UNITED NATIONS
GENEVA

United Nations Staff Mutual Insurance Society against Sickness and Accident

INTERNAL RULES

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Updated on 1 August 2025

UNSMIS
United Nations Staff
Mutual Insurance Society

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INTERNAL RULES

Rule I

ENTRY INTO FORCE AND SCOPE OF APPLICATION

1. These Rules were drawn up in accordance with article 4 of the Statutes and approved by the Director-General of the Office of the United Nations in Geneva. The internal rules have been amended and updated on 1 August 2025 following the recommendations of the Executive Committee and their approval by the Director General, UNOG. All amendments have been communicated to insured members following the procedures outlined in the Statutes and the Internal Rules.

2. The provisions of these rules shall apply, *mutatis mutandis*, to staff members of specialized agencies whose application to the plan has been accepted under the conditions set forth in Chapter III of the Statutes.

Rule II

DEFINITIONS

1. For the purpose of these Rules:

The Society, Health insurance plan or ***the plan*** — means the United Nations Staff Mutual Insurance Society against Sickness and Accident, at Geneva;

Rule — means one of the provisions of these Internal Rules;

Secretary — means the Executive Secretary of the Society;

Administration — means the Division of Administration of the United Nations Office at Geneva;

Coverage — means insurance coverage under the plan and entitlement to receive benefits as provided for by the Statutes and these Rules;

Protected person — means a family member as defined under these rules, or other person as specified under article 6, paragraph 4 of the Statutes;

Insured person — means a member of the Society or a protected person covered under the plan;

Calendar year — means the period 1 January – 31 December inclusive. Where affiliation takes place during the year, it shall apply to the period elapsing between the date of affiliation and 31 December. In the event of termination of insurance during the year, it means the period elapsing between 1 January and the date of termination, or between the date of affiliation and that of termination;

Staff member of the United Nations — means all officials holding contracts with the United Nations Office at Geneva or the Office of the United Nations High Commissioner for Refugees with the exceptions (save in cases approved by the Society) of field staff recruited locally;

Specialized agency affiliated to the Society — means, in accordance with article 6 of the Statutes, any specialized agency at Geneva which has signed an agreement with the Director-General of the United Nations Office at Geneva;

Organization in the United Nations family — means primarily United Nations headquarters, the United Nations Office in Vienna, the Economic and Social Commission and the specialized agencies whose headquarters are not located in Geneva;

Premium — means the contribution of the official plus the subsidy paid by the Organization.

Medical Emergency — means 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 — means 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 claim not being reimbursed.

Rule III

MEMBERSHIP

MEMBERS IN SERVICE

1. A member of the staff of the United Nations or of a specialized agency affiliated to the Society may participate as a member in the main plan of the Society provided that she/he is in possession of:

(a) A permanent or continuing appointment;

(b) A fixed-term or temporary appointment of a duration of three months or more.

2. A member of the staff of the United Nations or of a specialized agency affiliated to the Society in possession of a temporary appointment of a duration of less than three months may participate to the temporary plan of the Society in accordance with the provisions of Annex V to the Internal Rules of the Society.

3. Any person who has been affiliated with the Temporary plan of the Society under the provision of Annex V for an uninterrupted period of three months may become a member with the same medical benefits as members covered by Rules 1. (a) and 1. (b) above. Also, in such case, staff holding a temporary appointment joining the main plan of the Society may request that coverage be extended further to their eligible family members.

RETIRED MEMBERS

4. After-service coverage by a health insurance scheme is available only in the form of continuation of previous membership of the Society or of an insurance scheme of an organization of the United Nations family.

Thus any former staff member may continue to be a member of the Society after separation from service provided that on separation:

(c) She/he is affiliated to the Society or to a sickness insurance scheme of an organization in the United Nations family and is receiving a disability pension under the Regulations of the United Nations Joint Staff Pension Fund or compensation for disability awarded under appendix D to the Staff Rules; or

(d) She/he is 55 years of age or older, has been affiliated to the Society or to an insurance scheme of an organization in the United Nations family for at least five years for staff recruited before 1 July 2007, or for a minimum of 10 years for staff recruited on 1 July 2007 or thereafter, and is eligible and elects to receive a retirement, early retirement or deferred retirement benefit in accordance with the Regulations of the United Nations Joint Staff Pension Fund.

Full details on the eligibility requirements and administrative procedures relating to after-service health insurance coverage are set out in administrative instruction ST/AI/2007/3 on after-service health insurance.

Rule IV

CONDITIONS FOR ADMISSION

1. The staff member must apply for admission in writing, using a special Society form, within 31 days of his entry on duty, or on qualifying for membership of the Society, or during an annual enrolment campaign.

2. A member of the Society (other than a holder of a temporary appointment of less than three months) may obtain coverage by the Society for the following members of his family:

(a) A dependent spouse within the meaning of the Staff Rules;

(b) Unmarried children under the age of 21 years dependent on the staff member within the meaning of the Staff Rules;

(c) Children aged 18 or over in continuing dependency on account of permanent invalidity

within the meaning of the Staff Rules or the Regulations of the United Nations Joint Staff Pension Fund;

(d) Specially protected persons:

(i) A spouse and unmarried children under age 21 who are not recognized as dependents by the United Nations;

(ii) Unmarried children over 21 and under 30 years of age in full-time attendance at a school or university or not in regular employment or not having a regular income;

(e) Secondary dependents:

(i) A father, mother, brother or sister who is a secondary dependent within the meaning of the Staff Rules, subject to the benefit limitations listed in annex IV to these Rules.

3. Application for the admission of members of the family of a member of the Society in service may be made:

(a) At the time of application by the staff member for his own admission;

(b) Within 31 days of the arrival of the family members at the staff member's duty station;

(c) Within 31 days of marriage or birth;

(d) At the time of an annual enrolment campaign;

4. For secondary dependents (father, mother, brother or sister) within 31 days following the date on which their status as secondary dependents is recognized for the first time by the Organization, or during an annual enrolment campaign. The spouse and dependent children[1] of a former official who were affiliated to the Society or to a sickness insurance scheme of an organization in the United Nations family on the date of cessation of service of the staff member may be covered by the Society provided that the former staff member remains or becomes a member of the Society. The spouse and eligible dependent children of a staff member who was recruited on or after 1 July 2007 may be covered by the Society on the date of cessation of service of the staff member, provided that the former staff member remains or becomes a member of the Society and that the spouse and dependent children were enrolled in the Society or in a sickness insurance scheme of an organization in the United Nations family for a minimum of five years or two years if the spouse had coverage with an outside employer or a national government. However, in the case of dependents newly acquired within five years of the staff member's separation of employment, the two- and five-year participation requirements will not apply provided such dependent(s) is/are enrolled within 30 days of the effective date of the dependent relationship. Specially protected persons as defined in rule IV 2 (d) above may be covered only if they have been affiliated to one of the plans mentioned for at least the previous year.

5. A staff member in service cannot be considered as a dependent of a retired staff member for the purposes of the plan. She/he shall automatically be deemed to be a member.

6. When the application meets the requirements of the plan, the date of admission shall be that on which the application is received by the personnel department of the organization concerned in Geneva. In the case of newly-born children for whom application is made within 31 days of birth, admission shall be effective from the date of birth. In the case of new staff members, an application submitted within 31 days shall be effective from the first day of the contract, except where the staff member requests postponement of admission in order to avoid dual coverage. The staff member must provide written evidence to substantiate such request.

7. Application forms for admission to coverage by the Society will be provided by the Personnel Service at Geneva or are available from the Secretary of the Society. The responsibility for the making of an application within the terms and under the procedures laid down in these Rules rests with the staff member or other applicant for coverage or continued coverage in the plan. The Secretary will advise the applicant of acceptance of his application or of the further conditions or provisions to be complied with.

[1] «the spouse and dependent children» as being defined by Rule IV 2. (a), (b) and (c) of the Society's Internal Rules.

Rule V

CONDITIONS FOR EXTENSION OF INSURANCE

1. A member who enters on special leave without pay or is detached to an organization in the United Nations family which is not affiliated to the Society may maintain her/his membership of the Society and continued coverage by the Society of herself/himself and the members of her/his family with the status of insured persons by informing the Secretary in writing of her/his wish so to do. The member thus retains all her/his acquired rights vis-à-vis the payment of benefits or the admission of new members.

2. On transfer to a specialized agency affiliated to the Society, the staff member may arrange for continued membership of the Society and continued coverage for the members of her/his family with the status of insured persons by making an application to that effect to the personnel department of the receiving organization.

3. On separation from service, or on transfer to an organization in the United Nations family, a member may on application maintain coverage by the plan for herself/himself, and, where applicable, for the members of her/his family as protected persons, for a period not exceeding three months beyond the month of such separation or transfer, provided that she/he has been a member for six consecutive months. This period of extension does not count towards the eligibility period for After Service Health Insurance, except in the case of transfer to another organization of the United Nations family.

4.(a) A staff member recruited before 1 July 2007 who on separation from service (other than by summary dismissal) at age 55 or later, has been a member for a minimum of five years or a minimum of 10 years for staff recruited on 1 July 2007 or thereafter may extend her/his coverage in the plan, and that of eligible family members, provided that she/he is eligible and elects to receive a retirement, early retirement or deferred retirement benefit under the Regulations of the Joint Staff Pension Fund;

(b) A staff member who was a member and separated from service (other than by summary dismissal) with a disability benefit under the Regulations of the Joint Staff Pension Fund or with compensation for disability under appendix D of the Staff Rules may extend her/his coverage in the plan, and that of eligible family members.

Full details on the rules and conditions governing After-Service Health Insurance eligibility and acquired rights are set out in Administrative Instruction ST/AI/2007/3 on after-service health insurance.

5. The spouse, unmarried children under age 21 and specially protected persons may continue their coverage by the plan if:

(a) They are survivors of a staff member who died in service of the Organization and was a member of the Society; or

(b) They are survivors of a former staff member who died while still a member of the Society; provided that they were affiliated to the Society on the date of the death of the staff member and that they are receiving a periodic benefit under the terms of the Regulations of the Joint Staff Pension Fund, or of appendix D to the Staff Rules, or both.

6. Members wishing to extend insurance coverage for themselves and/or for members of their families in accordance with Rule V.1-V-3, must pay the full premium due to the Society. They must inform the Society in writing in advance.

7. Eligible members wishing to enroll in after service health insurance should follow the procedures outlined in Section 7 of ST/AI/2007/3. A survivor of the staff member or retired staff member must normally apply to the Society in writing within six months.

8. In the event of divorce, the Committee may examine the application of the divorced ex-spouse and continue his or her affiliation as an ex-spouse not dependent on the member, subject to payment of the premium in advance. Insurance coverage may not be continued for more than one year. However, if the divorced member is a pensioner, the Committee may accept the continuation of coverage on a permanent affiliation basis, at the request of the ex-spouse. A divorced spouse who becomes a specially protected person may not have new dependents and may not continue his or her affiliation upon remarrying.

Rule VI

CONDITIONS OF SEPARATION FROM THE SOCIETY

1. The date of separation from the Society, which determines the end of the period of membership, is taken to be the date of separation from service within the meaning of the Staff Rules or the date on which the conditions laid down in rules **IV** or **V** cease to be met (for instance, the date of the thirtieth birthday of the child or the day on which a child marries or obtains regular employment).

2. Members not wishing to continue insurance cover for themselves or the members of their families must inform the Society to that effect in writing giving three month's notice. If insurance cover is interrupted it can only be restored if the Executive Committee considers that the interruption was decided on in good faith and for valid reasons.

3. A member taking special leave without pay, regardless of duration, who decides not to continue insurance paying the total amount of the premium (rule **V.1**) cannot claim either reimbursement of expenditure incurred during that period or cumulative credits in respect of that period of leave. Except where the staff member requests otherwise, membership of the Society shall resume immediately on her/his return under the conditions applicable at the time of departure. Credits accumulated under annex III before departure shall be brought forward unchanged at the time of return.

Rule VII

PREMIUMS

1. In all cases premiums shall be payable for entire months of the calendar year and are calculated in accordance with the schedule in annex I of these Rules.

2.(a) The contributions of a staff member in service shall be calculated on the basis of net salary.

(b) For purposes of this calculation "net salary" means gross basic salary less staff assessment, plus post adjustment, spouse allowance, single parent allowance, transitional allowance, non-resident's allowance and language allowance where applicable.

(c) In the case of staff members employed part-time, the total amount of the premium to be charged by the Society (i.e. the staff member's contribution plus the subsidy paid by the United Nations) shall be calculated on the basis of the net salary which would be paid to the staff member if she/he was employed full-time; the amount of the subsidy paid by the Organization will be prorated to the time during which the staff member is actually employed.

(d) In cases of continuation of coverage under rule **V.1-3**, the above conditions shall apply to the last net salary of the staff member. For any period exceeding one year the amount shall be indexed annually at a rate fixed by the Executive Committee.

3. In the following cases the full premium (that is, the contribution as calculated in accordance with **annex I** of these Rules, plus the amount of the subsidy normally paid by the Organization in accordance with article XI of the Statutes) must be paid by the staff member:

(a) For continued coverage during a period of special leave without pay in accordance with rule **V.1**; where such special leave has been granted following illness or an accident, the premiums shall be calculated on the basis of one third of the net salary of the member on his last day of duty;

(b) For extended coverage in accordance with rules **V.3**.

4.(a) After separation, a former staff member who wishes to continue membership of the Society as a pensioner shall pay a premium calculated on the basis of all the income paid under the terms of the Regulations of the United Nations Joint Staff Pension Fund, or appendix D of the Staff Rules, or both, taking into account, where appropriate, the lump sum withdrawn on retirement. The minimum contribution is calculated on the basis of a pension corresponding to at least 20 year's service for staff members recruited before the 1st July 2007 and 25 years service for staff members recruited on the 1st July 2007 or thereafter.

(b) A floor premium is set each year by the Society: but the amount payable by participants with small incomes may be reduced by a proportion decided on by the Executive Committee.

(c) For purposes of calculating the premium payable by survivors, the surviving spouse, a child insured alone, or the eldest child if more than one is insured, will be considered as the head of the family and all other children will be considered as members of the family. Contributions will be calculated for the head of the family at the rate applicable to a member and, for the other dependent children, at the rate applicable to dependents.

5. In all cases the calculation of the contribution for a spouse will depend on her/his status as indicated in the table below.

6. The total amount of the insurance premium is paid jointly by the member and the Organization in accordance with annex I of these Rules. A former staff member who has not been affiliated to a sickness insurance scheme of an organization in the United Nations family for at least 10 years and was recruited before 1 July 2007 must pay the total amount of the premium, including the subsidy payable by the Organization, unless he is receiving an invalidity benefit. When the total period of membership of a former staff member, either as a staff member in service or as an after-service member of the sickness insurance scheme, reaches 10 years, the cost of the premium is borne jointly by the insured and the Organization. Staff holding a temporary appointment do not accrue credits towards becoming eligible for After-Service Health Insurance.

7. The contributions of members who are staff members in service shall be deducted from their salaries each month by the Organization. The contributions of retired members shall be deducted at source each month by the United Nations Joint Staff Pension Fund and credited directly to the Society's account.

8. Premiums in respect of insured persons not carried on the Geneva payroll must be paid in advance. Premiums of retirees which are not deducted by the United Nations Joint Staff Pension Fund must be paid in advance, on a quarterly, semi-annual or annual basis. Any delay in the payment of these premiums suspends entitlement to benefits. Premiums must be paid in Swiss francs or in United States dollars at a rate specified by the Society. If necessary, a member may be requested to pay a provisional premium subject to adjustment at a later date.

9. Contributions in respect of specially protected per-sons are payable at a flat rate. The Executive Committee shall fix the amount of the contribution for each category covered, so that the sums collected by the Society in respect of specially protected persons will be sufficient to cover the benefits payable to them, taking into account the experience gained with regard to the cost of protecting those persons. The status and corresponding premiums of specially protected persons are frozen on separation from service of the staff member, this independently of the amount of income of the specially protected persons and this until the death of the retired staff. Current premiums are given in annex I of these Rules.

SITUATION	CONTRIBUTING MEMBER	SITUATION OF SPOUSE	CALCULATION OF CONTRIBUTION	
			FOR THE MEMBER'	FOR THE SPOUSE
1	**Staff member**	Dependent (income less than G1 step 1)	Premium for member with dependent	Included in premium of member
2	**Staff member**	Not dependent; not staff member	Premium for member in service without dependents	Premium for specially protected person
3	**Staff member**	Not dependent; staff member of an organization affiliated to the Society	Premium for member in service without dependents	Premium for member in service without dependents
4	**Staff member**	UNJSPF pensioner recognized by the Society as dependent (income less than Gl, step 1 declared by staff member)	Premium for member in service with dependent	Included in premium of member
5	**Staff member**	UNJSPF pensioner with income (including pension) exceeding G1, step 1	Premium for member in service without dependents	Premium for retired member without dependents
6	**Retired staff member**	Dependent (income less than G1, step 1 declared by staff member)	Premium for retired member with dependents	Included in premium of member
7	**Retired staff member**	Not dependent	Premium for retired member without dependents	Premium for specially protected person
8	**Retired staff member with income (including pension) of less than Gl, step 1**	Staff member of an organization affiliated to the Society	The spouse, being in service, becomes the member and pays the premium for a member in service with dependents (situation 4).	The retired staff member becomes the spouse; His or her premium is included in that of the member.
9	**Retired staff member with income (including pension) exceeding G1, step 1**	Staff member of an organization affiliated to the Society	The retired staff member pays the premium for a retired member without dependents.	The spouse, being in service, stays the member and pays the premium for a member in service without dependents (situation 5).
10	**Retired staff member**	UNJSPF pensioner with income of less than Gl, step 1 declared to the Society	Premium for retired member with dependent	Included in the premium of the member
11	**Retired staff member**	UNJSPF pensioner with income (including pension) exceeding G1, step 1	Premium for retired member without dependents	Premium for retired member without dependents

[1] If there are recognized dependent children, the amount of the premium is calculated in accordance with annex I.

Rule VIII

BENEFITS

1. Benefits under the plan comprise basic benefits and supplementary benefits.

2. The procedures and conditions governing the submission and processing of claims are shown in annex II to these Rules.

3. Schedules showing the benefits payable under the plan and the conditions and limitations applicable thereto are provided in **annex III.**

4. In general, reimbursement of medical benefits is also subject to the following conditions:

(a) In the event of hospitalization following an accident or of proved emergency, the member must normally notify the Society within three days.

(b) Reimbursement in respect of certain medical benefits specified in **annex III** is subject to Prior Authorization by the Medical Adviser of the Society. To obtain that authorization, the member should apply to the Society in writing. Where application has not been made to the Society in advance, the Executive Committee may, on the Medical Adviser's recommendation, authorize payment of the benefits claimed as an exceptional measure, provided it is satisfied that the omission was caused by circumstances beyond the control of the claimant *(force majeure).*

(c) To safeguard the financial solvency of the plan and to avoid abusive charging practices, the Executive Committee charges the Secretariat of UNSMIS, after consultation with the Medical Adviser, to limit reimbursement to usual, reasonable and customary charges (URC) in a given region/area. The Secretariat of UNSMIS shall make all reasonable efforts to review the pricing with the provider before applying the URC.

To ensure that insured members are not penalized, the Secretariat of UNSMIS reserves the right to request a quote in advance for all non-emergency surgery. The Secretariat of UNSMIS is responsible for informing all insured members when an advance quote is required and/or to ensure any reimbursements limits, in accordance with the URC, are clearly communicated.

(d) In the event of serious or chronic illness requiring prolonged treatment, the Executive Committee may, after consulting the Medical Adviser of the Society, decide to apply certain provisions of these Rules in a flexible manner.

(e) If a member decides to obtain medical care (for example, hospitalization or a surgical operation) away from the duty station (in the case of a staff member) or the place of residence (in the case of a pensioner) at a place where medical costs are higher than in Geneva, reimbursement shall not exceed the cost of equivalent treatment provided in the canton of Geneva.

(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.

5. *Time-limit for submitting claims*

(a) All claims must be made within two years after the date on which the bill or account was established. This change comes into effect for any invoice issued after the date of 1st February 2021. It is the responsibility of the member to see that claims are submitted in due time.

(b) Where presentation of claims is delayed beyond the prescribed date, the Executive Committee may, in cases of *force majeure* and as an exceptional measure, extend the time-limit.

6. *Basic and supplementary benefits*

(a) Basic benefits are calculated taking into account the date of invoicing of medical acts and the date of processing, in accordance with the reimbursement rules stated in **annex II 1**. (a) and with the rules set forth in **annex III**.

(b) In certain cases supplementary benefits are applicable in respect of certain cost items as shown in annex III; they are calculated as follows:

(i) Amount of medical expenditure not reimbursed;

(ii) Less an amount of CHF 2,800 per insured person, with a ceiling of CHF 4,600 per family for each calendar year in which claims are submitted;

(iii) Reimbursement is effected on the basis of 100 per cent of (i)-(ii).

7. *Limitations, forfeiture, suspension of benefits*

(a) Expenses in respect of the consequences of accidents occurring before the date of affiliation are not covered by the Society.

(b) Any expenditure incurred after the expiry of the period of membership is not covered by the Society. However, if a course of treatment is continuing at the time when membership expires, in conformity with rule **VI.1** ., the person concerned will continue to be entitled to reimbursement of expenditure relating exclusively to that course of treatment on the Medical Adviser's recommendation for 90 days following the date of expiry, provided her/his period of membership of the Society has exceeded 24 months.

(c) In the event that a third party may be deemed either fully or partially liable, the member must inform the Society of the facts relating to the case as soon as possible If the Society considers that a third party may be held legally liable for an illness or injury giving rise to expenses reimbursable under these Rules, the Executive Committee may invite the member in writing to take all necessary steps to secure compensation from the third party concerned. In such a case, the Society will reimburse any reasonable legal costs payable by the member as a result of such action.

(d) Benefits shall be waived altogether or reduced to take account of recoveries available (i) from the United Nations under the Staff Rules or other provisions; (ii) from a third party who is liable in respect of the illness or accident giving rise to the claim; (iii) from another insurance providing coverage of the illness or accident giving rise to the claim.

(e) If benefits are payable by other sources for the illness or accident, the Society shall reimburse only that part which is not reimbursed by the other source, with respect of expenses normally covered; in no event shall the amount reimbursed, added to the reimbursement obtained from another source, exceed 100 per cent of the total expenses incurred.

(f) Benefits may be reduced in cases of injury deliberately inflicted by the insured person on himself.

(g) No benefits will be paid in respect of:

- Medicines delivered without a prescription;
- Pharmaceutical products not deemed to be reimbursable medicines under the criteria laid down by the competent health authorities in the country in which those products are purchased;

- Para pharmaceutical products such as dietetic foods and products, mineral waters and medicinal wines, toiletries, hair lotions, skin foods, thermometers, syringes and physiotherapeutic appliances;
- Aesthetic or similar treatments and surgical operations not considered as indispensable by the Medical Adviser and services normally included in the costs of consultations or visits;
- Paramedical treatment not considered as indispensable by the Medical Adviser (for example, chiropody, dietetic or energy assessments, fitness and similar programs);
- Treatments or therapies generally not recognized by the competent health authorities of the country in which they are practiced;
- The consequences of an accident of the insured person resulting from being on board (including as a passenger) in a delta-winged aircraft, a paraglider or a hot air balloon not approved for public transport, as well as any other type of aircraft not approved for public transport, as well as accidents following skydiving or bungee jumping;
- The consequences of an accident following the insured person's participation in any sport or competition that involves the use of motor vehicles (including aircraft and boats);
- The consequences of a sporting accident where the insured person is paid for said sports activities and/or the practice of all sports as at a professional level;
- The consequences of an accident following the practice of any sporting activity in violation of the safety rules defined by the public authorities or by the international [or national] sports federation concerned in such a way that the insured person could not ignore the risks.

(h) *Forfeiture and suspension of benefits*

The Executive Committee may decide that a member or an insured person has forfeited all or part of his entitlement to benefits from the Society, or that such entitlement shall be wholly or partially suspended;

- If an insured person fails to comply with the provisions of these Statutes and Internal Rules;
- If it is established that the person concerned has attempted fraudulently to obtain benefits to which he or she was not entitled;
- If a member or one of the persons protected by the Society refuses to undergo a medical examination prescribed by the Committee or by the Medical Adviser;
- If the member is late in paying the premiums due after separation from service.

Rule IX

ADMINISTRATION AND APPEALS

ADMINISTRATION

1. As provided in the Statutes, the Secretary of the Society shall carry out such duties as are required by the Statutes and Internal Rules, and as may be further directed by the Executive Committee and the Director General of the United Nations Office at Geneva. He shall be responsible for the day-to-day management of the Society. All applications, communications, requests for information, complaints or suggestions concerning the functioning of the Society shall be directed to the Secretary, who in her/his disposition of these items shall take into account any instructions and guidelines he may have received from the Executive Committee.

2. Taking into account any guidelines given by the Executive Committee, the Secretary shall make appropriate arrangements with the Administration regarding such services as may be required for the operation of the plan, including the payment of claims. The costs of implementing these Internal Rules shall be borne by the Society in accordance with article 14 of the Statutes.

3. During its examination of the annual report, or, if necessary, in the course of a year, the Executive Committee shall study the need to adjust the ceilings.

APPEAL PROCEDURES

4. Should a member contest the amount of a payment, he shall have the right to submit his claim to the Secretary within one year from the date of issue of the reimbursement advice. In cases of doubt, the Secretary may submit the matter to the Executive Committee for determination.

5. Should a member contest a decision taken by the Executive Secretary or the Medical Adviser, she/he must submit the complaint to the Executive Committee for determination. Complaints must be submitted within six months of the date at which the contested amount or decision was notified to the member.

6. In the event of a medical dispute, the member or the Executive Committee may request the nomination of a Medical Review Committee consisting of the Medical Adviser, a doctor designated by the member and a third doctor designated by the first two. The third doctor's fees shall be borne equally by the insured person and by the Society. The parties shall be bound by the conclusions of that Medical Review Committee.

7. Complaints made against any decision of an administrative nature taken by the Society's Executive Committee may be addressed to the Director-General of the United Nations at Geneva within 30 days of the date at which the decision was notified in writing. The dispute shall be submitted to an Arbitration Committee composed of two arbitrators, one to be appointed by the member and the other either by the Director-General or, in the case of a specialized agency affiliated to the Society, by the Executive in charge of the affiliated agency. The arbitrators shall appoint a third person as Chair. The decision of the duly constituted Arbitration Committee shall be final and binding upon the two parties.

ANNEX I

SCALE OF CONTRIBUTIONS

SUBJECT TO THE PROVISIONS OF THESE RULES, THE RATES OF CONTRIBUTION ARE AS FOLLOWS:

CATEGORY OF PERSON INSURED	FROM 1 JANUARY 2016	
	PAYABLE BY THE INSURED PERSON	PAYABLE BY THE ORGANIZATION
Staff member only	3,4%	3,4%
Staff member with one dependent	4,4%	4,4%
Staff member with more than one dependent	4,8%	4,8%
Retired staff member only	3,4%	6,8%
Retired staff member with one dependent	4,4%	8,8%
Retired staff member with more than one dependent	4,8%	9,6%
SPECIALLY PROTECTED PERSONS		
Non-dependent spouse	CHF 500.-	-
Non-dependent unmarried child under 21 years of age	CHF 150.-	-
Dependent unmarried child from 21 to 24 years of age	CHF 150.-	-
Dependent unmarried child from 25 to 29 years of age	CHF 230.-	-
SECONDARY DEPENDENT		
Father, mother, brother or sister considered as secondary dependents	CHF 575.-	-

ANNEX II

PROCEDURES AND CONDITIONS GOVERNING THE SUBMISSION AND PROCESSING OF CLAIMS

PAYMENT OF BENEFITS

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 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.

(b) In case of death of member, the "nomination of a beneficiary" he had made as a staff member in accordance with the Staff Rules shall be valid for purposes of determining the beneficiaries to whom any benefits due by the Society shall be payable. If the deceased insured person was a member of the family of the member, the benefits due by the Society shall be payable to the member or to the person deemed to be the head of the family for the purposes of the Society.

(c) Benefits shall normally be paid only to the member. In exceptional circumstances they may be paid to the person who actually paid the expenditure in respect of which the claim is made.

(d) The Society, after agreement with the member and a provider of services, may decide to pay the amounts reimbursable directly to the latter. A statement of the amounts paid and of any outstanding amount due to the provider of services shall be sent to the member.

(e) The Society may deduct from any benefit due to a member under these Rules any amount owed to it by that member.

2. *Formalities and vouchers to be produced*

(a) Basic benefits

(i) Claims must be made on a special form and accompanied by originals of bills or accounts made out in the name of the insured person, Prior Authorizations by the Medical Adviser (if any) and the prescriptions, certificates, estimates and other documents referred to in annex III. Duplicates, reminders or photocopies are not acceptable for reimbursement purposes. No modification, erasure or overwriting is permitted on bills.

(ii) Members must pay the expenses giving entitlement to reimbursement under these rules. The Society may require presentation of documentary evidence that payment has been made.

(iii) Doctors' bills and other bills must state the number and dates of the medical acts performed and their nature (consultations, visits, type of treatment, analysis, number of days of hospitalization, etc.) and their detailed costs.

(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. Chemists' bills must state the names of the medicines purchased as well as the price and the date 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.

(v) Dentists' bills must specify the date of beginning and end of treatment, the type of dental treatment and the cost.

(vi) Other bills or accounts must also contain all the particulars necessary to enable reimbursement to be made.

(vii) Medical treatment may be reimbursed only if the person dispensing the services has the right to practice and has been approved by the competent health authorities in the country in which the treatment is provided.

(b) Supplementary benefits

(i) Claims submitted by members shall be used for the calculation and payment of both basic and supplementary benefits. The classification of benefits shall be effected by the Society

(ii) Supplementary benefits shall be paid automatically when the annual threshold referred to in rule **VIII 6** *(b)* (ii) is reached.

ANNEX III

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.7, 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/her claim.

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.

	CONDITIONS OF REIMBURSEMENT	APPLICATION OF SUPPLEMENTARY PLAN	PRIOR AUTHORIZATION	OTHER CONDITIONS
1. DOCTOR'S FEES				
a. Doctors' 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 1000 chf per year.
b. Outpatient medical fees in a medical establishment	**80%**	**YES**	**NO**	
2. SURGICAL OPERATIONS (subject to **VIII.4** and **VIII.7** of the Internal Rules)				
a. Surgeons' and attendants' fees	**90%**	**YES**	**NO**	
b. Other surgery related expenses (op. theatre, anesthesia, dressings, etc.)	**90%**	**YES**	**NO**	
c. Comprehensive flat-rate charge for hospitalization including doctors' fees under annex III, items 1 and 2, and charges for treatment and stay (minimum 2-bed ward)	**90%**	**YES**	**NO**	
3. HOSPITALIZATION IN AN APPROVED ESTABLISHMENT (subject to **VIII.4** of the Internal Rules) including medical care provided by the staff of the establishment and other services normally provided by the establishment				
a. Hospitalization in a public ward room of a public establishment (6 beds minimum)	**100%**	**NO**	**NO**	Reimbursement is normally limited to 30 days per hospitalization.
b. Hospitalization in a semi-private room in an establishment approved by the competent health authorities of the country concerned	**90%**	**YES**	**NO**	Any extension of the length of stay is subject to approval by the Society's Medical Adviser, who will determine whether the treatment is curative. Supplement for private room not reimbursable.

	CONDITIONS OF REIMBURSEMENT	APPLICATION OF SUPPLEMENTARY PLAN	PRIOR AUTHORIZATION	OTHER CONDITIONS
c. Hospitalization in a private room in an establishment approved by the competent health authorities of the country concerned	UP TO THE MAXIMUM AMOUNT REIMBURSED FOR A SEMI-PRIVATE ROOM	UP TO THE MAX REIMBURSED FOR A SEMI-PRIVATE ROOM	NO	
d. Hospitalization in an establishment not providing semi-private care, approved by the competent health authorities of the country concerned	75%	NO	NO	
e. Day hospital at a rate inclusive of all accommodation expenses	90%	YES	NO	

4. POST-HOSPITAL AND/OR POST-OPERATION CONVALESCENCE

(accommodation, care and treatment):

a. In a hospital or a semi-hospital establishment	80% UP TO 30 DAYS	YES	NO	Any extension of convalescence under 4, (a) is subject to approval by the Society's Medical Adviser. Supplement for private room not reimbursable.
b. In a hospital or a semi-hospital establishment for more than 30 days of convalescence for further treatment	80% MAX. CHF 60 / DAY	NO	YES	

5. BREAST SURGERY

-Breast Implant Removal	AS FOR ITEM 1, 2 AND 3	YES	YES	Only when medically necessary following an accident and/or a medical emergency.
-Breast reduction surgery for medical reasons	AS FOR ITEM 1, 2 AND 3	YES	YES	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. Cost estimate and medical report to be provided.

	CONDITIONS OF REIMBURSEMENT	APPLICATION OF SUPPLEMENTARY PLAN	PRIOR AUTHORIZATION	OTHER CONDITIONS
6. MEDICAL OR PARAMEDICAL BENEFITS RELATED TO A LONG-STAY IN A MEDICALIZED ESTABLISHMENT (INCLUDING NURSING AND GERIATRIC CARE AND OTHER SERVICES NORMALLY PROVIDED BY THE ESTABLISHMENT)	100% UP TO A MAXIMUM OF CHF 120.- PER DAY	NO	NO	
7. SHORT-TERM NURSING CARE	80%	NO	NO	Daily nursing care for a period exceeding 30 days is considered as long-term nursing care.
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	
9. HOME HELP **a.** Nursing or home help services required after an illness or an operation when convalescence does not entail hospitalization	80% MAXIMUM OF 30 DAYS AND OF CHF 45.- PER DAY	NO	NO	When prescribed by the attending doctor, specifying the person's health state of dependency. Individuals in receipt of home care or hygiene and mobility benefits (item 10) cannot cumulate these benefits.
b. Long-term home help services	80% UP TO A MAXIMUM OF CHF 250.- PER MONTH	NO	YES	

	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.
	PARTIAL DEPENDENCY: MAXIMUM 50% OF CHF 120.- PER DAY			

11. SPA CURES AT ESTABLISHMENTS APPROVED BY THE HEALTH AUTHORITIES OF THE COUNTRY CONCERNED:				
a. Costs of treatment	**80%**	**NO**	**YES**	Maximum of three cures over a period of 5 calendar years and of 21 days per stay.
b. Accommodation	**NOT REIMBURSED**	**NO**	**NO**	
NOT REIMBURSABLE: THALASSOTHERAPY, SLIMMING AND BIOLOGICAL CURES				

12. DETOXICATION TREATMENTS **a.** Detoxication treatments (alcohol, drugs) - Accommodation and/or treatment	**80% MAX IN AN ESTABLISHMENT APPROVED BY THE SOCIETY AND FOR A PERIOD APPROVED IN ADVANCE BY THE SOCIETY**	**NO**	**YES**	Lifetime maximum of three cures or treatments.
b. Stop smoking treatments	**80%**	**NO**	**NO**	

	CONDITIONS OF REIMBURSEMENT	APPLICATION OF SUPPLEMENTARY PLAN	PRIOR AUTHORIZATION	OTHER CONDITIONS
13. NUTRITIONAL TREATMENT				
a. For obesity BMI > 15 and < 30: medical treatment and sessions with an approved dietician	**80% MAX. CHF 70.- PER SESSION, MAX. 10 SESSIONS LIFETIME**	**NO**	**YES**	Upon doctor's prescription.
BMI < 15 or > 30: medical treatment and sessions with an approved dietician	**80% MAX. CHF 70.- PER SESSION, MAX. 10 SESSIONS LIFETIME**	**NO**	**NO**	
BMI > 35: medical treatment in hospital establishment and treatment costs	**80%**	**NO**	**YES**	Medical Advisor's Prior Authorization and approval of the duration.
BMI > 40: hospitalization and surgical procedures (if loss of weight > 35% of initial body weight, stabilized over 12 consecutive months, reconstructive surgery may be covered)	**AS FOR ITEM 1, 2 AND 3**	**YES**	**YES**	
b. Other medical conditions. Medical treatment and sessions with an approved dietician	**80% MAX. CHF 70.- PER SESSION, MAX. 10 SESSIONS LIFETIME**	**NO**	**YES**	Upon doctor's prescription.
14. PHARMACEUTICAL EXPENSES (subject to **VIII.7.g** of the Internal Rules)				
a. Products reimbursed according to the criteria of the competent health authorities of the country concerned	**80%**	**NO**	**NO**	The purchase of medication over internet is only reimbursed if bought over an internet site of the country of residence or of work of the member. Cross-border internet purchases are not reimbursable.
b. Recommended vaccinations	**80%**	**NO**	**NO**	
c. Homeopathic and phytotherapeutic products	**80% MAX. CHF 1,500.-/ YEAR**	**NO**	**NO**	
d. Products not reimbursed according to the criteria of the competent health authorities of the country concerned	**NOT REIMBURSED**			

	CONDITIONS OF REIMBURSEMENT	APPLICATION OF SUPPLEMENTARY PLAN	PRIOR AUTHORIZATION	OTHER CONDITIONS
e. Expensive medicine that costs at least CHF 500.- per month for a consecutive duration of at least 3 months	80%	YES	YES	Failure to submit a request for authorization in advance will result in the reimbursement at 80% without the application of the supplementary plan.
15. MEDICAL IMAGERY (X-RAYS, ETC.), LABORATORY ANALYSES AND TESTS	80%	YES	NO	
16. OTHER: INJECTIONS, RADIOTHERAPY AND OTHER SPECIALIZED TREATMENTS APPROVED BY THE MEDICAL ADVISER	80%	YES	YES	

17. FUNCTIONAL REHABILITATION TREATMENTS:

	CONDITIONS OF REIMBURSEMENT	APPLICATION OF SUPPLEMENTARY PLAN	PRIOR AUTHORIZATION	OTHER CONDITIONS
a. Physiotherapy, kinesitherapy, chiropractic, osteopathy, etiopathy, occupational therapy (ergotherapy), diathermy, ultrasounds, infrared, hydrotherapy, inhalations, fangotherapy. Acupuncture and mesotherapy treatments for functional rehabilitation purposes performed by the treating physician are reimbursed under the same conditions as functional rehabilitation treatments.	**80% MAX. CHF 70.- PER SESSION**	**YES AS FROM THE 31 ST 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.
b. Sessions of lymphatic drainage	**80%**	**YES**	**YES**	If the doctor's prescription mentions cancer, Prior Authorization is not required.

18. MENTAL AND DEVELOPMENTAL HEALTH:

a. Psychiatric or medico-psychological examination	**80% ONCE PER YEAR**	**YES**	**NO**	
b. Psychotherapy:				
i. Inpatient treatments:				
• Hospital charges	**PLEASE REFER TO CONDITIONS IN CASE OF HOSPITALIZATION IN AN APPROVED ESTABLISHMENT**	**YES**	**NO**	

	CONDITIONS OF REIMBURSEMENT	APPLICATION OF SUPPLEMENTARY PLAN	PRIOR AUTHORIZATION	OTHER CONDITIONS
• Treatment by a specialist who is not part of the staff of the hospital	**90% MAX.**	**YES**	**NO**	
ii. Outpatient treatments or day hospital consultations				
• consultations by a psychiatrist including remote /telehealth care so long as there is a valid medical prescription, and the therapist is qualified and recognized by the local authorities in the country where they practice.	**80% MAXIMUM 12 SESSIONS PER CALENDAR YEAR**	**YES**	**YES AS OF THE 13TH SESSION**	Consultations by a psychiatrist beyond 12 sessions per year must be presented to the medical adviser for Prior Authorization. The report must detail a medical reason as to why regular psychiatrist treatment is needed in lieu of psychotherapy. A psychiatrist who provides psychotherapy treatment will be reimbursed within the limits of psychotherapy. Psychiatry sessions beyond 12 sessions per calendar year will be reimbursed as psychotherapy (80% up to a maximum of CHF 120 per session) if there is no Prior Authorization of the Medical Adviser
• Psychotherapy (max 50 sessions per annum) including remote /telehealth care so long as there is a valid medical prescription and the therapist is a qualified and recognized therapist in the country where they practice.	**80% MAX CHF 120.- PER SESSION**	**NO**	**NO**	A medical prescription by a Medical Doctor is imperative for psychotherapy sessions to be considered for reimbursement. The maximum number of sessions mentioned may be waived if the seriousness of the case so justifies, on the recommendation of the Medical Adviser.

	CONDITIONS OF REIMBURSEMENT	APPLICATION OF SUPPLEMENTARY PLAN	PRIOR AUTHORIZATION	OTHER CONDITIONS
• Emergency/Crisis psychiatrist visits in a medicalized establishment	**80%**	**YES**	**NO**	
• Therapies to help individuals with autism spectrum disorder (ASD), such as, but not limited to: Applied Behavior Analysis (ABA), Play Therapy, Relationship Development Initiative (RDI), Sensory Integration and Related Therapies and any other clinically proven ASD therapy. ***PLEASE NOTE:*** *Psychotherapy and Psychiatry sessions that are part of ASD treatment are reimbursed in accordance with Psychiatry and Psychotherapy reimbursement rules.* *Occupational Speech therapy and Psychomotricity sessions that are part of ASD treatment are reimbursed in accordance with the rules governing these benefits.*	**80%**	**YES**	**YES**	A medical prescription by a Medical Doctor is imperative for psychotherapy sessions to be considered for reimbursement. If the insured person is younger than 18 years, there is no limit on the number of treatment sessions. If the insured person is older than 18 years, the maximum number of sessions mentioned may be waived if the seriousness of the case so justifies, on the recommendation of the Medical Adviser.
c. Sleeping cures in an establishment with agreement of UNSMIS	**80% (TIME LIMIT)**	**NO**	**YES**	
d. Day hospital accommodation charges	**NOT REIMBURSED**			

19. LOGOPAEDICS, SPEECH THERAPY AND/OR PSYCHOMOTOR TREATMENTS UNRELATED TO LEARNING DIFFICULTIES	**80% MAX CHF 80.- PER SESSION**	**NO**	**YES**	Submission to the Society of an assessment by an approved logopaedist or speech therapist based on a doctor's prescription.

	CONDITIONS OF REIMBURSEMENT	APPLICATION OF SUPPLEMENTARY PLAN	PRIOR AUTHORIZATION	OTHER CONDITIONS
 **20. MEDICAL APPLIANCES** **a.** Prosthetic appliances (other than dental)	**80%**	**NO**	**NO FOR WALKERS, CORSETS, MANDIBULAR PROSTHESES, WIGS IN CASE OF CANCER, PURCHASE AND RENTAL OF BREAST PUMPS, INSULIN PUMPS, BLOOD GLUCOSE METERS AND STRIPS** **YES FOR ORTHOPEDIC SHOES, ELECTROSTIMU-LATION AND LIGHT THERAPY LAMPS**	Upon doctor's prescription. Prosthetic appliances not listed here require Prior Authorization. Heal and sole fittings purchases in pharmacy or specialized store are not reimbursable.
b. Made-to-measure orthopedic arch supports with medical prescription	**80% MAX. CHF 200.- MAX. ONE PAIR EVERY YEAR**	**NO**	**NO**	Internet purchases (even cross-border) for prosthetic appliances are reimbursable so long as supported by a medical doctor's prescription and the Prior Authorization of Medical Adviser if required.
c. Lumbar support belts, neck braces (minerva jackets) joint support appliances with medical prescription	**80% MAX. CHF 300.- PER ITEM**	**NO**	**NO**	
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. Any electrical device attached to a manual wheelchair will be considered under the electric wheel chair reimbursement, cumulatively with the manual wheel chair.

	CONDITIONS OF REIMBURSEMENT	APPLICATION OF SUPPLEMENTARY PLAN	PRIOR AUTHORIZATION	OTHER CONDITIONS
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**	
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**	
e. Hearing aids, excluding replacement in case of loss or breakage	**80% MAX. CHF 2,600.- PER HEARING AID/PER EAR, MAX. ONE APPLIANCE EVERY 5 YEARS INCLUDING REPAIR COST AND BATTERIES**	**NO**	**NO**	The use of the device must be certified as necessary by an otologist and the prescription must be accompanied by an audiogram.
f. Breathing device (nCPAP)				Upon doctor's prescription.
• Initial trial period	**80% MAX. 6 FIRST MONTHS**	**NO**	**NO**	
• Purchase or long term rental	**80% MAX. CHF 2,800.- EVERY 5 YEARS INCLUDING REPAIR COST AND BATTERIES**	**NO**	**NO**	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**	

	CONDITIONS OF REIMBURSEMENT	APPLICATION OF SUPPLEMENTARY PLAN	PRIOR AUTHORIZATION	OTHER CONDITIONS
21. OPTICAL CARE				
a. Corrective eyeglasses (including contact lenses, bifocal or trifocal lenses or progressive lenses or any other corrective lens) provided that they are certified as necessary by an oculist, ophthalmologist, optician or optometrist. The prescription or invoice must indicate the corrective value in diopters. The eye exam done by an optician is not reimbursable.	**80% MAX. CHF 525.-/ YEAR CUMULATIVE OVER TWO CALENDAR YEARS**	**NO**	**NO**	In case of new membership, the reimbursement maximum is in proportion to the number of months of coverage. In the case of a previous affiliation of at least 2 years with another health insurance plan of the United Nations system, the full annual credit given will be available from the first day of affiliation. Cross-border internet purchases are reimbursable.
b. Cataract surgery • Supplement for specific lens is reimbursed under item **21 a.** • Femtocataract (laser surgery)	**90% MAX. CHF 2,500.-/ EYE** **90% MAX. CHF 1,500.-/ EYE**	**NO** **NO**	**NO** **YES**	
c. Refractive surgery of the cornea (laser surgery)	**80% MAX. CHF 2,000.-/ EYE IN THE LIFESPAN**	**NO**	**NO**	Refractive surgery for presbyopia is not reimbursable.
d. Intravitreal injection (doctor fees) The medication for the intravitreal injection is reimbursed as medication as detailed in item **14 e.**	**80% MAX. CHF 500.- FOR DOCTOR FEES**	**NO**	**NO**	
e. Canes, Smart Canes, Braille Printers, Screen readers, and any technology-based device that assists in the reading and mobility of a legally recognized blind / visually impaired individual	**80% MAX CHF 3,500 EVERY 5 YEARS INCLUSIVE OF REPAIR COSTS**	**NO**	**YES**	Canes and Smart Canes do not need a Prior Authorization. Braille Printers and other technology-based devices will need the Prior Authorization of the medical advisor and proof that the insured member I legally recognized as blind/ visually impaired

	CONDITIONS OF REIMBURSEMENT	APPLICATION OF SUPPLEMENTARY PLAN	PRIOR AUTHORIZATION	OTHER CONDITIONS
 **22. ODONTO-STOMATOLOGICAL TREATMENT (DENTAL TREATMENT) AND LABORATORY CHARGES FOR DENTURES, PROSTHETIC DENTAL FEES AND RADIOLOGY/RADIOGRAPHY FEES**	**80% MAX. CHF 2,500.-/ YEAR CUMULATIVE OVER TWO CALENDAR YEARS**	**NO**	**NO**	New members accrue the annual maximum on a monthly pro-rata basis. Individuals affiliated at least 2 years with another health insurance plan of the United Nations system, will received the full annual credit from the first day of affiliation. In the event of accident or severe illness, reimbursement beyond the annual ceiling can be considered as medical treatment following the Prior Authorization of the Medical Adviser. Medical implants and possible bone grafts necessary for the implants are reimbursable within the annual credit limit.
 **23. ORTHODONTIC TREATMENT, INCLUDING THE COST OF THE APPARATUS**	**80% UP TO THE MAXIMUM OF DENTAL CREDITS (ITEM 22)**	**NO**	**NO**	
 **24. MAXILLO-FACIAL SURGERY IN THE EVENT OF HOSPITALIZATION REPARATIVE MAXILLO-FACIAL SURGICAL OPERATIONS LISTED BELOW PERFORMED BY SPECIALIZED MAXILLO-FACIAL SURGEONS ARE REIMBURSED BY UNSMIS WITH THE PRIOR APPROVAL OF THE MEDICAL ADVISER:** • cranio-facial malformation • facial fissures • orthograthics • bone grafts • temporo-mandibular articulation	**90%**	**YES**	**YES**	

25. REPRODUCTIVE HEALTH

	CONDITIONS OF REIMBURSEMENT	APPLICATION OF SUPPLEMENTARY PLAN	PRIOR AUTHORIZATION	OTHER CONDITIONS
a. Prenatal Diagnostics	**80%**	**YES**	**NO**	Genetic test require Prior Authorization
b. Preparation for birth/delivery	**80% MAX. 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 and nursing fees **i.** Obstetrician or midwife's fees and nursing fees	**90%**	**YES**	**NO**	Obstetrician or midwife's fees and nursing fees during a hospital delivery are reimbursed as per Item 3, Hospitalization in an approved establishment
ii. After the delivery, 6 sessions or visits by a midwife or nurse	**80%**	**YES**	**NO**	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.

	CONDITIONS OF REIMBURSEMENT	APPLICATION OF SUPPLEMENTARY PLAN	PRIOR AUTHORIZATION	OTHER CONDITIONS
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, 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	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 recognised specialised centre. 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 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.

	CONDITIONS OF REIMBURSEMENT	APPLICATION OF SUPPLEMENTARY PLAN	PRIOR AUTHORIZATION	OTHER CONDITIONS
›				(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.

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.

	CONDITIONS OF REIMBURSEMENT	APPLICATION OF SUPPLEMENTARY PLAN	PRIOR AUTHORIZATION	OTHER CONDITIONS
27. TRANSPORT Repatriation costs are not reimbursable. Transportation costs by a private care 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**	
d. Expenses for rescue (help and evacuation) if not related to a sporting activity that was done in violation of the safety rules defined by the public authorities or by the international [or national] sports federation concerned in such way that the insured person could not ignore the risks. The transport must be made by a means which corresponds to the medical requirements of the case.	**50% MAX. CHF 5,000.- PER YEAR**	**NO**	**NO**	
28. FUNERAL EXPENSES				
As far as they are not paid in full or in part by the Organization	**80% MAX CHF 1,000.-**	**NO**	**NO**	

ANNEX IV

SECONDARY DEPENDENTS

Benefits payable in respect of a dependent father, mother, brother or sister, insured in accordance with **rule IV** of the Internal Rules of the Society, shall be subject to the following procedure:

BENEFITS

The benefits payable shall include only basic benefits. The supplementary plan shall not be applicable. Benefits shall be paid in accordance with the procedure laid down by the Internal Rules of the Society and shall be calculated in the manner specified in **annex III** of these Rules, except for those benefits which are subject to an exclusion, limitation or waiting period as described below:

Exclusions: No benefit shall be paid for the following:

- Medical or paramedical benefits related to a long-term stay in a medicalized establishment or at home (item **6**)
- Long-term nursing care (item **8**)
- Nursing and home-help charges (item **9**)
- Benefits for care in the home (nursing or home health services): assistance with hygiene and mobility (item **10**)
- Cures (items **11** and **12**)
- Sessions with a dietician (item **13 (b)**)
- Maxillo-facial operations (item **24**).

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**)
- Mental and Developmental health (item **18**)
- Prosthetic appliances (item **20 (a)**)
- Hearing aids (item **20**)
- Eyeglasses (item **21 (a)**)
- Dental treatment (item **22** and **23**).

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

- Dental treatment (item **22** and **23**). 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.–.

Secondary dependents can enroll within 31 days of recognition of the dependency, upon joining duty station or during the annual enrolment campaign.

ANNEX V

PLAN FOR TEMPORARY STAFF WITH CONTRACTS OF A DURATION OF LESS THAN THREE MONTHS

CONDITIONS OF ADMISSION TO THE TEMPORARY PLAN OF THE SOCIETY AND PERIOD OF COVERAGE

Staff members holding a temporary appointment of a duration of less than three months may seek coverage under the Temporary plan of the Society. Holder of temporary appointments initially of less than three months cannot insure the members of their families.

The period of insurance coverage extends from the first to the last day of the employment contract, inclusive. The member of the Temporary plan cannot retain insurance coverage following the date of expiration of her/his contract, and expenses incurred after that date will not be reimbursed by the Society.

Benefits paid to staff insured under **Rule III 2.** of the Internal Rules of the Society shall be subject to the following procedure.

BENEFITS

Benefits shall be payable only for sickness or accident occurring in the course of employment and shall comprise only basic benefits. The supplementary benefits plan shall not apply. Benefits shall be paid in accordance with the procedure laid down by the Internal Rules of the Society and shall be calculated in the manner specified in **annex III** of these Rules, except for those benefits which are subject to an exclusion or limitation as prescribed below:

Exclusions: No benefit shall be paid for the following:

- Medical or paramedical benefits related to a long-term stay in a medicalized establishment (item **6**)
- Long-term nursing care (item **8**)
- Nursing and home-help charges (item **9**)
- Benefits for care in the home (nursing or home-health services): assistance with hygiene and mobility (item **10**)
- Cures (items **11** et **12**)
- Treatments for obesity (item **13 (a)**)
- Mental and Developmental health (item **18**)
- Medical appliances (item **20**)
- Hearing aids and breathing device (item **20**)
- Optical care (item **21**)
- Dental treatment (item **22** and **23**), 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**)

- Reproductive health (item **25**)
- Transport (item **27**)
- Funeral expenses (item **28**)

Overall reimbursement ceiling: The overall amount of benefits paid by the Society shall be subject to a ceiling of CHF 20,000.- per accident or case of sickness and/or hospitalization.

EXTENSION OF COVERAGE AFTER THREE MONTHS

Any person who has been affiliated for an uninterrupted period of three months under the Temporary plan of the Society becomes eligible for joining the main plan of the Society with the same medical benefits as members holding permanent, continuing, fixed-term and temporary contracts of more than three months. In case a holder of a temporary contract is extended for a cumulative duration of three months or more, the staff member may also enroll her/his eligible family members in the main plan of the Society, this at the same time she/he enrolls her/himself to the main plan.

ANNEX VI

RESERVES AND PROVISIONS

Article 13 of the Statutes clearly defines the minimum and maximum amounts of the reserve fund.

The creation of any ad hoc reserve or provision will have to be approved by the Director General of UNOG following a recommendation of the Executive Committee of UNSMIS.

ANNEX VII

BRIDGING MECHANISM

Due to expected downsizing/organizational restructuring of organizations participating in UNSMIS, the Executive Committee has recommended, and the Director-General UNOG agreed, to implement a bridging mechanism for ASHI eligibility.

In order to be considered eligible for the bridging mechanism the insured member must:

- Be subject of an agreed termination or abolition of post.
- Be at least 50 years of age but less than 55 years of age at the time of separation.
- Have at least 10 years of cumulative participation in a health insurance scheme of an agency signatory to the Inter-Organization Agreement concerning Transfer, Secondment or loan of Staff among the Organizations applying the UN Common System of Salaries and Allowances. Participation as a temporary staff does not count towards the 10-year vesting period.
- Be a holder of a fixed term, continuing or permanent appointment at the time of separation.
- Be eligible and elect to receive a periodic benefit from the UNJSPF.
- Apply for the bridging mechanism prior to separation or within 30 days thereafter.

Financial obligations:

- Individuals eligible for the bridging mechanism and who request it, will be responsible for contributing their share and the organization's share of the monthly health insurance premium until reaching the age of 55, where they will be eligible to request ASHI. Individual participating Organizations may choose to continue paying the Organization's share of the premium.
- Full Payment Requirement: The total insurance premium (both participant and organizational shares) must be paid in full for coverage to remain effective.
- Premiums should be paid in advance (quarterly, biannually, or annually) to ensure uninterrupted coverage.
- In the event of re-employment during the bridging period, the member must notify UNSMIS immediately to terminate the bridging mechanism.

Administrative considerations:

- Enrollment in the bridging mechanism is optional and must be formally requested by the staff member.
- Coverage during the bridging period is contingent upon timely premium payments.
- Upon reaching age 55 and meeting ASHI eligibility, the insured member is responsible for requesting ASHI as per standard procedure.
- Any interruption in coverage will void ASHI eligibility.

The possibility to opt for a bridging mechanism will expire on 31 December 2026. After this date this Annex will be deleted. Should the Executive Committee feel the need for the mechanism to be extended beyond said date, a new recommendation will be presented to the Director-General, UNOG.

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