AMENDMENTS TO THE INTERNAL RULES OF THE SOCIETY
APPLICABLE FROM 1 February 2025

This communication aims to inform insured members of the changes in the internal rules of UNSMIS. Some changes are required to clarify existing rules, some new rules have bene introduced and some rules, or part of, have been deleted.

All changes are shown in italic and/or struck through. Aware of the numerous changes, UNSMIS will organize virtual townhall meetings and will also circulate a more succinct summary of the changes that directly impact insured members as well as communicate the changes through the bi-monthly newsletter and the with pop up messages on the e-claims portal.

The updated Internal Rules will be published on the website effective 1 February 2025.

Rule II – In the interest of clarity the below definitions are added to the existing rule.

Medical Emergency -- refers to an unanticipated, acute medical condition that necessitates immediate medical intervention due to the risk of severe health deterioration or threat to life if treatment is delayed. Medical emergency is characterized by the inability to postpone treatment due to the severity of the condition which requires the admission to hospital for emergency care within 72 hours.

Prior Authorization-- is a prerequisite approval process requiring the insured to obtain clearance from the UNSMIS Medical Adviser before proceeding with scheduled medical care. This approval must be sought well in advance of the planned treatment, allowing UNSMIS to review the medical necessity and cost considerations. Only upon receiving prior authorization will coverage for the treatment be extended in accordance with UNSMIS policy. Failure to request Prior Authorization where needed may result in part or all of the concerned claims not being reimbursed.

Rule VIII - Benefits

To safeguard the finances of UNSMIS and limit elective care for non-residents in the USA, the following paragraph is added to Rule VIII, Paragraph 4.

(f) For insured members whose duty station (for staff members) or legal place of residence (for other insured members) is not within the United States of America, the following rules apply to medical treatments received in the USA:

I. Treatments listed under benefits 2, 3, 5, 13, 16, 24 and 25 of the table in Annex III are subject to prior authorization from the UNSMIS Medical Adviser, unless these are received due to a Medical Emergency and/or an accident as defined under Rule II of the Internal Rules. This is in addition to treatments requiring Prior Authorization as listed in table in Annex III

II. Requests for prior authorization must be submitted no later than 30 days before the planned treatment date together with details of the upcoming surgery and a pre-operative medical report.

III. Reimbursement for the treatments above shall be limited to the cost of equivalent treatment in the canton of Geneva, an estimated cost ceiling will be specified in the prior authorization. Any expenses exceeding this ceiling will be borne entirely by the insured member unless additional costs are pre-approved by UNSMIS.

IV. Other benefits under Annex III that do not require prior authorization under the UNSMIS Internal Rules remain reimbursable under standard UNSMIS terms.

V. Treatments deemed to be medical emergency will be reimbursed under standard UNSMIS terms. UNSMIS reserves the right to determine medical emergency and to assess claims for coverage eligibility in accordance with its policy.

Rule VIII - Benefits

Deletion of Paragraph 7 of Rule VIII, Maximum Supplementary Plan.

~~7. Maximum supplementary benefits~~

~~(a) Maximum credit~~

~~The total amount of supplementary benefits (maximum credit or ceiling) which a member may receive may not exceed 35,000 Swiss francs.~~

~~This maximum shall apply separately to each insured person. Each insured person shall be entitled to the maximum credit as from the date of his admission.~~

~~(b) Renewal of maximum credit~~

~~The payment of supplementary benefits shall terminate as soon as the maximum of 35,000 Swiss francs is reached. A member who has begun to use or has exhausted her/his credit (or that of an insured person of his family) of 35,000 Swiss francs may at any time request in writing a new credit in order to restore the credit ceiling to the maximum figure of 35,000 Swiss francs.~~

~~The Executive Committee shall make its decision after consultation with the Medical Adviser of the Society. The new maximum credit shall take effect from the date of the Executive Committee's decision granting it.~~

Annex I - Increase of SPP Monthly premia

Specially protected persons		
Non-dependent spouse	CHF ~~350.~~ *500*	-
Non-dependent unmarried child under 21 years of age	CHF ~~130.~~ *150*	-
Dependent unmarried child from 21 to 24 years of age	CHF ~~130.~~ *150*	-
Dependent unmarried child from 25 to 29 years of age	CHF ~~200.~~ *230*	-
Secondary dependent		
Father, mother, brother or sister considered as secondary dependents	CHF ~~500.~~ *575*	-

Annex II - Paragraph 1(a) is amended to explicitly define the amount of currency exchange fluctuation.

1. *Reimbursement procedure*

(a) Claims will be processed and benefits will be paid by the Financial Resources Management Service of the United Nations Office at Geneva from the funds of the Society. Claims must be sent to the Reimbursement Unit of the Society. Expenditure incurred in currencies other than Swiss Francs will be reimbursed in Swiss francs at the official United Nations exchange rate applicable on the date of processing of the invoice. In the case of a currency ~~subject to wide~~ *fluctuation of 20% or more* and at the written request of the member, reimbursement will be calculated at the official United Nations exchange rate applicable on the date of payment of the invoice if supporting evidence is attached at the time of submission of the Claim.

Annex II - Paragraph 2(a)(iv) is amended to clarify the definition of a prescription.

(iv) For all purchases and treatments not performed by a doctor, a prescription is required. Prescriptions duly established *prior to treatment* must not be older than six months ~~and must be revalidated after the first renewal~~. Chemists' bills must state the names of the medicines purchased as well as the price and the date ~~or~~ *of* purchase. If renewal of a course of treatment proves necessary, this must be specified on the prescription, with an indication of the treatment or medicine to be renewed, as well as the frequency of dosage and/or the amount.

Annex III - Medical benefits definition updated to provide more clarity for the medical adviser role.

1. MEDICAL BENEFITS

~~Expenses incurred in respect of any of the acts listed in the following table, unless otherwise stated and subject to the provisions of rules VIII.4 to VIII.8, shall be reimbursed at the rate of 80 per cent under the basic benefit plan.~~

~~Supplementary benefits may be paid in accordance with rules VIII.6 and VIII.7.~~

~~Reimbursement is subject to the procedures and conditions set forth in annex II.~~

~~For certain medical benefits the prior authorization of the Society in writing must be requested in accordance with rule VIII.4 (b). The member must append that written authorization to his claim.~~

~~Unless otherwise stated, such authorizations are only valid for a period of six months running from the date on which they are granted. The Medical Adviser shall determine the categories in which treatments not listed in this annex may be classified for purposes of reimbursement.~~

~~Please note that for all treatments that are based on sessions, UNSMIS applies a maximum limit of one session per day, irrespective of duration or length. Individuals who may require more than one session per day, outside of a hospitalization, must submit a written report for Prior Authorization by the Medical Adviser.~~

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The role of the medical adviser, within the framework of the internal rules, is to assess the safety, efficacy, and effectiveness of medical interventions. The medical adviser plays a critical role in bridging the gap between scientific evidence and healthcare decision-making. The medical adviser reserves the right to request additional information, propose alternatives or deny prior authorization if the treatment is experimental and/or if he/she deems the treatment to be unsafe, not medically effective and/or cost ineffective.

The Medical Adviser shall determine the categories in which treatments not listed in this annex may be classified for purposes of reimbursement. Unless otherwise stated, such authorizations are only valid for a period of six months running from the date on which they are granted.
Please note that for all treatments that are based on sessions, UNSMIS applies a maximum limit of one session per day, irrespective of duration or length. Individuals who may require more than one session per day, outside of a hospitalization, must submit a written report for Prior Authorization by the Medical Adviser.

Annex III – Table of Benefits

Benefit 1 in the Schedule of Benefits, Annex III, coverage is extended to cover preventive medical check-ups.

Benefits	Conditions of reimbursement	*Application of supplementary plan*	Prior authorization	Other conditions
1. Doctor's Fees **a) Doctor's Fees**	80%	Yes	No	*Preventive medical check-ups without diagnosis and prior authorization (prescription should detail the required exams and medical reason) are covered up to 1,000 CHF per year.*
b) Outpatient medical fees in a medical establishment	80%	Yes	No	

Benefit 5 in the Schedule of Benefits, Annex III, is deleted, to the advantage of the insured member.

Benefits	Conditions of reimbursement	*Application of supplementary plan*	Prior authorization	Other conditions
a) ~~5. Long-term hospitalization in an establishment approved by the health authorities of the country concerned~~	~~80% up to 365 days~~ **~~Supplement for private room not reimbursable~~**	~~no~~	~~yes~~	~~Hospitalization at home prescribed by a doctor is reimbursable at 80% with the application of the supplementary plan.~~
~~Any extension of the period of hospitalization by an additional 180 days is subject to approval by the Medical Adviser, who shall determine whether the treatment is curative or of an indispensable palliative nature.~~				
~~If this is not the case, the insurance cover will be reduced in stages as follows:~~ ~~80% with a daily maximum of CHF 180.- for 180 days;~~ ~~80% with a daily maximum of CHF 120.- for 180 days;~~ ~~80% with a daily maximum of CHF 60.- per day, for an indefinite period.~~				

Introduce breast surgery rule, Benefit 5 in the Schedule of Benefits, Annex III , with limits and requirements to clarify coverage on aesthetic implants removal due to accident, illness and or medical emergency and breast reduction.

Benefits	Conditions of reimbursement	Application of supplementary plan	Prior authorization	Other conditions
5. Breast surgery				
- Breast Implant Removal	*As for item 1, 2 and 3*	*Yes*	*Yes*	*- Breast reduction is covered only when medically necessary following an accident and/or a medical emergency.* *- A medical report from a surgeon other than the one performing the surgery including history of medically justified symptoms.* *- Weight of tissue removed should be equal or superior to 500 grams per breast.* *BMI should not be over 25.*
-Breast reduction surgery for medical reasons	*As for item 1, 2 and 3*	*Yes*	*Yes*	*- Cost estimate and medical report to be provided*

Add point b) to Benefit 8, Long Term nursing care

Benefits	Conditions of reimbursement	Application of supplementary plan	Prior authorization	Other conditions
8. Long-term nursing care a) Long-term nursing care at home or in a medical establishment provided by persons not on the staff of the establishment	80% up to a maximum of CHF 80.- per day	No	Yes	For renewal requests, prior authorization is not required.
b*) Personal care at home (assistance with hygiene and mobility)*	*80% maximum of CHF 45.- per day*	*No*	*Yes*	

Clarification that benefits 8 and 9 are not non cumulable with benefit 10 as per current practice.

Benefits	Conditions of reimbursement	*Application of supplementary plan*	Prior authorization	Other conditions
10. *Dependency* Benefits for care in the home (nursing or home health services): assistance with hygiene and mobility	Total dependency; maximum 100% of CHF 120.- per day	No	Yes	The Medical Adviser must first approve a detailed medical report indicating the degree of dependency of the person as regards basic activities of daily life (e.g. eating, getting in/ out of bed, continence, washing/bathing, dressing, mobility indoors) *Benefits 8 and 9 cannot be cumulated with this benefit*

Update Benefit 13 on nutritional treatment, reconstructive surgery will be considered with less restrictive conditions.

Benefits	Conditions of reimbursement	*Application of supplementary plan*	Prior authorization	Other conditions
13. Nutritional treatment - BMI > 40: hospitalization and surgical procedures (if loss of weight > ~~50 kg~~, *35% of initial body weight, stabilized over 12 consecutive months,* reconstructive surgery may be covered)	As for item 1, 2 and 3	Yes	Yes	

Update Benefit 14 related to recommended vaccinations to remove doctor ‘s prescription as a requirement along with the other conditions attached.

Benefits	Conditions of reimbursement	*Application of supplementary plan*	Prior authorization	Other conditions
14. Pharmaceutical expenses (subject to VIII.7.g of the Internal Rules) Recommended vaccinations ~~on doctor's prescription~~	80%	No	No	~~Para pharmaceutical products are reimbursable only on recommendation of the Medical Adviser following an accident.~~

Update Benefit 17 to include fees charged by medical practitioner when home visit is needed

Benefits	Conditions of reimbursement	*Application of supplementary plan*	Prior authorization	Other conditions
17. Functional Rehabilitation Treatments Physiotherapy, kinesitherapy, chiropractic, osteopathy, etiopathy, occupational therapy (ergotherapy), diathermy, ultrasounds, infrared, hydrotherapy, inhalations, fangotherapy	80% max CHF 70 per session	Yes , from the 31st session	No	Doctor's prescription must specify the number of sessions and the actual length of treatment. If this period exceeds six months, the treating physician must reassess the treatment after six months and issue a new prescription. *Reasonable and customary charges for the medical practitioner's home visit are reimbursed at 80% if the insured person is unable or cannot leave the premises due to circumstances.*

Complete Benefit 20 on medical appliances (breathing devices nCPAP) and specify the 6 months trial period prior to long term rental or purchase. Introduce (g) section related to medical beds and mattresses' reimbursement.

Benefits	Conditions of reimbursement	*Application of supplementary plan*	Prior authorization	Other conditions
d) i) Manual *wheelchair*	80% max. CHF 3,500.-, one every five years, including repair cost. *Costs for rental over 3 months will be deducted from the available purchase credit.*	No	Yes	Upon doctor's prescription and cost estimate.
ii) Electric *wheelchair*	80% max. CHF 5,000.-, one every five years, including repair cost. *Costs for rental over 3 months will be deducted from the available purchase credit.*	No	Yes	Any electrical device attached to a manual wheelchair will be considered under the electric wheel chair reimbursement, cumulatively with the manual wheel chair.
iii) Electric *wheelchair* with verticalization functions	80% max. CHF 17,000.- , one every five years, including repair cost. *Costs for rental over 3 months will be deducted from the available purchase credit.*	No	Yes	
f) Breathing device (nCPAP) - Initial trial period - Purchase *or long term rental*	80% max. 6 first months 80% max. CHF 2,800.- every 5 years including repair cost and batteries	No	No	Upon doctor's prescription. Maintenance costs of the equipment may be reimbursed but are deducted from the 5 years overall credit. Cross-border internet purchases are reimbursable.
~~€~~ g-) Medical beds & mattresses needed as a consequence of surgery and/or chronic incapacitating illness (rental or purchase)	*80% max. CHF 3,000.- every 5 years*	No	*Yes*	

Maternity and Infertility benefits has been deleted and is replaced with a broader benefit, Reproductive Health, providing better coverage to IVF treatments and prenatal diagnostics amongst other things.

Benefits	Conditions of reimbursement	Application of supplementary plan	Prior authorization	Other conditions
~~**26. Maternity**~~	-	-	-	~~Costs for new born child not enrolled are not covered.~~
~~a) During pregnancy: coverage of all tests and ultrasound scans~~	~~80%~~	~~yes~~	~~no~~	-
~~b) Preparation for the delivery~~	~~80% max. CHF 200.~~	~~no~~	~~no~~	-
~~c) Obstetrician or midwife's fees and nursing fees~~	~~80%~~	~~yes~~	~~no~~	-
~~d) Surgical operation (caeserian)~~	~~90%~~	~~yes~~	~~no~~	-
~~e) Stay in a clinic or hospital~~	~~Same conditions as for item 3~~	~~yes~~	~~no~~	-
~~f) After the delivery, coverage of 6 sessions or visits by a midwife or nurse if the length of stay in the medicalized establishment was not greater than 6 days~~	~~80%~~	~~yes~~	~~no~~	~~Upon doctor's prescription.~~
~~**27. Infertility treatment**~~ ~~The costs covered by the total credit include all care relating to infertility treatment, such as : medical procedures, consultations and examinations, including egg retrieval and embryo transfer, laboratory tests and fees, including fees for sperm preparation, hatching, micro-injection, embryo transfer, ICSI, freezing and cryopreservation, biologist's fees, scans, nursing care and services, operating fees, theatre charges, post-op, outpatient day care, materials and anaesthesia, medicaments, and other expenses normally associated with such treatment.~~	- ~~80%. max. CHF 20,000. in the lifespan~~	- ~~no~~	- ~~yes~~	- ~~A coverage form will be provided and has to be submitted with each medical reimbursement claim relating to such treatment.~~
25~~-26~~. Reproductive Health *a) Prenatal Diagnostics*	*80%*	*Yes*	*No*	*Genetic test require prior authorization*
b) Preparation for birth/delivery	*80% maximum CHF 200*	*Yes*	*No*	*Classes must be given by a recognized nurse or midwife in the concerned jurisdiction.*

c) Home delivery with assistance from a midwife, nurse, or physician	*80%*	*Yes*	*No*	
d) Hospital delivery in a clinic/hospital	*90%*	*Yes*	*No*	
e) Obstetrician or midwife's fees *i. Obstetrician or midwife's fees and nursing fees* *ii. After the delivery, 6 sessions or visits by a midwife or nurse*	 *90%* *80%*	 *Yes* *Yes*	 *No* *No*	*Obstetrician or midwife's fees and nursing fees during a hospital delivery are reimbursed as per Item 3, Hospitalization in an approved establishment.* *Classes must be given by a recognized midwife in the concerned jurisdiction.* *A medical prescription is required*
f) Sterilization	*80%*	*Yes*	*Yes*	*The sterilization must be required due to an underlying medical condition. Voluntary sterilization and voluntary reverse sterilization are not covered.*
g) Infertility treatments	*80% maximum CHF 20,000 in a lifetime* *This limit includes all care related to the treatment.* *Medical procedures, consultations, and examinations, including egg retrieval and embryo transfer, laboratory tests and fees, including fees for sperm preparation, hatching, micro-injection,*	*Yes*	*Yes* *The medical report will need to include the below information:* *-Exams done and results* *-Treatment undertaken already* *- Treatment proposed* *- Cost estimate*	*It refers to any medical procedure (invasive or non-invasive) aiming to induce pregnancy by means of standard reproductive medicine and carried out in a recognized specialized center.* *Costs related to any type of donor or reproductive cells storage to postpone pregnancy are not covered.* *Surrogacies are not covered, unless the surrogate mother is an UNSMIS*

	embryo transfer, ICSI, embryo freezing and cryopreservation, biologist's fees, scans, nursing care and services, operating fees, theatre charges, post-op, outpatient day care, materials and anesthesia, medicaments, and other expenses normally associated with such treatment. *The list is not exhaustive*			*insured, in which case the notion of insurable interest prevails, and the surrogacy would be treated as a regular pregnancy.* *Only the costs strictly related to the insured member are eligible for reimbursement* *Adoption costs are not covered as they are not medical in nature.* *Patient must be below the age of 45 at the time the planned treatment commences.* *For the purpose of reimbursement, infertility is defined as the failure to become pregnant:* *(a) The inability of opposite-sex partners to achieve conception after at least one year of unprotected intercourse.* *(b) The inability of a woman, with or without an opposite-sex partner, to achieve conception after at least 3 trials of medically supervised artificial insemination over a one-year period.* *(c) For a male without a female partner after at least 2 abnormal semen*

				analyses obtained at least 2 weeks apart. *(d) For an individual or their partner who has been clinically diagnosed with gender dysphoria*

A new benefit, Benefit 26, is added to cover Genetic tests and liquid Biopsies.

Benefits	Conditions of reimbursement	Application of supplementary plan	Prior authorization	Other conditions
26. Genetic Test and liquid biopsy	*80%*	*No*	*Yes*	*Test prescribed by a geneticist other than the one performing the test , medically justified up to 100 genes tested to confirm the current suspected illness or direct family illness history in order to adapt the treatment, detailed medical report with patient history.*

Clarify Benefit 27 on transportation: emergency transportation by ambulance and round trip each way up to 200 kms.

Benefits	Conditions of reimbursement	Application of supplementary plan	Prior authorization	Other conditions
27. Transport				Repatriation costs are not reimbursable. Transportation costs by a private car are not reimbursable.
a) Emergency transport *(ambulance)* to the nearest place of treatment	80%	Yes	No	
b) Other transport in an ambulance up to 200 km	80%	No	Yes	
c) Round trip transport for outpatient treatment to the nearest place where appropriate treatment can be obtained up to a distance of 200 km *each way*	80%	No	Yes	

Annex IV

The title changes from Special Protected Person (SPP) to Secondary dependents, the ceiling is raised to CHF 12,000.- instead of CHF 10,000.- for the first year (define year as 12 months from the date of affiliation). The secondary dependent can enroll maximum 31 days from recognition of dependency from Human Resources or when joining at the duty station or during the yearly enrollment campaign.

Exclusions: No benefits shall be paid for the following:

- Maxillo-facial operations (item *24* ~~25~~).

Waiting period (for new affiliates): Expenses incurred for the following items during the first year of coverage shall not be reimbursed:

— Functional rehabilitation treatment (item 17)

— ~~*Psychiatric and psychoanalytical treatment*~~

— *Mental and Developmental health* (item 18)

— ~~Prosthetic~~ Medical appliances (item 20 (a))

— Hearing aids (item *20* ~~21~~)

— Eyeglasses (item *21* ~~22~~ (a))

— Dental treatment (item *22 and 23* / ~~23 and 24~~).

Limitation: The cost of the following items shall be reimbursed up to the limits shown:

— ~~*Psychiatric treatment (item 18)*~~

~~*In patients: 50 sessions per year*~~

~~*Out patients: 35 sessions per year*~~

— Dental treatment (item *22 and 23* / ~~23 and 24~~). CHF 1,000.– per annum, non-cumulative.

Overall ceiling for reimbursements: During the first year, the overall amount of benefits paid by the Society shall be subject to a ceiling of *CHF 12,000*
~~CHF 10,000 . For persons enrolled during the annual enrolment campaign, the overall amount of benefits paid by the Society shall be subject to a ceiling of CHF 10,000.- per year for three calendar years.~~
Secondary dependents can enroll within 31 days of recognition of the dependency, upon joining duty station or during the annual enrolment campaign.

Annex V
Adjust the text as in annex IV

- Treatments for obesity (item 13 (a))
~~- Psychiatric and psychoanalytical treatment~~
- *Mental and Developmental health* (item 18)
- ~~Prosthetic~~ Medical appliances (item 20)
- Hearing aids and breathing device (item *20* ~~21~~)
- Optical care (item *21* ~~22~~)
- Dental treatment (item *22 and 23* 23 ~~and 24~~), only emergency treatments approved by the Medical Advisor will be reimbursed at 80% up to a maximum of CHF 500.-
- Maxillo-facial operations (item *24* ~~25~~)
- ~~Maternity~~ *Reproductive health* (item *25* ~~26~~)
~~- Infertility treatment (item 27)~~
- Transport (item *27* ~~28~~)
- Funeral expenses (item *28* ~~29~~)

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