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 No internal limit Maximum surgical charge		
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 exception 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 grater 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 heath insurance program, a program that covers all employees enrolled with social security, eligible s, and pensioners. Eligible s 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 anthroscopy, 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 s 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 s, 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 Nat onal 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 shot-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 heathcare 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 (IPSFA) and the Higher Mayoralty.
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 Mayoralty 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.