims on 1 January 2010, an employee must have at least 9 months of contributions in the previous 12 months to be eligible for certain advanced surgical procedures and services (such as arthroscopy, treatment of hernias, and angiography). PhilHealth introduced this change in Circular 28 on 29 July 2009, citing PhilHealth Board Resolution Number 1281.

Benefit

Medical benefits include hospitalizations of at least 24 hours, inpatient room/board, drugs for inpatient care, lab work, and outpatient/day surgeries.

Covered medical benefits are subject to the following ceilings that vary based on type of hospital and type of medical procedure:

- ▶ General practitioner fees: PHP 300 a day to PHP 600 a day
- ▶ Specialist practitioner fees: PHP 500 a day to PHP 800 a day
- ▶ Room & board: PHP 300 to PHP 1,100
- ▶ Drugs & medicines: Up to PHP 40,000
- ▶ X-ray, labwork, & other services: Up to PHP 30,000

Influenza A (H1N1) “Swine Flu” Benefit

On 4 June 2009, the Philippines Health Insurance Corporation (PhilHealth) announced a new Influenza A (H1N1) (“swine flu”) benefit effective from 1 May 2009. PhilHealth introduced this benefit in Circular 25 of 2009, citing PhilHealth Board Resolution Number 1260.

Eligibility

The H1N1 benefit is payable to all PhilHealth members and their spouses who have a virus infection confirmed by the Department of Health. PhilHealth members must have at least 3 months of contributions in the past 6 months to be eligible for this benefit.

The AH1N1 benefit is also payable to healthcare professionals who contract the virus through working in a Department of Health hospital and contracting the virus from working in the hospital or for caring for a patient suffering from the virus as confirmed by the Department of Health.

The benefit is applicable to treatment in Department of Health facilities (“referral centers”) for AH1N1 and private hospitals if the infection was confirmed or coordinated by the Research Institute for Tropical Medicine (RITM) or with a laboratory certified by the Department of Health.

Benefit

The benefit is up to PHP 75,000 for all PhilHealth members and their spouses, and the benefit is up to PHP 150,000 for healthcare professionals.

The AH1N1 benefit breakdown is as follows:

- ▶ Room and board: PHP 1,500 a day up to PHP 10,000 (PHP 20,000 for healthcare professionals)
- ▶ Medicine, operating room fees, X-rays, lab work, medical supplies, and transportation (ambulance): PHP 50,000 (PHP 100,000 for healthcare professionals)
- ▶ Professional fees: PHP 1,000 a day up to PHP 15,000 (PHP 30,000 for healthcare professionals)

The AH1N1 benefit is payable for an eligible infection only once in a 90-day period. The total benefit period is subject to the overall 45-day annual maximum.

MANDATORY

Employers with at least 50 employees are required to provide certain medical services.

- ▶ 50 to 200 employees: Full-time nurse.
- ▶ 200 to 300 employees: Full-time nurse, part-time doctor, part-time dentist, and an emergency medical facility.
- ▶ More than 300 employees: Full-time nurse, full-time doctor, full-time dentist, dental facility, and an emergency medical facility.

MARKET PRACTICE

Employers often provide 100% employer-paid supplemental medical benefits such as an HMO plan or reimbursement plan. The HMO plan is most common. Coverage is comprehensive (emergency, inpatient, outpatient, preventive, and routine care). s are typically included on the plan. Benefits under these plans are typically subject to an annual cap (PHP 150,000 per medical incident).

The Philippines has some of the highest medicine prices in the Asia-Pacific region. In order to address the prohibitive cost of medicines, in June 2008 the president signed the affordable medicine bill into law (Republic Act 9505).

This law most significantly does the following:

- ▶ Loosens rules on the local testing and production of generic versions of patented drugs.
- ▶ Allows importation of patented medicines from countries where they are available at a lower cost.
- ▶ Gives the government the right to produce patented drugs in times of national emergency.
- ▶ Introduces the presidential power to impose price ceilings on certain medications upon the recommendation of the health secretary (including medicines for chronic illnesses, disease prevention, and those listed in the Philippine National Drug Formulary's Essential Drug List).

POLAND

In 2003, Poland reverted to a centralized approach to health care with a single national health fund (Narodowy Fundusz Zdrowia, or NFZ) . Regional branches of the NFZ contract for services locally; requirements and prices for these services are unified. Public and non-public health care providers who have concluded contracts with the competent regional branch of the National Health Fund are obliged to provide services within the general health insurance system.

Under the current system, patients are allowed to choose their own doctors and hospitals.

Virtually all of the cost of medically necessary services is covered—including physician consultation, surgery, hospital confinement and treatment, in-hospital medical visits, dental and vision care (subject to copayments) , emergency care, long term and hospice care, and prescription drugs (with many subject to copayments) . Sanatorium care is also covered if approved by a physician.

In recent years, it has become increasingly apparent that the system has serious deficiencies.

MARKET PRACTICE

The current problems with the health care delivery system in Poland have resulted in overcrowded public medical care facilities and a reduction in the quality of health care. The growth in utilization of private health services has been accompanied by increasing involvement of employers. Medical coverage is being provided to their employees in one of two ways. In some cases, they purchase insurance that enable their employees (and their s) to receive private medical treatment. In other cases, the employer contracts directly with the medical provider to cover employees and s for a fixed per capita charge.

Insured Medical Plans

The medical insurance market is developing. There are several insurers offering health insurance. Most policies will have copays. However, insurance may not help the most pressing problem -- access to quality care on a timely basis. It is still far more common for companies to contract directly with private medical providers and pay a per capita fee based on the scope of services made available to their employees (which may vary by employee group) .

Pre-paid Medical Plans

Most companies set up an agreement with a private medical clinic to provide medical services to management level employees and their families. Typically, the employer will pay a subscription fee in advance (effectively a prepaid medical plan) . The services to be provided may be limited--for example, to periodic medical examinations (required by law) and basic services. It also is possible for employers to enter into an agreement with a clinic for all employees--but the employee pays for the services as needed.

Some 2 million people—about 5% of the Polish population—used private medical services in 2008, according to data from the Chamber of Insurance. Even though health services are available at little or no cost under the public health system, the total private expenditure for health care services was PLN 28 billion in 2008, compared with public expenditure of PLN 48 billion. The Chamber projects private expenditure to reach PLN 40 billion by 2012. The growth in the use of private health services is largely due to inadequate funding of the public system, resulting in increasingly antiquated and inadequate hospitals and medical facilities, a shortage of medical professionals (primarily due to low salaries) , and lengthy delays in receiving specialist treatment. Nearly 10% of all hospitalizations in 2008 were in private facilities, compared with about 1% two years earlier. There are 190 private hospitals and about 14,000 private health centers in Poland, compared with 2,600 public health centers. About 600 of the 1,500 analytical laboratories in Poland are privately operated, and more than half of the patients requiring dialysis are receiving it in private facilities.

PORTUGAL

SOCIAL SECURITY

Eligibility

Under a social plan administered by the National Health Service, all residents of Portugal have access to health services, and primary care is delivered through a combination of public facilities and hospitals in the private sector, most of which are operated as nonprofit organizations.

Benefit

Health services include consultations, nursing services, social services, vaccinations, diagnostic laboratory and Xray, inpatient services, house calls, home health care, and outpatient services.

Inpatient services are free of charge. Patients who have the ability to pay are required to share in the cost of certain outpatient services. Co-payments are waived for services related to pregnancy, childbirth and family planning. They are also waived for children up to and including age 12, employees and pensioners with income less than or equal to the minimum wage, registered unemployed people, pensioners with an occupational disability of at least 50% and persons with specified serious, long-term, or chronic illnesses.

MARKET PRACTICE

As a result of an increasing demand and the inefficiency of the National Health Services, employer-sponsored health insurance plans are gaining popularity.

The typical private health plan includes hospitalization, physicians' fees, diagnostic procedures, health exams, prescriptions, dental care, and maternity care.

Also applicable to these plans are co-insurance premiums, deductibles, and annual out-of-pocket maximums.

A typical medical benefit plan design is as follows:

Benefit	Co-Insurance Factor	Overall Annual Maximum
In-patient Expenses	80% – 90%	EUR 7,500 – 50,000
Out-patient Expenses	70% – 80%	EUR 1,500 – 3,500
Vision Care	80%	EUR 1,000 – 3,000
Prescription Drug	70% – 80%	EUR 250 – 600
Dental Care	70% – 80%	EUR 200 – 1,000
Maternity Care	80% – 90%	EUR 1,000 – 3,500

ROMANIA

SOCIAL SECURITY

Eligibility

The national health insurance scheme covers employees and their s.

Benefits

Medical benefits include general care, specialist care, hospitalization, drugs, medical appliances, maternity care, transportation, and other services. There are no co-payments, but tips for medical staff is common and expected.

MARKET PRACTICE

Companies typically provide supplemental medical coverage. Most commonly this is through contracting with a private medical facility to cover employees for routine care. More comprehensive coverage is typically only provided to higher-level employees. These higher-level employees may be covered by a health insurance policy.

Cost sharing is typical (employees pay RON 50 to RON 100), and so are co-payments. The cost of supplemental medical coverage is tax-deductible up to RON 250 each for the employee and employer.

s are normally covered at the employee's cost.

RUSSIA

SOCIAL SECURITY

Eligibility

Participation in Russia's medical insurance program is mandatory for all citizens.

Benefit

The mandatory medical insurance program covers basic medical and emergency care in state facilities. Covered care includes hospitalization, vaccinations, maternity care, laboratory services, and certain critical services (i.e. cancer and tuberculosis treatments). These services do not require copayments, but in practice patients are expected to make cash payments such as in the form of tips for doctors and other medical staff.

Cash payments are normally required for prescription drugs; however, during hospitalization, some groups (pregnant women, retirees, war veterans, disabled people, and people with certain medical conditions) receive free or discounted prescription drugs.

MARKET PRACTICE

A majority of companies provide supplemental medical benefits for employees and their s. Most companies have plans or arrangements that call for employees to pay a portion of the premium for their own coverage and at least half of the premium for covering s.

The most typical arrangement is through private health insurance policies. Demand for these plans is increasing, as the quality of the state-run system has been declining due to lack of funding.

Employers may also make arrangements for employees to have access to specified hospitals and clinics, with the company paying the costs directly to the facility.

Employers must still contribute to the Medical Insurance Fund, regardless of whether private plans are in place or not.

Typical voluntary plans generally provide the following:

▶ Outpatient services include a full range of medical services, dental care, annual health check, diagnostics, laboratory tests, massage, acupuncture, manual therapy and exercise therapy, home visits, and temporary disability examinations.

▶ Inpatient services include doctors' consultations, diagnostics, laboratory tests, surgery, anesthesia, intensive care, rooms with standard two beds, board, nurse services, and prescription drugs.

▶ Ambulance services include transport to and from a medical facility.

Although there are no co-payments under the health insurance system, tipping doctors and hospital staff is typical and is generally expected.

SAUDI ARABIA

SOCIAL SECURITY

The national healthcare system covers all Saudi citizens and their s, providing general care, diagnoses, preventive care, rehabilitation, hospitalization, and medicine.

MANDATORY

Health Insurance

As of November 2008, employers must cover their all employees (Saudis and non-Saudis) with health insurance. Insurance coverage must include medical treatment, hospitalization, surgery, medicines, x-rays, child birth, pediatric care, vaccinations, preventive care, and dental care (excluding orthodontics and dentures). The minimum coverage for a health insurance plan is a limit of SAR 250,000 per person annually. Patients are subject to a copayment of 20% (capped at SAR 100). The premium is agreed upon by employers and insurers.

A number of foreign insurers have been licensed to provide private health coverage. Only insurance from registered cooperative insurance companies fulfills the mandatory insurance requirement.

Employers that own qualified medical facilities for their employees may be exempt from insuring for treatment provided in the those facilities.

MARKET PRACTICE

Employers typically provide the standard minimum of coverage (a limit of SAR 250,000 per person annually), though upper management may be covered under a plan with a limit of twice that amount.

SINGAPORE

There are several sources of medical care: public healthcare, social security (mandatory and voluntary programs), and supplemental programs.

Government Healthcare Subsidies

The government provides both citizens and permanent residents with healthcare subsidies so that they pay less for healthcare services than foreigners. The maximum subsidy rate for citizens ranges from 50% to 75% depending on facility and service, and the rate for permanent residents ranges from 40% to 65%. These subsidies are means tested and reduced for those with higher incomes.

On 28 January 2010, the Ministry of Health announced that the healthcare subsidy for permanent residents would be reduced in stages in 2011 and 2012, resulting in a reduction of 10 percentage points.

The subsidy rates will be reduced in two stages, each with a reduction of 5 percentage points per stage. The subsidy rates for healthcare services at public hospitals and national centers will be reduced on 1 January 2011 and 1 July 2011. The rates at intermediate and long-term care facilities (nursing homes, hospices, rehabilitation centers, and community hospitals) will be reduced on 1 July 2011 and 1 January 2012.

SOCIAL SECURITY

CPF

CPF programs include Medisave (compulsory savings account), Medishield (opt-out insurance plan for serious illness), Eldershield (opt-out long-term insurance), and Integrated Shield Plans (voluntary plans through private insurers). Also, from November 2007, the CPF modified its rules, allowing members with serious illnesses to withdraw their savings; a doctor's memo documenting the illness is required. Withdrawal amounts are determined on a case-by-case analysis, but if the illness is terminal, 100% of the savings may be withdrawn.

Medisave

Eligibility

CPF members may withdraw funds from their Medisave account to pay for qualified medical expenses. Medisave funds are primarily applicable to hospitalization expenses of the CPF member or the member's spouse, children, parents, or grandparents; Singaporean citizenship/residency requirements only apply in the case of CPF members' grandparents. Medisave funds may also be applied to certain outpatient procedures.

Qualified hospitalization expenses include: daily ward charges, doctors' fees, surgical operations, inpatient medical treatment, medicines, rehabilitative, medical supplies, implants, and prostheses introduced during surgery.

Qualified outpatient expenses include: Hepatitis B vaccinations, assisted conception procedures, renal dialysis treatment, radiotherapy and chemotherapy for cancer patients, and HIV anti-retroviral drugs.

Benefit

There are different daily maximums for various hospital expenses that may be paid for with Medisave funds. As of 1 June 2010, the following apply:

- ▶ Hospital charges: SGD 450
- ▶ Community hospitals: SGD 250 to SGD 5,000 depending on the operation
- ▶ Outpatient surgery (day surgery): SGD 300
- ▶ Psychiatric treatment: SGD 150 (including a doctor's daily attendance fee of SGD 50) subject to an annual maximum of SGD 5,000
- ▶ Day care at Daily Rehabilitation Centers: SGD 25 a day up to SGD 1,500 a year

MediShield

MediShield is a catastrophic illness insurance plan operated by the CPF Board. Singapore citizens and permanent residents are automatically enrolled, but may opt out. This plan can help cover expenses in the event that Medisave funds are depleted. CPF members may use funds from their Medisave Account to pay for MediShield premiums (capped at SGD 800), co-payments, and deductibles. MediShield only covers treatment and care in Singapore.

Premiums are as follows:

Age at Next Birthday Premiums

1 to 30	33
31 to 40	54

41 to 50	114
51 to 60	225
61 to 65	332
66 to 70	372
71 to 73	390
74 to 75	462
76 to 78	524
79 to 80	615
81 to 83	1,087
84 to 85	1,123

The ceiling amount for withdrawing Medisave funds for MediShield premiums is SGD 1,150 for those aged 80 and older as of 1 December 2008

Eligibility

All CPF members are automatically enrolled in this plan, but they may opt out. CPF members must be 75 years old or younger to apply for MediShield, but MediShield provides coverage until age 85.

Benefit

MediShield plans cover approximately 80% of large medical bills accrued in Class B2/C hospital rooms (rooms with 4 or more beds). Patients must pay a deductible and any relevant co-payments; the patient is only obligated to pay the deductible once in a policy year for the cost of hospitalization.

Deductibles are as follows:

- ▶ Ward charges for Class B2 hospital rooms or higher (6 beds in the room or less): SGD 1,500
- ▶ Ward charges for Class C hospital rooms (8 or more beds in the room): SGD 1,000

Co-payments apply as follows:

- ▶ 20% of expenses between the deductible and SGD 3,000, plus
- ▶ 15% of expenses between SGD 3,000 and SGD 5,000, plus
- ▶ 10% of expenses in excess of SGD 5,000.

The annual MediShield claim limit is SGD 50,000 and the lifetime claim limit is SGD 200,000. Some of the daily claim limits are as follows:

- ▶ Ward charges: SGD 450
- ▶ Intensive Care Unit (ICU) ward charges: SGD 900
- ▶ Surgical procedures: SGD 1,100
- ▶ Surgical implants and approved medical consumables: SGD 7,000

MediShield is primarily for hospital care, but certain outpatient treatments are also covered, including treatment for serious and/or chronic disorders such as chemotherapy and kidney dialysis.

Previously, there was the MediShield Plus program, a supplemental medical insurance program that provides coverage beyond MediShield, a catastrophic illness insurance plan operated by the CPF Board. The CPF Board privatized the program in 2005, and insurer NTUC Income acquired the program and it is now called the Income Shield Plan. MediShield Plus participants had their coverage automatically transferred to the Income Shield Plan as of 1 October 2005. The plans were renamed NTUC Income Plan MA and NTUC Income Plan MB. No additional medical underwriting was required. NTUC Income Plan MA and Plan MB are no longer offered to new participants, although current members may continue their coverage.

ElderShield

ElderShield is a severe disability insurance scheme which covers long-term care, particularly during old age. Singapore citizens and permanent residents that are CPF members are automatically enrolled in this program at age 40, but they may opt out. The premium is determined at the age of entry and does not increase with age; premiums are payable until age 65. CPF members may pay the premium for basic ElderShield with Medisave funds, and this is not subject to a cap. Purchase of ElderShield Supplement coverage (for additional coverage) with Medisave funds is subject to a cap of SGD 600 per person per year.

There are 2 ElderShield schemes: ElderShield300 (that provides a flat payout of SGD 300 a month for a maximum of 60 months) and ElderShield400 (that provides a flat payout of SGD 400 a month for 72 months).

ElderShield300

covers those who enrolled between 2002 and 2007 and ElderShield400 covers those who enrolled since 2007. ElderShield supplements may be purchased from 3 insurers: Aviva, Great Eastern, and NTUCIncome.

Integrated Shield Plans

Integrated Shield Plans are voluntary Medisave-approved plans offered by private insurers that may offer benefit levels higher than that of MediShield. Policyholders of Integrated Shield Plans are entitled to MediShield benefits, but all transactions (premiums and claims) go through the private insurer. Through the CPF's Private Medical Insurance Scheme, CPF members may use Medisave funds to pay for Integrated Shield Plan premiums, subject to an annual cap of SGD 800.

An approved plan must enhance the MediShield coverage. For example, it might provide maximums claim amounts that are higher than those under MediShield, or it might offer additional benefits that are not covered under MediShield (provided they are not specifically excluded from MediShield coverage for outpatient treatment) .

An approved plan cannot offer cash benefits. Also, it cannot offer coverage for overseas treatment; dental work; private nursing and nursing home services; vaccinations; transportation-related services; or infertility, assisted conception, or contraceptive procedures.

Coinsurance cannot be less than 10%; however, the policy may provide that the coinsurance requirement is waived when out-of-pocket expenses exceed SGD 25,500.

The deductible in a policy year cannot be less than the following amounts: SGD 3,000 for Class A and private hospital care, SGD 2,000 for Class B1 hospital care, SGD 1,500 for Class B2 hospital care, and SGD 1,000 for Class C hospital care.

The plan must be integrated with MediShield and jointly insured by the CPF Board and the insurance company. The patient will receive the higher of the benefits under the integrated plan or MediShield.

Coverage is guaranteed renewable, subject to the same exceptions that apply to MediShield. Premium loading for selected individuals at the time of joining the plan (or later) is not permitted. Exclusions cannot be added to the policy once it is in effect.

Premiums for this coverage may still be deducted from an individual's Medisave account up to SGD 800 per year. Participants may have no more than one Medisave approved plan integrated with Medisave.

Portable Medical Benefits Scheme (PMBS) & Transferable Medical Insurance Scheme (TMIS)

Both the Portable Medical Benefits Scheme (PMBS) and the Transferable Medical Insurance Scheme (TMIS) provide medical coverage to employees during periods of unemployment. Employers must offer PMBS or TMIS in order to qualify for a full 2% tax deduction from total payroll for medical expenses; also, to qualify, employers must cover 20% of local employees under PMBS or 50% of local employees under TMIS. Employers that do not offer PMBS or TMIS are only eligible for a 1% tax deduction.

Under PMBS, employers make additional contributions to employees' Medisave Accounts (at a minimum of 1% of the employee's monthly salary, maximum 1% of the CPF contribution limit) for the employee to purchase approved personal medical insurance.

TMIS enables employees to extend inpatient insurance coverage up to 12 months after leaving employment. The minimum group size for TMIS is 11 employees.

MANDATORY

Employers are required to purchase medical insurance for foreign employees that do not hold an employment pass. Minimum coverage is SGD 15,000 and must include inpatient care and day surgery. This minimum applies to all new policies and all existing policies on the applicable renewal dates.

MARKET PRACTICE

It is common practice for employers to provide supplemental medical and dental coverage. Plans are typically non-contributory for employee coverage, but cost sharing may be required for coverage. Some company plans may also require employee cost-sharing for portion of dental. Vision and health-screening coverage is less common. Companies typically cover hospitalization and surgical expenses through an insurance policy. Outpatient care and dental may either be insured or self-insured.

If s are eligible, employees are typically required to pay a portion of the premium for care.

Employee copayments of 10% to 25% (depending on type of medical care) may be applicable.

Employers are eligible for a 1% tax deduction for medical expenses (up to 2% of total payroll) . This tax deduction is increased to 2% if they cover employees with either the Portable Medical Benefits Scheme (PMBS) (minimum of

20% of local employees) or the Transferable Medical Insurance Scheme (TMIS) (minimum of 50% of local employees), which provide medical coverage to employees during periods of unemployment.

Hospital & Surgical

Private hospital and surgical plans normally offer the following levels of coverage:

- ▶ Daily room and board: SGD 250 to SGD 388
- ▶ Intensive care: SGD 10,000
- ▶ Surgical fees: SGD 5,500 to SGD 7,500
- ▶ Hospital miscellaneous services: SGD 3,000 to SGD 5,000
- ▶ Pre-hospitalization specialist, pre-hospitalization x-rays/labs, and/or post-hospitalization follow-up: SGD 500 to SGD 1,500
- ▶ Supplemental accident expense: SGD 1,000 to SGD 2,500
- ▶ Miscarriage: SGD 1,000
- ▶ Death benefit: SGD 3,000 to SGD 5,000
- ▶ Extended major medical: SGD 50,000 to SGD 100,000 per disability

Employers may also add outpatient coverage to this insurance, but many self insure for outpatient coverage.

Dental

Dental coverage is common. A typical plan would include SGD 50 per visit for preventive care plus coverage for xrays, gum treatment, surgical care, dentures, and caps/crowns/bridges for repair due to accidents. The typical annual cap is SGD 2,000.

Vision

Vision benefits are available but not common. Employers may offer or reimburse an annual eye exam.

Health Screening

Group medical insurance plans seldom come with a health screening feature, but if offered is typically between SGD 300 and SGD 400 a year. It is common for progressive companies to install corporate health screening programs separate from medical insurance. Senior executives generally enjoy a more comprehensive and detailed package. In some cases the health screening option is age , and often an annual allowance is allowed, so the employee can choose whatever battery of tests they wish.

SOUTH AFRICA

South Africa does not have a national health system, though the subject has been under study for several years. Private insurance coverage is available through government-approved medical schemes. In September 2010, the African National Congress (ANC) released a document that provides details about the long-awaited national health insurance (NHI) program that eventually will become law. Given that the ANC is the ruling party in the government, its proposal is likely to have most of the elements that are in the final legislation. The proposal is expected to be enacted into law in mid-2011. Implementation would begin in 2012 and be phased in over 14 years.

Proposed National Health Insurance (NHI) Program

The NHI program would be administered by the NHI Fund, a separate government agency within the Ministry of Health that is to be established within 5 years. The main responsibility of the NHI Fund would be to receive funds, pool these resources, and purchase services on behalf of the entire population. The Fund would negotiate and contract with the health care providers. (The ANC document says that it supports this type of single payer system because evidence from other countries has shown that the cost of administration under a single-payer system is around 3% lower than the cost under a multi-payer system.)

All health providers would be accredited. The accreditation process would be supported by quality improvement and quality assurance programs. The government is aiming to have at least 25% of all hospitals accredited by the start of the program in 2012. Private providers could continue to operate outside of the scope of the NHI framework but would not receive NHI funds if they were not accredited.

Details still are being worked out regarding how the program would be financed. It is expected that the main source of revenue will be from general taxation; other sources are likely to be employer and employee payroll related contributions, an income tax surcharge, and an increase in the value added tax. Preliminary research about the cost indicates that the share of the overall government budget that is allocated to health will rise from 12% to 14.5%.

Eligibility

Membership in the NHI would be compulsory for all South African citizens and legal residents. All members would have an NHI card that included the health history of the patient.

Members would register with a health provider. They would have freedom of choice of a health provider who is available in the area where the member resides. Members would be able to request a change in their provider registration once each year.

An individual could participate in a voluntary approved medical scheme, but premiums paid to such schemes no longer would be tax deductible. It is too early to tell how many current medical scheme members would elect to discontinue their existing private coverage and rely solely on state services; a health expert who worked on the ANC plan predicts that 40% of the members might leave the private plans.

Benefits

The NHI plan would provide a comprehensive package of services, including primary care and preventive services, inpatient and outpatient care, emergency care, prescription drugs, and rehabilitation. Medically unnecessary services and expensive therapies, as determined by the Benefits Advisory Committee, would not be covered.

There would be no copayments or patient charges for services provided.

The fee-for-service system of paying health care providers would be phased out. Instead, health providers would receive risk-adjusted capitation payments that are linked to target utilization and cost levels. Thus, a health provider would be paid a specified amount for each member that is registered with him; this would be the total payment regardless of the services provided. (This is the traditional method of payment used by HMOs in the U.S.)

The capitation payment would be a uniform amount for defined levels of providers, regardless of public or private ownership. Services with high costs would be excluded from the capitation payment and reimbursed by the NHI Fund separately.

Public Healthcare

During recent years, the real per capita expenditure on public sector health services has been relatively stagnant, with the result that there is a serious shortage of doctors, nurses and hospital beds. The ANC document calls attention to the "misalignment between the public and private health sectors," noting that there is an oversupply of hospital beds in the private sector; the current occupancy rate is 65%. There are more than twice as many hospital beds per beneficiary of private sector hospital services as there are for those on the public sector. In 2005, there

was one general doctor for every 243 medical scheme members, compared with one doctor for every 4,193 public sector patients.

About 80% of the population receives health care services in government-financed hospitals and clinics, which are struggling with financial difficulties, medical talent flight abroad or to the private sector, and HIV/AIDS. The effects of the pandemic have been felt especially in the health care sector. The need to allocate personnel and money to provide care and treatment to those with AIDS has resulted in a shortage of professional personnel and a general decline in the public health care infrastructure.

The emphasis in the first 5 years of the new NHI program would be on improving access to health care services in the most seriously underserved areas.

MARKET PRACTICE

Private health care coverage is provided to some 7 million beneficiaries by about 160 medical schemes. About 40 of these schemes are open to the public. The others are schemes that were established by employers. Most companies provide medical benefits for employees and their s through the company's own medical plans, a multi-employer plan, or one of the medical schemes that is open to the general public.

Multi-employer plans and medical schemes that are open to the public offer several different programs of coverage. These programs differ in the size of the premium and the extent of coverage. A typical package of benefits calls for payment of the full cost of hospitalization in a public or private hospital (possibly with a limit such as ZAR 100,000 per patient per year for confinement in a private hospital) , ancillary hospital charges, operating theatre fees, medications (often subject to patient co-payments if they are dispensed outside of the hospital) , intensive care, radiology and pathology, laboratory and X-ray services, maternity expenses (often with a limit, such as ZAR 12,000) , surgical procedures, and out-of-hospital medical consultations (usually with a patient co-payment or a limit on the number of visits per year) . By law, all medical schemes must provide an AIDS management package of coverage.

Medical Schemes

Premiums paid by an employer for medical scheme coverage are tax deductible up to an aggregate of 20% of the employee's income for the total of retirement, life insurance, and medical scheme contributions. The employee has a tax deduction of ZAR 670 for his/her coverage, plus ZAR 670 for the spouse and ZAR 410 for each additional member, as of 1 March 2010.

The Medical Schemes Act, as amended, provides the basis for the regulatory environment of all health insurance plans. Following are some of the key provisions:

All medical schemes must provide coverage for 270 diagnosis and treatment services and 27 chronic conditions, the so-called Prescribed Minimum Benefits (PMBs) . The list of PMBs is supposed to be reviewed at least every two years by the Department of Health.

All medical schemes must adhere to the community rating rules. Essentially, this means that all schemes must charge the same premium for the basic plan of PMB coverage, regardless of gender, medical history, or age (with some exceptions) . Premium adjustments can be made based on the member's income and the number of s to be covered.

Open enrollment rules apply. Thus, an employee cannot be refused coverage on the basis of his/her health, provided that the coverage is elected at the time of employment. If the election is delayed, the plan may require a three-month waiting period between the date of enrollment and the date that coverage begins. Also, if the employee is age 35 or older and has not had medical scheme coverage in the past three months, a premium surcharge can be assessed if he/she does not join the plan upon employment.

Medical schemes are required to allow a member to continue coverage as long as the required premium continues to be paid. At retirement, the individual has the right to continue coverage under his/her chosen medical scheme or switch to a new scheme.

Medical schemes will be subject to the Risk Equalization Fund (REF) rules, once they take effect. (Though the REF legislation is in place, the system is being tested before it is introduced.) Under the REF rules, risks are shared by all medical schemes so that no scheme will be able to benefit from "cherry picking" (designing and marketing the plan in such a way that it is attractive to low-risk groups) . Those medical schemes with a large number of younger and healthier members will have to pay into the equalization fund; those schemes with a large number of older and less health members will receive payments from the fund.

Medical schemes must be operated by non-profit entities. Thus, employers, insurers, or brokers who set up a scheme do so under a trust arrangement.

Typically, the medical schemes cover an employee, his/her spouse, and their children who are younger than age 23. Some plans permit an individual to extend coverage to his/her parent, sibling, or grandchild. Most employers share the cost of the coverage with their employees. According to the 2005 Old Mutual Survey of Health Care, the average company subsidy per month was ZAR 883. For several years, companies have put a cap on the amount of their subsidies. The survey authors noted that these caps have resulted in employees bearing an increasing amount of the cost of coverage to the extent that some employees no longer can afford to have coverage. Data from the survey shows that 58% of those with monthly earnings of ZAR 5,000 to ZAR 6,000 were covered by a medical scheme, whereas less than 1/3 of employees with a lower level of earnings had coverage. Rising medical costs is a major concern in South Africa, with premiums for a single person sometimes exceeding ZAR 1,000 per month. In an effort to control costs, an increasing number of medical schemes are adopting managed care arrangements. Under this approach, payment of benefits is conditioned on the patient receiving primary health care services from a doctor who is on a list of doctors who have been "approved" by the medical scheme; it is presumed that an approved doctor will not subject the patient to unnecessary services and that he will agree to a discounted fee schedule.

AIDS Management Programs

HIV/AIDS has had a profound impact on South African society. The virus is particularly strong among people in the sexually active age group (age 20 to 40), which also is the main age group of the majority of the South African work force.

In recent years, most medium and large employers have implemented AIDS management programs. Usually they provide information, counseling, and testing. An increasing number of the company programs include medication.

SPAIN

SOCIAL SECURITY

The social security system provides complete medical coverage for all citizens and legal residents of Spain. Under the contributory system, medical benefits are provided to employees and their families, and to pensioners. Medical benefits are provided through the National Health Service (Servicio Nacional de Salud or SNS) network of healthcare services providers, which include national, regional and local public healthcare facilities, as well as private hospitals and specialist medicine center contracted by the SNS.

Eligibility

There is no minimum contribution requirement for use of this system.

Benefit

The SNS provides medical care at two levels: primary and specialized.

Primary care is provided at local clinics and healthcare centers, or at the patient's home. It includes consultations with general practitioners, basic diagnostic and lab tests, preventive check-ups, basic rehabilitation services, basic mental health services and basic dental care.

Specialized care is provided through public hospitals, as well as private hospitals and private specialist practices contracted by the SNS. It includes consultations with specialists, surgery, hospitalization, complex diagnostic and therapeutic procedures, and non-basic mental health and rehabilitation services.

The SNS also provides for urgent care through all of the facilities in its network of providers, public and private. In addition, SNS provides for prosthetics, implants, wheelchairs and other medical aids and devices, at little or no cost to the patient.

Prescription drugs are available without charge in cases of chronic illness or if the patient is hospitalized; however, for drugs that are dispensed outside of the hospital, patients generally have to pay between 10% and 40% of the cost of medicines prescribed by a physician, with the SNS paying the balance.

MARKET PRACTICE

Supplemental private health insurance is typically provided by large and multinational employers in Spain. It is a tax advantageous benefit, with premiums exempt from corporate and social taxes up to an annual limit of EUR 500 per covered individual (employee, spouse, and s) . Employer-sponsored private medical coverage is not considered a benefit in kind and is not taxable to the employee.

While the care available through the SNS network is of high quality, long waits can be a problem and increase absenteeism. Supplemental private health insurance allows employees to receive care more quickly and choose their doctor and private hospital. It also covers inpatient private rooms, the copayments of the state system, and additional services not provided by the SNS network. If the employer does not provide private health insurance, individuals frequently will purchase coverage for themselves and their families. The coverage is provided by both commercial insurance companies and mutualidades (non-profit health providers) . Co-payments typically apply. The employer typically covers premiums for health insurance at 100% for employees, and at 50% for employees' s.

SURINAME

SOCIAL SECURITY

The State Health Insurance Fund of Suriname (SZF) runs the national medical coverage program. Currently, the premium for coverage ranges from SRD 38 to SRD 145 per month. Participation is not mandatory for private sector employers and employees.

MANDATORY

Non-Surinamese residents are required to have health insurance.

MARKET PRACTICE

Most employees of private companies that are covered by collective agreements and their families are covered through these agreements. About 20% of the population is covered in this way.

Most private companies prefer to self insure, rather than purchasing insurance through an insurance company or the SZF. Large companies have developed clinics on site for employees and their families.

Most general practitioners are in private practice and serve patients who are covered by the SZF, employer plans, or are self-paying. Most specialists provide consultations through clinics at private and public hospitals.

SWEDEN

The National Board of Health and Welfare supervises health care in Sweden. The program is administered by each county. Medical care is provided through local government hospitals and outpatient clinics. A great majority of the hospitals are owned by the counties; there are only a few private hospitals. Care in public hospitals is considered to be very good. Patients are registered with their personal physician; almost all doctors are affiliated with the public health system.

SOCIAL SECURITY

Eligibility

All residents who are registered with their local social security office have health care coverage.

Benefits

Covered health care services include the entire range of medical and dental care. Copayments are assessed for hospitalization, dental care, and some medical services; the amount varies from county to county. The typical copayment for a medical visit is SEK 140, with a SEK 900 maximum payment in a 12-month period. There also are copayments for prescription drugs, with a maximum payment of SEK 1,800 in a 12-month period. Copayments do not apply for maternity cases or for children; medical care is provided free to persons under the age of 20, and free dental care is provided to those younger than 19.

MARKET PRACTICE

Private health care has developed only since the 1990s, allowing individuals to pay for quicker access to health facilities. Thus, senior management employees often will be given private health insurance coverage.

Supplemental benefits typically are not provided for other employees.

A study by Synovate, an international research organization, shows a significant increase in the number of Swedes who have signed up for private insurance. The study showed that 35% of those surveyed had private health insurance, compared with 32% last year. Thirty-two percent of the respondents had insurance that supplemented the social security unemployment coverage; a year ago, only 18% had supplementary coverage. The study was based on interviews with 2,521 employed persons between the ages of 18 and 25. It was conducted between 16 April and 12 May 2009 for Folksam, a large mutual insurance company that is closely associated with the union movement. The author of the study said that the results were not surprising, considering that social security benefit levels are being reduced and that it is becoming more difficult to obtain compensation from the system. A spokesman for the LO, the umbrella trade union organization, said that many of those with supplementary insurance have taken out coverage under a group insurance arrangement that was concluded between the LO and Folksam. The agreement, signed in 2008, was established as a response to the government's cutback on social benefits, he said. To date, 8 of the LO's 15 trade union federations are participating.

SWITZERLAND

MANDATORY

Switzerland does not have a federal health insurance program, but there are laws that govern the requirements for a basic insurance system.

The federal government in Switzerland is limited in the role of medical care delivery because such delivery is managed at the level of the 26 cantons. Each canton decides the type and scope of health care services to be provided to residents, with half the costs covered by the cantons through general revenues and half by patient insurance.

Standard Basic Health Insurance

The laws governing the requirements for a basic insurance system mandate membership in a health care fund in all cantons, yet allow each individual to choose a higher coverage, which the individual is responsible for financing.

Eligibility

Coverage and financing requirements for standard basic health insurance are as follows:

- ▶ Mandatory coverage within three months of birth or residency
- ▶ Uniform levels of benefits for all basic insurance coverage
- ▶ Uniform premium rates for all insured adults residing in the same region or canton

Benefit

The following benefits are provided to all residents of Switzerland:

- ▶ Hospitalization in public ward
- ▶ Medical treatment
- ▶ Medicines
- ▶ Worldwide accident coverage
- ▶ Maternity
- ▶ Accident (if not covered by National Accident Insurance)

Basic insurance covers hospitalization and medical costs provided by approved hospitals and doctors. Dental expense coverage is limited to treatments of specified diseases. Supplemental coverage is available, but benefits vary according to the level of coverage (private and semiprivate hospital room and board, unrestricted choice of physicians and hospitals, alternative treatments, certain prescription drugs, and dental and vision care) .

Insured patients are covered for expenses incurred for emergency medical care outside Switzerland. The maximum reimbursed amount is 2x the normal amount covered by the health insurance fund. The minimum deductible for basic standard insurance for an adult is CHF 300 and CHF 0 for a child up to 18 years of age or a fulltime student up to 25 years old. Individuals may opt for a larger annual deductible (from CHF 500 to 2,500) in order to receive a reduction in annual premiums. Monthly premiums typically run from the CHF 300s for lower deductibles to the CHF 100s for higher deductibles.

Coinsurance payments are required in the amount of 10% of costs incurred above the annual deductible subject to an annual maximum of CHF 700 for adults and CHF 350 for children. There is also a CHF 10 per day charge for hospitalization.

MARKET PRACTICE

Supplemental benefits are not typically provided.

TAIWAN

SOCIAL SECURITY

Taiwan's healthcare system is financed through the National Health Insurance (NHI) system, funded by contributions from the government, employers, employees, and residents. Participation in NHI is compulsory for all employees, for citizens and residents with at least 4 months of residence in Taiwan, and for the s of these employees, citizens, and residents.

Taiwan is in the process of passing healthcare reform. The legislature was expected to complete a final reading of the new National Health Insurance Bill by December, but failed to do so. This bill is primarily focused on the adjustments of premiums, to be effective as from 2012. The major conflict is over how premium rates should be calculated and the definition of household income. The draft bill currently proposes setting a high and low income limit to differentiate the premium for individuals with different levels of income.

Eligibility

NHI covers all employees and their s because participation is compulsory.

Benefits

NHI will only cover expenses incurred from doctors and medical facilities under an Bureau of National Health Insurance (BNHI) contract. Coverage includes but is not limited to hospitalization, outpatient, Chinese medicine, dental, childbirth, physical therapy, home care, treatment such as hemodialysis (kidney failure procedure) for serious illness, emergency care, psychiatric care, and preventive care.

Co-payments and outpatient user fees apply. For all inpatient and most outpatient care, co-payments are 10% for stays under 30 days (capped at TWD 26,000 for each stay and TWD 43,000 for the year) , 20% for stays longer than 30 days, and 30% for stays longer than 60 days. Co-payments for prescription drugs range from TWD 20 to TWD 200, based on drug cost. Outpatient user fees range from TWD 50 to TWD 450, based on the type of care (outpatient, emergency, traditional medicine, or dental) and the type of facility (teaching hospital, regional hospital, district hospital, or clinic) .

MARKET PRACTICE

Supplemental group health plans are commonly provided to supplement the NHI plan. The level of employer sponsored benefits usually depends upon the classification of an employee's position, with some plans offering the same benefit to all employees.

Employee coverage is usually non-contributory, and coverage is usually contributory.

A typical plan would include inpatient benefits and cancer benefits. Few employers provide outpatient coverage for employees because NHI already includes this benefit.

It is common to offer employees an annual physical exam, and to offer executives a more exhaustive exam at a higher cost.

THAILAND

SOCIAL SECURITY

Employers with at least one employee are required to have health insurance coverage through social security. Insured employees are eligible for free necessary medical care in SSO-designated facilities. Insured employees may be reimbursed at SSO-set rates for medical care at any hospital (including non-registered hospitals) in case of an emergency or accident; reimbursement must be requested within 72 hours. Transportation between hospitals is also reimbursed. There is a limit on receiving free emergency care at nonregistered hospitals (2 outpatient and 2 inpatient visits) .

Reimbursement for outpatient, inpatient, and dental treatment are limited as follows:

Type of Service Reimbursement Limit

Outpatient medical treatment THB 1,000 (per visit)

Outpatient laboratory tests THB 200

Outpatient physician's fees THB 200

Inpatient medical treatment THB 2,000 (per day)

Inpatient major operations THB 16,000

Inpatient room and food charges THB 700 (per day)

Inpatient additional treatment in an intensive care unit THB 4,500 (per day)

Inpatient high-tech medical procedures (certain procedures) THB 4,500

Dental service (extraction, filling, removing dental plaque) THB 250 (per service) THB 500 (per year)

Dental overdentures for 1 to 5 teeth THB 1,200

Dental overdentures for more than 5 teeth THB 1,400 (in a period of 5 years)

Universal Health Care Coverage

The "30 Baht Scheme" is a universal health care program that provides universal medical care for those without insurance or who have limited coverage. Participants purchase a card from the local health authorities and this provides basic medical diagnosis and treatment for THB 30 per hospital visit.

MANDATORY

By law, employers with 500 employees or more are required to provide employees with a doctor on site or have one on call.

MARKET PRACTICE

Companies typically provide supplemental health insurance coverage for treatment in private facilities. Employers generally provide medical benefits with coverage for employees and their immediate family. Coverage includes inpatient and outpatient benefits.

Some multinational companies will cover outpatient services in the range of THB 10,000 for staff, THB 20,000 for managers, and THB 30,000 for directors. Coverage for specific inpatient services varies widely.

Thailand increased the personal income tax deduction limit for life insurance premiums from THB 50,000 to THB 100,000 for the current tax year, but it has also introduced an exclusion of the portion of the premium allocated to healthcare and other non-life riders to the policy. Previously, the entire premium was eligible for personal income tax deduction.

TUNISIA

SOCIAL SECURITY

Provision of Health Services

The Ministry of Public Health is responsible for providing health services. It is estimated that about 80% of the population has access to health care. There is a two-tier system of health services.

► Most of the population receives health services under the public system of government-controlled hospitals and clinics.

► The private system is financed by insurance proceeds and patient payments. It accounts for about 12% of hospital beds, generally with better equipment than in the public hospitals. The system also has private clinics, primarily in urban areas. About 50% of all doctors, 73% of dentists, and 80% of pharmacists work in the private sector.

New Health Insurance Fund

Law 2004-71 established a new health insurance system and a new administrative body, the CNAM (Caisse Nationale d'Assurance Maladie) , which merged formerly separate administrative bodies for the private and public sector. Actual implementation of the law began in 2007 and still continues.

Per the law, CNAM is in charge of establishing a standard list of included medical benefits. Supplemental coverage will be available with co-payments. Private insurers are to be allowed to offer coverage through this new mandatory health insurance system according to CNAM guidelines.

Social Security (CNSS) Transition Coverage

While CNAM is being implemented, social security (CNSS) will continue to cover benefits.

Eligibility

To be eligible for a short-term disability benefit, the employee must have had at least 50 days of contributions in the last 2 quarters or 80 days in the last 4 quarters. s are also covered including the spouse and children younger than age 20 (without limit if disabled) , parents age 55 or older, and non-married daughters without an income.

Benefit

The insured patients receive medical services provided by government hospitals and health establishments. Some specialized services are provided by private health establishments through conventions and protocols. Benefits include hospitalization; medical, surgical, and specialist care; laboratory and X-ray services; kidney dialysis, appliances, spa treatment, and medicines.

MARKET PRACTICE

The new CNAM system, which took effect 1 July 2006, provides basic medical coverage for everyone, with opportunity for companies to purchase supplementary insurance for their employees. This will mean that the current CNSS system will be changed, subject to transition measures.

Companies are permitted but not required to provide complementary health insurance. Currently, the company that sponsors such a health plan receives a 2% reduction in the CNSS contribution; to qualify, the employer must pay a minimum of 50% of the premium, and the patient's co-payment for medical costs cannot exceed 20%.

Private medical insurance covers services under both the public and private systems, though generally the private system is used because of higher standards in care and because they provide the insured the opportunity to receive private care instead of ward care under the CNSS system.

Private insurance coverage usually includes full medical/surgical diagnosis and treatment, including medicines and hospitalization. Most plans are structured as major medical plans, with a patient co-payment (usually 10%) , "inside limits" on the number of days of hospitalization and intensive care confinement, and overall limits on all claims paid for a person in a calendar year (for example, TND 2 million) . Temporary loss of earnings and permanent invalidity also may be covered.

The coverage is normally provided by group medical insurance, underwritten by insurance companies and mutual societies, often in conjunction with other business insurance coverage. Individual private medical insurance is available but is not common.

Group private medical insurance premiums are tax deductible for the employer, but not for the employee.

TURKEY

SOCIAL SECURITY

The social security system Sosyal Sigortalar Kurumu (SSK) administers a national health program.

Eligibility

To be eligible for medical benefits, employees must have 120 days of contributions with at least 90 days in the previous 12 months. Employees' s are covered for employees with 120 days of contributions in the previous 12 months.

Benefit

Social security covers hospitalization, general medical care, specialist care, lab tests, transportation, and medication (subject to a 20% co-payment for medication acquired on an outpatient basis) as provided through social security system facilities. The maximum benefit period for medical services is 6 months.

MANDATORY

Certain foreigners must be covered under SSK's national health program. This requirement applies to foreign nationals who have been in Turkey for at least a year, have a residence permit, and do not have health insurance coverage in their home country. The monthly premium is TRY 182.

MARKET PRACTICE

Most companies provide supplemental medical benefits. Most cover the full cost of premiums, though some do require employee participation. Companies will usually only extend coverage to s in the case of senior employees and these employees may be expected to cover part of the premium for s.

In-patient benefits include hospitalization, surgery, maternity care, and minor treatments. Out-patient benefits include medical practitioner and specialist fees, prescribed medication, and diagnostic procedures. A co-payment rate of 20% is typical.

Some companies provide dental and vision coverage, but this is less common.

UKRAINE

SOCIAL SECURITY

Ukraine does not have a national health insurance system. The public health system provides basic services including hospitalization, general care, preventive care, lab work, dental care, and maternity care. Some patient fees may apply.

MARKET PRACTICE

Although voluntary forms of health coverage are not yet common, company-sponsored group insurance is the primary type that exists. The provision of supplementary health coverage by foreign companies to local nationals and their families is typical.

Many companies prefer to compensate employees for their personal expenses, primarily for drugs and medical services, up to a specified maximum. Among domestic companies there is reported to be limited interest in providing additional health coverage to employees.

UNITED ARAB EMIRATES

The UAE does not have a national health insurance program, but health insurance is required for all employees in Abu Dhabi and all residents in Dubai (beginning in 2010).

Health cards are available to all employees in the UAE to entitle holder to free medical treatment at public hospitals. Employers are required to pay the fee for these health cards (AED 100 for UAE residents, AED 300 for expatriate employees except for those working in Abu Dhabi because these expatriate employees are covered through mandatory health insurance).

Abu Dhabi Health Insurance Program

Health insurance is now required for all expatriate employees (Law 23 of 2005) and all UAE nationals in Abu Dhabi.

Expatriate Employees

Employers are required to provide health insurance to all expatriate employees, their spouses, and up to 3 children (under age 18). Gulf Cooperation Council (GCC) nationals are exempt. Expatriate employees' health insurance must include basic coverage including: hospitalization, medical exams, treatment, primary care, tests, X-rays, dental care (not orthodontics or dentures), prescription drugs, and accommodation fees for family members or other caregivers. The ceiling for coverage is AED 250,000. Copayments are applicable; there are set fees for services (ranging from AED 10 for a laboratory test or X-ray to AED 500 for inpatient maternity services) and a 30% copayment for prescription drugs (capped at AED 1,500 a year).

UAE Nationals

Abu Dhabi implemented a new compulsory health insurance program for all UAE nationals in April 2008, expanding upon the existing compulsory health insurance for expatriates. This program is free of charge and includes a mandatory periodic medical examination "Weqaya" and a comprehensive health insurance scheme "Thiqa" (for which all UAE nationals are eligible regardless of their present medical condition). The program covers all healthcare and medical treatment services at public and private hospitals, medical centers/clinics, emergency care, and hospitalization. This program is administered by the Health Authority Abu Dhabi (HAAD), Daman (the largest health insurer), and the Abu Dhabi Health Services Company (Seha).

In 2009, the Thiqa health insurance scheme introduced a 50% co-payment for dental care and medication from private facilities. Medication is still free if prescribed in a private facility but obtained in a public facility. The Health Authority of Abu Dhabi (HAAD) announced this change in mid-February.

Dubai Health Insurance Program

Dubai postponed the implementation of its compulsory health insurance scheme until 2010 (originally scheduled to begin in 2009).

Employers were to begin contributing a flat fee health benefits contribution (HBC) of AED 600 to the Dubai Health Authority (DHA) for all employees and ensure that all employees were registered for outpatient practice care clinics. Under the scheme, employees seeking care would be responsible for making co-payments of AED 25.

Those initial steps have effectively been postponed until further notice if given about the 2010 implementation schedule. The DHA still intends to implement the scheme in phases beginning in 2010 and concluding in 2015.

The compulsory health insurance scheme will provide the following benefits to residents of all incomes:

- ▶ primary out-patient care
- ▶ prescription drugs
- ▶ long-term community care
- ▶ childhood immunizations
- ▶ children's dental care
- ▶ mental health
- ▶ ambulatory specialist care
- ▶ non-emergency in-patient care
- ▶ acute and emergency care

The delay will most likely impact lower-income residents who will not be able to avail themselves of highly subsidized basic care.

MARKET PRACTICE

Most international companies secure supplemental private medical insurance coverage for their employees.

UNITED KINGDOM

BENEFITS AT A GLANCE

The government provides the Basic State Pension and gives tax incentives for workers to fund their own personal pensions. In 2012, the government will introduce a new “personal accounts” retirement program that will require a mandatory 3% contribution from employers, who must automatically enroll their employees. Similar to the trend well under way in the U.S., the U.K. is moving from a classical pension or defined benefit system to a defined contribution system. The National Health Service provides publicly funded health care, but private health insurance is also common. The insurance and financial products markets are highly developed and competitive.

The United Kingdom has a mixture of public and private hospitals to provide services to patients. An individual may receive free hospital care in a National Health Insurance (NHS) hospital, or receive (and pay for) care in a private hospital or in private beds (“pay beds”) in an NHS hospital. He/she may be treated by his/her personal physician under the NHS, waiting in the doctor’s surgery (office); alternatively, he/she may be treated privately by the same doctor—by appointment, or at home if the illness warrants it.

In the United Kingdom, an individual’s decision to go public or private is not solely a “class” issue, as it is in most countries with a dual public/private system. The decision also depends upon the nature of the illness. Emergency treatment normally would be provided at an NHS hospital or clinic; serious and more expensive disabilities also may be treated through the NHS. On the other hand, elective procedures and relatively simple treatments are treated privately. In short, the NHS provides the safety net of medical care, with private treatment available for those who are seeking convenience and added comfort.

SOCIAL SECURITY

Hospital, surgical, and medical services are provided through the comprehensive National Health Service (NHS). Services are provided at no charge (with a few exceptions) to all those who are ordinary residents of the United Kingdom, including the spouse and children. An individual who is working in the United Kingdom and, therefore, who is paying national insurance contributions, is considered to be an ordinary resident. Emergency treatment also is provided at no charge, even if the patient is not an ordinary resident.

The NHS provides a wide range of hospital services, general and specialist medical and surgical care, X-rays, radiology, physical and rehabilitative therapy, prostheses, and community health services. Virtually all NHS medical services are provided at no charge to the patient, with the following exceptions:

- ▶ Prescription drugs: Outpatients are charged GBP 7.20 per prescription as of 1 April 2009 in England; however, a patient can receive all prescriptions for a 3- or 12-month period under a prepayment plan at a cost of GBP 28.25 and GBP 104.00, respectively. Many of those who are not in the workforce are exempt from paying, including persons aged 60 or older, those who are younger than 16 (or 19 if a full-time student), and those receiving specified income-tested benefits. In addition, there are no prescription drug charges in Wales; they are being phased out in Scotland (by 2011) and Northern Ireland (by 2010).
- ▶ Dental services: The patient must pay GBP 16.50 for a routine exam; GBP 45.60 for a filling, extraction or root canal; and GBP 198.00 for extensive work, including crowns. The charge does not apply to persons younger than 18 (or full-time students who are age 18), pregnant women and new mothers, and those on income support.
- ▶ Vision care: Up to GBP 19.80 is paid for a vision exam. There is a voucher system for eye glasses and contact lenses; those ordering eye glasses or contacts that are more expensive must pay the excess charge. Many of those who are not in the workforce are exempt from paying for the vision exam, including persons aged 60 or older, those who are younger than 16 (or 19 if a full-time student), those who are diagnosed as being diabetic, those with a risk of glaucoma, those who are blind or severely sight-impaired, and those on income support.

A voucher system (similar to that for eye glasses) also applies for wigs and fabric supports.

MARKET PRACTICE

Private Medical Insurance

Private medical insurance (PMI) is one of the most popular employee benefits; it is estimated that about 3.6 million employees are covered under PMI plans in their place of employment. One survey ranked PMI second in popularity among employees. (Pensions was first.) Some companies are offering PMI coverage as an optional benefit under a flexible benefits plan; these plans are discussed in the section on Incentives and Perquisites.

There are several reasons for the popularity of PMI coverage. One of the main reasons is that it enables plan members to receive medical care on a timely basis. For some years, the NHS has been plagued with long waiting lists for treatment—especially for non-urgent care. The length of waiting varies, depending upon location; however, at the end of February 2008, according to government data, only 75% of English patients received the required treatment within 18 weeks of seeing their general practitioner.

Another important reason for the popularity of PMI coverage—especially among management-level employees—is the ability to be hospitalized in a private room, rather than in a hospital ward. Furthermore, those with PMI coverage are able to schedule surgical procedures at a time that is convenient to them.

The typical PMI plan will reimburse medical/surgical services, hospital accommodations, and ancillary expenses in full. Most plans do not require copayments or deductibles; a limit on the payment for psychiatric treatment may be applied, but not for most other services.

The PMI coverage often is provided to employees through a group arrangement, with the company paying part or all of the cost. It is estimated that about half of the companies offering PMI coverage for employees also make it available to s of employees. In 2006, the average premium for PMI coverage was GBP 682 per employee.

The PMI plan may be provided by a non-profit provident association, or through a commercial insurance company. Alternatively, the employer might self-insure the coverage, setting up a health trust and having the plan administered by an in third party such as an insurer, consultant, or broker.

Dental Insurance

As noted previously, the NHS requires a patient copayment for dental services from most individuals in the working population. Also, in some geographic areas, dentists have terminated their NHS contracts; their dental services are provided directly to the patient at a cost that usually is higher than the cost under the NHS. As a consequence, insurance to pay the cost of dental treatment is becoming more popular. Some companies are offering dental coverage as an optional benefit under a flexible benefits plan; these plans are discussed in the section on Incentives and Perquisites.

Most dental plans pay a percentage of the cost of treatment—often 75%—with a maximum payout during a 12-month period. The coverage normally covers general treatment (exams, routine fillings, and root canals) as well as 50% of the cost of crowns, bridges and dentures. Orthodontia and cosmetic dentistry usually are excluded.

Employee Assistance Programs

There is a growing tendency for British employers to introduce programs in the workplace that promote psychological health and well-being among employees. These employee assistance programs (EAPs) often provide counseling—usually by telephone, but sometimes in face-to-face sessions—in both personal matters (family and emotional issues, divorce, alcohol and drug abuse, etc.) and work matters (working relationships, harassment and bullying, personal and interpersonal skills, stress management, etc.) .

Confidentiality is a key element in the EAP programs. The programs are being marketed by in organizations that are in of the employer, including companies associated with provident associations and commercial insurers.

Supporters of the EAP concept point out that the costs associated with these programs are frequently offset by the savings from reduced absences and greater productivity.

VENEZUELA

SOCIAL SECURITY

Medical benefits are available to all citizens and legal residents of Venezuela through the Public National Health System (SPNS). This public health system is composed of the Popular Power Ministry of Health (MPPS), the Venezuelan Institute of Social Security (IVSS), the Ministry of Education's Provident Social Assistance Institute (IPASME), the Military Forces Provident Social Assistance Institute (IPSA) and the Higher Mayorality.

Non-contributory medical benefits are financed with national and municipal revenues, while those pertaining to the contributory system are financed by employer and employee contributions. The Venezuelan Institute of Social Security (IVSS) finances and insures most employees and their s, as well as pensioners, through hospitals and outpatient clinics both public and private. Certain groups of employees are insured under other contributory system state bodies: the IPASME for teachers and educational staff, the IPFSA for armed forces personnel, and the Higher Mayorality for government and municipal officials.

The Venezuelan health care system is composed of three subsectors: public, private and semi-private:

The public subsector is integrated by multiple health institutions, which are financed with state funds and employment contributions and managed and supervised by the state.

The private subsector is composed of health institutions that are financed with private funds (e.g. private health insurance, pre-paid medicine plans, direct membership with the institution) and that are not managed by the state.

The semi-private subsector is integrated by private and public health institutions that are financed both with private and state funds. The state contracts with private institutions to offer specific and/or specialized health services, while private health insurance and pre-paid medicine carriers contract with public institutions for the same end.

Eligibility

There is no minimum qualifying period.

Benefit

The Venezuelan public health system guarantees the provision of medical benefits at no charge for the insured. These benefits include general and specialist medicine, hospitalization, diagnostic test, prescription drugs, dental care, and prosthetics and rehabilitation treatments.

Medical services are provided at three levels:

- ▶ Level I: basic general outpatient medical services without distinction of patient's gender, age or reason for consultation.
- ▶ Level II: specialized and technical outpatient medical services, and specific gender and age care.
- ▶ Level III: highly specialized and technical care, with or without hospitalization.

MARKET PRACTICE

The majority of private companies in Venezuela offer private group health medical plans, as the public health care subsector is overcrowded and public medical care is deficient.

Most private group medical plans provide comprehensive coverage of outpatient services, hospitalization, ambulance and emergency services, and dental and vision care, with 100% reimbursement and a fixed deductible each year for each incident of sickness. Deductibles range from VEF 30 to VEF 100, and are applied to the reimbursement amount. The annual maximum coverage for basic plans is typically between VEF 3,000 and VEF 215,000.

Private group medical plans also typically offer a discount prescription drug program.

Supplemental medical coverage, including surgical and maternity expenses, and critical or serious illnesses coverage care may be added to basic health coverage for an additional fee. The annual maximum coverage for supplemental plans ranges from VEF 12,000 to VEF 250,000.

Premiums for private group medical plans are typically shared by employers and employees. Employee contributions may reach up to 50% of the premium; typically, however, employers pay 75% of the premium. Some companies cover the employee only, the latter having to cover his or her dependants.

VIETNAM

SOCIAL SECURITY

Employees are covered by the social security compulsory health insurance 30 days after beginning contributions. The social security health insurance is based on a reimbursement system and covers most medical services in public facilities (limited to those included in health insurance regulations) and some services in private facilities. Co-payments are applicable to expenses beyond VND 7,000,000. Voluntary health insurance is also available through the social security system.

MARKET PRACTICE

Companies typically provide supplemental medical coverage with annual limits (such as VND 5,000,000 for outpatient and VND 50,000,000 for inpatient). Employers typically cover the full premium. Some employers exclude coverage. The most common way to provide this additional coverage is through a medical insurance policy, though some companies choose to maintain a self-insured medical reimbursement scheme.

Dental coverage is typically included.

Foreign-invested companies may provide travel expenses or other provisions for managerial and skilled expats to go abroad for health care treatment. International private medical insurance is also marketed for expats in Vietnam.

ZIMBABWE

SOCIAL SECURITY

The social security system does not include a national health insurance system.

MARKET PRACTICE

Typically the coverage available from the medical aid societies are not in direct competition with the life industry products currently offered.

Eligibility

While requirements differ from region to region at least one society region requires a minimum of 20 principal members. Depending on the employer's policy on medical aid, members are permitted to register a spouse and own or legally adopted children. Per discretionary authority within in societal regions, the family members may be accepted as special dependants. Unless a member is transferring from another medical aid scheme or package, an age limit of 60 years usually applies.

Benefit

Typically the life products tend to be in the form of critical illness cover; that is, a tax-free lump sum after diagnosis of a serious medical condition and medical aid societies cover the immediate costs of treatment. Conditions covered range from strokes, heart attacks, and heart surgery to cancer, kidney failure and organ transplants. The benefit payable is typically a percentage of underlying life coverage to a maximum of 90%. The underlying life coverage remains active either partially or in full and the benefit paid does not necessarily have to be spent on medical expenses.

On a self-funded basis, a specialist facility is now available in the market that enables companies with employees suffering with HIV/AIDS to provide for their healthcare costs. Supplied by the client company, the fund is administered by the insurer. The amount of the fund and the potential benefits are based on an analysis of the company's employees, the client company's requirements and the percentage of employees that are known or assumed to have the virus. For a predefined set of limits funding for HIV/AIDS medical costs is then available to all employees.

An example of some of the annual benefits available under a top of the range medical aid society package are as follows:

- ▶ Rehabilitative services – up to annual limit.
- ▶ Prosthetics and appliances – 90% of cost up to annual limit
- ▶ Homes for the disabled – paid up to annual limit
- ▶ Homes providing nursing care – paid up to annual limit
- ▶ Medical air rescue services – paid in full in Zimbabwe
- ▶ Optical appliances – frames and lenses (100% up to two year limit)
- ▶ Blood transfusion – 20% co-payment applies.
- ▶ Dental costs – 20% co-payment applies.
- ▶ Drugs on prescription from outside of Zimbabwe – 90% of cost up to annual family limit.
- ▶ Drugs from a pharmacy – subject to an annual limit based on size of family.
- ▶ Drugs from hospitals – paid in full.
- ▶ Private, government, mission or municipal hospitals – private ward paid in full.
- ▶ Pathology and radiology – 20% co-payment applies.
- ▶ Medical specialists – paid in full.
- ▶ Maternity care – 70% paid (nine ante-natal and five post-natal visits).
- ▶ General practitioners – paid in full.

Global travel cover is available. Up to 90% of the cost may be refunded in local currency (at the foreign exchange auction rate) subject to the annual limit and the prior approval of the society for medical treatment not available in Zimbabwe.

Waiting periods apply as follows:

- ▶ 6 months for specialist treatment, MRI, CT scans and nuclear medicine, spectacles/contact lenses and admission/treatment at a hospital.

- ▶ 9 months for maternity benefits.
- ▶ 12 months for internal prosthetic devices, nursing homes and specialist foreign treatment.
- ▶ 24 months for hemodialysis and chemotherapy.