Rules of the CERN Health Insurance Scheme

1st June 2014 Edition

Revised 1st November 2016
Preamble

The Director-General of the European Organization for Nuclear Research,

Considering the Convention establishing the European Organization for Nuclear Research (CERN) signed in Paris on 1 July 1953, as amended on 17 January 1971;

Considering Article 21 of the Agreement between the Swiss Federal Council and CERN establishing the legal status of the Organization in Switzerland, signed on 11 June 1955, under which the Organization is exempt from all compulsory contributions to general social protection schemes, on the understanding that the Organization will so far as possible and under conditions to be agreed upon, insure with Swiss insurance funds those of its agents who are not assured an equivalent social protection by the Organization itself;

Considering Article 1 of the Agreement between the Government of the French Republic and CERN, signed on 30 December 1970, under which members of the personnel of the Organization are exempt from French laws relating to social security and family allowances and under which the Organization undertakes to protect the members of its personnel against the financial consequences of illness, maternity, occupational illnesses and accidents, disability and old age within the provisions of the social protection scheme it has set up;

Considering the provisions of the CERN Health Insurance Scheme, as previously laid down in the Health Insurance Agreement 605/ADM between CERN and the Austria insurance company;

Considering the Council decision of 18 June 1999 to modify the administration of the CERN Health Insurance Scheme by approving a new contract for the administration of the said Scheme replacing the Agreement 605/ADM;

Considering the need to set out in a separate document the "Rules of the CERN Health Insurance Scheme" including the general principles, the contributions and the benefits of the CERN Health Insurance Scheme, as previously laid down in Agreement 605/ADM, initially approved by the Council of the Organization on 6 October 1970;

Considering the Council decision of 15 December 2000 to introduce cover against the risks associated with dependence (long-term care) into the CERN Health Insurance Scheme;

Considering the provisions of Chapter IV of the CERN Staff Rules and Regulations entitled "Social insurance cover";

Considering that the Council of the Organization, in accordance with the Staff Rules, fixes the contributions of the Organization as well as the benefits and contributions of the members of the personnel relating to social insurance measures taken by the Organization;

Considering the Council decision of 16 December 2010 to make certain modifications to the contributions payable to the CERN Health Insurance Scheme and to authorize the Director-General to take timely measures to limit the increase of the CERN Health Insurance Scheme expenses by encouraging the use of health care providers and treatments which provide the best quality-to-cost ratio.

Hereby adopts the "Rules of the CERN Health Insurance Scheme", as amended on 1 June 2014.
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Chapter I – General Provisions

Section 1 – General Provisions

I 1.01 MANAGEMENT OF THE SCHEME

The Director-General shall be responsible for the management of the Scheme and shall determine and implement the relevant associated structures.

The benefits and contributions shall be decided by the Council on the proposal of the Director-General following discussion at the Standing Concertation Committee, pursuant to Article S IV 2.07 of the Staff Rules. The Director-General is authorised by the Council to take timely measures to contain the increase of expenditure of the Scheme by encouraging use of healthcare providers offering the best value for money.

I 1.02 RULES

The Rules of the Scheme shall be adopted and amended by the Director-General on the basis of the decisions concerning contribution levels and benefits taken by the CERN Council.

I 1.03 OBJECTIVE OF THE SCHEME

The objective of the CERN Health Insurance Scheme, hereafter referred to as "the Scheme", is to safeguard its Members against the financial consequences of illnesses, accidents and maternity by providing for reimbursement of expenses resulting from medical treatment, in accordance with the conditions laid down in these Rules.

Under certain circumstances, the Scheme safeguards its Members against the financial consequences of disability.

I 1.04 MUTUALITY

The Scheme, to which the Organization and the Members contribute, is based on the principle of mutuality.

I 1.05 AUTHENTIC VERSION

Both the English and French texts of these Rules shall be authentic.

I 1.06 GENDER

Reference to Members in the masculine gender shall apply equally to both sexes, except where it is clear from the context that the provisions relate exclusively to either men or women.

I 1.07 CONFIDENTIALITY

Any document or information containing personal administrative or medical data relating to a Member shall be treated confidentially.

Persons having access to such personal data in the exercise of their functions are bound by professional secrecy and may not communicate the content of the information to which they have access to unauthorized persons.

In particular, professional medical secrecy shall be preserved.

I 1.08 INTERPRETATION OF THE RULES

The provisions of the present Rules shall be interpreted in accordance with their terms and purpose.

In the event of difficulty in applying these Rules, notably in the event of silence of the texts, reference may be made subsidiarily and by analogy to Swiss and/or French legislation governing social security and health insurance matters.

I 1.09 ADMINISTRATION AND DECISIONS

The administration of benefits shall be entrusted to a specialist contractor (hereafter the “Third-Party Administrator”), as defined in Article II 1.20. The Third-Party Administrator is mandated to apply the present Rules in accordance with the provisions of the contract for the administration of the Scheme concluded with the Organization.

The administration of the contributions shall be under the overall responsibility of the CERN department responsible for finance.

All decisions pursuant to these Rules shall be taken on behalf of the Director-General of the Organization.
I 1.10
TYPES OF INSURANCE COVER

The Scheme provides for three types of insurance cover for non-occupational illnesses and accidents:

- Normal Health Insurance Cover (see Chapter III).
- Reduced Health Insurance Cover (see Chapter IV).
- Short-term Health Insurance Cover (see Chapter V).

The Scheme also provides cover for occupational illnesses and accidents in accordance with the provisions set out in Chapter VI.
Chapter II – Definitions

Section 1 – Definitions

II 1.01 ILLNESS
Any certified impairment of a Member's health, including his mental health, which affects him against his will and is not caused by an accident.

II 1.02 ACCIDENT
Any event due to the action of a sudden and external force, irrespective of its nature and origin, affecting a Member against his will, causing certified physical injury.

Any personal physical effort resulting in physical injury to a Member is regarded as an accident.

Provided that they are not obviously caused by illness or degenerative phenomena, the following bodily injuries in the list below, which is exhaustive, shall be deemed to be the result of an accident, even if they are not caused by a sudden, external force:

- fractures;
- strains;
- sprains and pulled muscles;
- dislocated limbs;
- injuries to ligaments;
- eardrum injuries;
- injuries resulting from a fall;
- back pain and hernia resulting from physical strain;
- severe injuries resulting from radiation;
- electric shocks, including those caused by lightning;
- asphyxia, intoxication caused by gas or fumes, poisoning or burns caused by the involuntary absorption of poisonous or corrosive substances;
- drowning caused by immersion hypothermia;
- death caused by a circulatory condition.

The contents of this list, which derives from Article 9 of the Swiss Federal law on Accident Insurance (OLAA) of 20 December 1982, shall be automatically adapted to reflect any changes in this article. This Law may be consulted on the internet site of the Swiss Confederation: http://www.admin.ch

II 1.03 OCCUPATIONAL ILLNESSES AND ACCIDENTS
Any illness contracted or any accident suffered by a member of the CERN personnel that the Organization deems to be of occupational origin.

II 1.04 DEPENDENCE
Permanent or long-term inability to perform the ordinary functions of everyday life unaided.

II 1.05 MATERNITY
The physical condition of a woman from conception to childbirth and all medically related occurrences resulting therefrom.

II 1.06 MEDICAL TREATMENT
All examinations carried out and all treatment given with a view to restoring or preserving health and/or physical integrity. Vaccination is also considered to be medical treatment. The treatment must be recognized as medical treatment by the competent health authorities of the State in which it is provided.

II 1.07 HOSPITAL
Any establishment providing medical, surgical or functional rehabilitation treatment recognised as a hospital by the competent health authorities of the State concerned.

II 1.08 PUBLIC HOSPITAL
Any hospital recognised as public by the competent health authorities of the State concerned.

II 1.09 PRIVATE HOSPITAL
Any hospital that does not correspond to the definition in Article II 1.08.
II 1.10 APPROVED HOSPITAL
Any public hospital as defined in Article II 1.08, or
Any private hospital:
– in Switzerland, provided that it has concluded a tariff agreement with the Scheme;
– outside Switzerland, provided that it has concluded a tariff agreement with the national social security scheme and that it applies similar tariffs for medical treatment and accommodation to the Members of the Scheme.

II 1.11 UNAPPROVED HOSPITAL
Any hospital that does not correspond to the definition in Article II 1.10.

II 1.12 SPECIALISED INSTITUTION
Any establishment, other than a hospital, providing patients with care, medical assistance and rehabilitation measures for long periods (medico-social establishments (MSE) or any similar type of facility).

II 1.13 MEDICAL PRACTITIONER
Any physician qualified and licensed by the competent national authority to exercise his profession in the State in which the treatment is provided.

II 1.14 CERTIFICATION
Provision of a certificate provided by a medical practitioner attesting to a specific medical condition affecting a Member’s state of health.

II 1.15 CONSOLIDATION
Certification that no further improvement in the patient’s state of health can be expected from appropriate medical treatment.

II 1.16 CURE
Certified disappearance of the impairment of the patient’s state of health resulting from an illness or accident.

II 1.17 RELAPSE
Certified worsening of the patient's state of health resulting from an illness or accident, not attributable to external factors, occurring within 10 years from the date of consolidation and necessitating medical treatment.

II 1.18 MEDICAL AUXILIARY
Any person qualified and licensed by the competent national authority in the State in which the treatment is provided to dispense treatment on the basis of a medical prescription and assist the medical profession in treating and caring for the victims of illnesses or accidents.
The acts performed by medical auxiliaries must be consistent with the medical prescription.

II 1.19 HOME-NURSE
Any person qualified to assist dependent persons in performing the ordinary functions of everyday life.

II 1.20 THIRD-PARTY ADMINISTRATOR
The company with which the Organization has concluded a contract for the administration of the Scheme.

II 1.21 MEMBER
Any Main Member (see Article II 1.22) and the members of his family (see Article II 1.23) as defined in these Rules, unless otherwise specified.

II 1.22 MAIN MEMBER
Any member of the CERN personnel for whom membership of the Scheme is compulsory under the terms of his contract of employment or association with the Organization, and any person fulfilling the necessary conditions to opt for membership of the Scheme and having opted for membership under the provisions of these Rules.

II 1.23 FAMILY MEMBER
Any member of the family of the Main Member as defined by the CERN Staff Rules and Regulations. In these Rules, the term “spouse” shall mean either the spouse in the case of marriage or the partner in the case of a registered partnership recognized by the Staff Rules and Regulations. Similarly, the terms “marriage” and “divorce” are considered to be synonymous with "partnership" and "annulment of the partnership".

II 1.24 MAIN CONTRIBUTION
Obligatory contribution paid by the Main Member of a family or, where both spouses are Main Members of the Scheme, by the Main Member who is in receipt of the higher income.

II 1.25 SUPPLEMENTARY CONTRIBUTION
Contribution payable in addition to the main contribution in certain circumstances where both spouses have an income or a retirement pension deriving from a professional activity.
II 1.26  
INCOME
Any remuneration, salary, honoraria or fees deriving from a professional activity.
Unemployment and maternity benefits are not regarded as income.

II 1.27  
RETIREMENT PENSION
Any payment from an old age insurance scheme.
Invalidity pensions are not regarded as retirement pensions.

II 1.28  
SIMILAR HEALTH INSURANCE
The following are regarded as similar health insurance:
- subject to the bilateral agreements between Switzerland and the European Union, any health insurance provision under a national scheme of a Member State of the European Union;
- any individual or collective private health insurance providing benefits and levels of reimbursement in the State in which the member resides that are at least equivalent to those guaranteed by the Swiss Federal Law on Health Insurance (LAMal).

II 1.29  
COSTS BORNE BY THE INSURED MEMBER (referred to hereinafter by the French acronym FCA)
The non-reimbursed part of the expenses, up to the applicable ceiling, for the items covered by the General Reimbursement Rule.

II 1.30  
GENERAL REIMBURSEMENT RULE
Rule defining the reimbursement rates according to the Costs Borne by the Insured Member (FCA) cumulated by the Member over a calendar year.
Details of the reimbursement rates according to the FCA are set out in Articles A I 1.01 and A III 1.01.

II 1.31  
BONUS
An increase in the reimbursement rate as defined in Articles A I 1.01 and A III 1.01 for some benefits covered by the General Reimbursement Rule, provided that the reimbursement rate does not exceed 100%.
Details of the amount of the bonus and the items to which it applies are provided in the table of benefits covered by Normal Health Insurance Cover in Annex I and in the table of benefits covered by the Short-Term Health Insurance Cover in Annex III.

Chapter III – Normal Health Insurance Cover

Section 1 – General Description
The Normal Health Insurance cover provides for reimbursement of a major portion of the reasonable and customary expenses resulting from medical treatment that have been incurred by Members benefiting from this cover under the conditions specified in these Rules.
The Normal Health Insurance also provides for a death benefit and long-term care benefits, as well as an allowance for reduced earning capacity of family members.

Section 2 – Membership
Membership of the Normal Health Insurance is compulsory for:
- staff members, fellows and apprentices, except during periods of special unremunerated leave lasting one complete calendar month or more;
- students, except during periods of unpaid absence lasting one complete calendar month or more.
III 2.02
VOLUNTARY MEMBERSHIP OF MAIN MEMBERS

The following persons may opt for membership of the Normal Health Insurance irrespective of the State in which they reside:

- associates and users, aged below 65, whose contract of association with the Organization runs for three months or more;
- beneficiaries of the CERN Pension Fund who have opted to remain Members of the Scheme without interruption since the departure of the Main Member from CERN;
- former CERN staff members who have opted for a deferred pension and to remain Members of the Scheme without interruption since their departure from CERN;
- staff members and fellows for any period of special unremunerated leave lasting one complete calendar month or more;
- students for any period of unremunerated absence lasting one complete calendar month or more;
- children of a Main Member who are no longer dependent within the meaning of the CERN Staff Rules and Regulations and who are less than 26 years of age. Their membership remains dependent on that of the Main Member.

III 2.03
FAMILY MEMBERS

With the exception of apprentices' family members and of children who are no longer dependent, family members (as defined by the CERN Staff Rules and Regulations) of a Main Member are Members benefiting from the Normal Health Insurance cover through the Main Member.

However, a family member who himself belongs to a category of the CERN personnel and whose membership of the Normal Health Insurance is compulsory is considered as a Main Member within the meaning of Article II 1.22.

III 2.04
CONTINUATION OF COVERAGE

The following categories of Members, in the event that their entitlement to cover under the Normal Health Insurance ceases for any reason, except in the event of exclusion from the Scheme under Article VII 4.11, may remain Members of the Scheme for a further maximum period of 12 months upon request, provided that they are not entitled to opt for membership under the terms of Article III 2.02:

- staff members, fellows, students or apprentices; the members of their families are covered in accordance with the conditions in Article III 2.03;
- in the event of divorce, the ex-spouse and his dependent children who are considered as family members of the Main Member on the date the divorce became final;
- in the event of death of the Main Member, the members of his family at the time of his death.

Notwithstanding the foregoing, former staff members receiving unemployment benefits from the Organization may remain Members for a further maximum period of 60 weeks.

Section 3 – Territorial Scope

The Members are covered for expenses resulting from medical treatment anywhere in the world. The provisions of Article VII 4.07 shall apply.
Section 4 – Benefits

The cost of medical treatment and accommodation shall be reimbursed in accordance with the General Reimbursement Rule enshrined in Article II 1.30, except:

- in the case of hospitalisation in a public hospital as defined in Article II 1.08, in which case these costs are 100% reimbursed, except where hospitalisation is in the private or semi-private sector of the hospital. In this latter case, the General Reimbursement Rule shall apply.
- in the case of hospitalisation in an unapproved hospital, as defined in Article II 1.11, in which case these costs are 80% reimbursed.

Doctors’ fees during hospitalisation shall be reimbursed according to the conditions in force in the hospital concerned.

In any event, the supplement for accommodation and board in a single-bed ward invoiced by the hospital shall be exclusively borne by the Member.

All other medical expenses subject to reimbursement as well as the rates and ceilings are specified in Annex I of these Rules.

The maximum amounts of expenses that can be reimbursed per item (ceilings) are determined annually by CERN for application as from 1 January of the following year.

In the event of death of a CERN staff member, or of a member of his family (within the meaning of the CERN Staff Rules and Regulations), an indemnity is paid in accordance with Annex I of these Rules.

Any Member suffering permanent or long-term inability to perform the ordinary functions of everyday life unaided may apply to receive long-term care benefits under the conditions specified in Annex V of these Rules.

Payment of an allowance for reduced earning capacity may be claimed under the conditions specified in Annex II of these Rules.

Section 5 – Contributions

The main and supplementary contributions for Normal Health Insurance cover are expressed as a percentage (Article III 5.09 and Article A IV 1.01) of the Member's Reference Salary (Chapter IX, Section I).

The rate of contribution and its apportionment between the Organization and the Member are specified in Annex IV, Section I of these Rules.
III 5.03 MAIN CONTRIBUTION

Unless otherwise specified in Articles III 5.05 and III 5.07, a main contribution is payable for each Main Member. The main contribution is the product of the contribution rate indicated in Article A IV 1.01 and the following reference salaries:

- Staff members, fellows, students: Reference Salary I
- Associates, users, former CERN staff members who have opted for a deferred pension and to remain Members of the Scheme without interruption since their departure from CERN: Reference Salary II
- Apprentices: 50% of Reference Salary II
- Children of a Main Member who are no longer dependent: 40% of Reference Salary II
- Beneficiaries of the CERN Pension Fund: Reference Salary III

III 5.04 PAYMENT OF THE MAIN CONTRIBUTION

The main contribution payable by a staff member, fellow, paid associate, student or beneficiary of the CERN Pension Fund is deducted each month from the remuneration or payment received from the Organization or from the pension received from the CERN Pension Fund.

In all other cases, the main contribution is paid by the Member to the designated bank account of the Scheme each month in advance.

III 5.05 MAIN OR SUPPLEMENTARY CONTRIBUTION

Where both spouses are either staff members or fellows, the main contribution is payable in respect of the spouse working full-time whereas the supplementary contribution is payable in respect of the spouse working part-time.

Where both spouses work full-time or both work part-time, the main contribution is payable in respect of the spouse whose remuneration calculated on the basis of Reference Salary I gives the higher contribution, whereas the supplementary contribution is payable in respect of the other spouse.

Where both spouses are beneficiaries of the CERN Pension Fund, the main contribution is payable in respect of the spouse whose pension calculated on the basis of the Reference Salary III gives the higher contribution, whereas the supplementary contribution is payable in respect of the other spouse.

III 5.06 NO CONTRIBUTION

Unless otherwise specified in Articles III 5.03 and III 5.07, no contribution is payable in respect of family members (as defined in the CERN Staff Rules and Regulations) of the Main Member.

III 5.07 SUPPLEMENTARY CONTRIBUTION

The supplementary contribution, payable in respect of the Members listed below, is the product of the contribution rate(s) indicated in Article A IV 1.02 and the following reference salaries:

1. Staff members and fellows, married to a staff member or a fellow paying the main contribution based on Reference Salary I: Reference Salary IV

2. The spouse:
   - of a staff member, fellow or beneficiary of the CERN Pension Fund, and
   - who is not a staff member, fellow, student or apprentice himself, and
   - who is not covered by another similar basic health insurance as defined in Article II 1.28, and
   - who has a monthly gross income or monthly retirement pension (including the CERN pension) deriving from professional activity of more than 2500 CHF: Reference Salary V
III 5.08
PAYMENT OF THE SUPPLEMENTARY CONTRIBUTION

The supplementary contribution payable by a staff member or a fellow under Article III 5.07, paragraph 1 is deducted each month from the remuneration of the Member concerned.

The supplementary contribution for spouses under Article III 5.07 paragraph 2 is deducted from the remuneration, payment or pension of the Main Member.

III 5.09
CONTRIBUTION RATE

The contribution rate is a percentage of the Member's Reference Salary (Chapter IX, Section 1), as specified in Article A IV 1.01.

III 5.10
ADJUSTMENT OF THE CONTRIBUTION RATE

The contribution rate defined in Article III 5.09 is examined annually for the following calendar year, taking into account:

- the past and foreseen evolution of cost factors such as demographic trends, price changes, new medical treatment, etc.;
- the estimated total amount to which the contribution rate of active members of the personnel and beneficiaries of the CERN Pension Fund is applicable for the following calendar year;
- the forecast level of funds remaining in the CERN Health Insurance Reserve Fund at the end of the calendar year; and,
- any other relevant factor.

If necessary, a proposal to adjust the contribution rate is submitted to the Council of the Organization.

III 5.11
CONTRIBUTION FOR CONTINUATION OF THE INSURANCE COVER

The monthly contribution required for continuation of Normal Health Insurance is:

- for a member of the personnel terminating his active employment, that corresponding to the total contribution paid by the Member and the Organization on his behalf during his last month as a member of the personnel;
- for ex-spouses of Main Members, the amount of the monthly contribution based on Reference Salary II.

Section 6 – Obligation to Furnish Information

Any staff member, fellow or beneficiary of the CERN Pension Fund who is a Member of the Normal Health Insurance is obliged to notify CERN in writing of any other health insurance cover from which his spouse benefits, as well as, where applicable, any income or retirement pension deriving from professional activity of which his spouse is in receipt.

When requested to do so, the Member concerned has the obligation to submit supporting documentation regarding the information furnished in accordance with Article III 6.01.

Any change in the income or health insurance cover of the Member's spouse must be notified to CERN in writing within 30 calendar days after occurrence of the change.

The effective date of a change notified by the Member in accordance with Article III 6.03 is the first day of the month in which the change occurred.

Failure by a Member to furnish information in accordance with Article III 6.01 entails the deduction from his CERN remuneration or CERN pension of the highest supplementary contribution based on Reference Salary V, as defined in Article IX 1.05.

In cases of late notification or false declaration, any supplementary contributions due will be deducted retroactively. However, no contributions already paid will be reimbursed.

Where a Member has declared, in accordance with Article III 6.01, that his spouse benefits from another similar health insurance as defined in Article II 1.28, his spouse must submit the bills for reimbursement to that other health insurance first.
COMPLEMENTARY REIMBURSEMENT

Any medical expenses not reimbursed by the other similar health insurance, including any difference between the amount reimbursed by the other similar health insurance and the actual expenses incurred, may be submitted for reimbursement in accordance with the provisions of the present Rules.

Chapter IV – Reduced Health Insurance Cover

Section 1 – General Description

Reduced Health Insurance offers reduced benefits compared to the Normal Health Insurance for some categories of associated members of the CERN personnel during their stay at CERN.

Section 2 – Membership

Associates and users may subscribe to Reduced Health Insurance provided that their contract with the Organization runs for three months or more.

The family members of the Main Member are not covered by this insurance.

Section 3 – Territorial Scope

The territorial scope of the Reduced Health Insurance is the same as that specified for Normal Health Insurance in Article III 3.01.

Section 4 – Benefits

Members of the Reduced Health Insurance enjoy the same benefits as those listed in Annex I for the Normal Health Insurance, with the exception of those indicated in Article IV 4.02.

The following items are excluded from the Reduced Health Insurance cover:

- treatment given by medical auxiliaries;
- prostheses, orthopaedic appliances and hearing aids;
- dental prostheses;
- optics (spectacles, contact lenses and refractive surgery);
- the cost of accommodation in a respite care home or in a unit for those waiting for space to become available in a suitable institution;
- long-term care benefits;
- indemnity in the event of death.

Section 5 – Contributions

The contribution for Reduced Health Insurance is 50% of Reference Salary II (as defined in Article IX 1.02) multiplied by the contribution rate indicated in Article A IV 1.01.

The contribution rate is examined annually in accordance with Article III 5.10. If necessary, a proposal to adjust the contribution rate is submitted to the Council of the Organization.

The contribution is paid by the Member to the designated bank account of the Scheme each month in advance.
Chapter V – Short-term Health Insurance Cover

Section 1 – General Description

The Short-term Health Insurance is a limited health insurance cover specially designed for members of the CERN personnel with short-term contracts who do not benefit from health insurance cover against the financial consequences of illnesses and accidents in Switzerland and/or in France.

Section 2 – Membership

Members of the CERN personnel, holding a contract with the Organization of less than three months may subscribe to the Short-Term Health Insurance during their stay at CERN.

A family member of a Main Member subscribing to the insurance is only covered if he pays the contribution for this insurance cover.

Section 3 – Territorial Scope

The Members are covered on the continental and island territory of Europe, and on duty travel authorised by the Organization outside Europe under the conditions set out in Article V 3.02.

During duty travel outside Europe authorised by the Organization, the Main Member and the members of his family accompanying him are covered for the expenses resulting from necessary medical treatment within the following ceilings:

- for out-patient treatment: the regulated price applicable in the Canton of Geneva at the time of treatment;
- for stays in hospital: reimbursement of cost of accommodation with a ceiling of 500 CHF per day.

Section 4 – Benefits

Details of the reimbursement conditions are given in Article III 4.01.

The other benefits covered by the Short-term Health Insurance are listed in Annex III of these Rules.

Benefits in respect of medical conditions existing prior to the beginning of the contract with CERN are not covered by the Short-Term Health Insurance.

Section 5 – Contributions

The contribution for Short-Term Health Insurance is a paid on a daily or monthly basis. The corresponding amounts are specified in Article A IV 1.03. The contribution must be paid in advance for the entire period of cover.

Children up to the age of 18 shall be entitled to a 50% reduction.

The contributions shall be examined annually. If necessary, a proposal to adjust the contribution rate shall be submitted to the Council of the Organization.
If the contract of the member of the CERN personnel is extended, the contribution for the new contract period must be paid before the previous one expires in order for insurance cover to be maintained. If the length of the contract is shortened, no contributions paid will be reimbursed.

The insurance cover shall take effect provided that the contribution is paid by the first working day after arrival at the Organization at the latest.

Chapter VI – Occupational Illnesses and Accidents

Section 1 – General Description

Occupational accidents and illnesses give entitlement to coverage of the expenses for medical treatment directly associated with them.

Section 2 – Membership

Members of the Scheme covered by the Normal, Reduced or Short-Term Health Insurance are automatically covered against the financial consequences of occupational illnesses and accidents.

Section 3 – Territorial Scope

The insurance cover for occupational illnesses and accidents is world-wide.

Section 4 – Benefits

Subject to the applicable prior opinions or agreements, medical treatments directly linked to an occupational illness or accident is reimbursed at the rate of 100%, without any limit or ceiling.

Medical treatment ceases to be reimbursed under the occupational scheme in the event of cure or consolidation. The entitlement to such reimbursement resumes only in the event of a relapse.

The reimbursement benefits for occupational accidents and illnesses applicable to members covered by Normal, Reduced and Short-Term Health Insurance are specified in Annex 1.

No medical treatment resulting from occupational illnesses contracted or accidents sustained before the beginning of the insurance cover provided for in this Chapter is reimbursed under the occupational scheme.

The deadline for claiming reimbursement of medical treatment expenses resulting from occupational illnesses or accidents is identical to that specified in Article VIII 1.01. This period begins on the date on which the illness or accident was recognised to be an occupational illness or accident by the Organization or on the date on the bill, whichever is the later.
Section 5 – Contributions

The Organization pays 100% of the contribution for the occupational illnesses and accidents cover.

The contribution rate, as indicated in Article A IV 1.04, is a percentage of the reference salaries in Chapter IX Section 1.

The contribution rate for occupational illness and accident cover is examined annually for the following calendar year, taking into account:

- the past and foreseen evolution of cost factors such as price changes, new medical treatments, etc.;
- the estimated total amount to which the contribution rate of active Members is applicable for the following calendar year; and
- any other relevant factor.

If necessary, a proposal to adjust the contribution rate is submitted to the Council of the Organization.

Chapter VII – Common Provisions

Section 1 – Non-concurrence of Benefits Rule

Any other benefit received as a result of compulsory membership of a national social-security or equivalent scheme shall be deducted from the benefits provided for by the CERN Health Insurance Scheme. The Member concerned is required to inform the Third-Party Administrator if he is in receipt of any such benefit. This provision does not apply to other benefits resulting from membership of a scheme to which the Member has opted to contribute.

Where medical expenses have been partly reimbursed by another insurance, the Member must inform the Third-Party Administrator and is entitled to submit a reimbursement claim to the Scheme only for the balance due.

If the reimbursement under the primary scheme is subject to an annual deductible, the latter is not reimbursed by the Scheme.

Section 2 – Cosmetic Treatment and Surgery

Courses of rejuvenation treatment and cosmetic treatment and surgery, except in the case of disfigurement or serious burns to the hands, are not covered by the Scheme. However, repair and reconstructive surgery is covered, subject to prior agreement, if it is rendered necessary as a result of the occurrence of a guaranteed risk or an accident or illness suffered less than two calendar years before the start of insurance coverage for the Member concerned.
Section 3 – Grounds for Refusal, Reduction or Withdrawal of Benefits

The allowance for reduced earning capacity, the long-term care allowance and the indemnity in the event of death may be refused, reduced or withdrawn, temporarily or permanently, if the person concerned has caused or worsened his own condition either intentionally or by serious negligence, or by committing a crime or criminal offence.

Furthermore, the cost of treatment for the after-effects of a treatment not covered by the Scheme is not refundable.

Section 4 – General Insurance Provisions

Each Member of the Scheme receives an insurance card which indicates:
- the name and first name of the Member;
- the insurance number;
- the period of insurance cover.

Each Member is free to choose his own medical practitioner and medical establishment.

Reimbursements are made on condition that the expenses incurred are covered by a medical prescription, except in the case of emergency transport.

The acts performed by medical auxiliaries must be consistent with the medical prescription.

Members receive benefits that are subject to a ceiling exclusively on the basis of a ceiling calculated pro rata temporis of the duration of their membership of the Scheme.

This provision does not apply in the event of death of the Member.

No benefits are paid in the event of missed appointments.

In exceptional circumstances, a Member may request that a benefit exceeding the reimbursement ceiling or a benefit not listed in these Rules be granted to him.

Where the Third-Party Administrator observes that the rate applied for a given treatment significantly exceeds the reasonable usual rate for the treatment concerned, he may limit the amount refunded to the usual rate applied in the region in which the treatment is provided. In order to avoid this measure, the Member must check with the Scheme beforehand whether the rate proposed is acceptable.

Any sum paid by the Scheme and unduly accepted by a Member must be paid back without delay. In the event of death of the Member, long-term care daily allowances already received do not have to be refunded.

The Third-Party Administrator may decide to suspend all or part of the benefits concerned:
- of a Member who fails to comply with the provisions of these Rules;
- of a Member who refuses to undergo a medical examination prescribed by the Medical Advisor of the Third-Party Administrator;
- of a voluntary Member of the Scheme who is late in paying the contribution due;
- of a Member in case of suspicion of fraud.

The Third-Party Administrator, with CERN’s prior consent, may refuse to reimburse the suspended benefits.

Any member of the CERN personnel who is a Member of the Scheme and who fails to comply with the provisions of these Rules shall be liable to disciplinary action in accordance with the CERN Staff Rules and Regulations.
**VII 4.11 EXCLUSION FROM THE SCHEME**

Following a hearing of the Member concerned, the Organization may exclude a Member who has opted for membership of the Scheme:
- in the event of failure to pay the contribution within 30 calendar days from the date on which the contribution is due;
- in the event of fraud or proven attempt to defraud.

**VII 4.12 REIMBURSEMENT IN THE EVENT OF DEATH OF A MEMBER**

In the event of death of a Member, any outstanding reimbursement shall be paid to the heirs.

The claim for reimbursement of medical expenses incurred for the deceased must be submitted within the deadline indicated in Article VIII 1.01.

**VII 4.13 HOSPITAL GUARANTEE**

Where hospitalisation is in an approved hospital pursuant to Article II 1.10, at the request of the hospital or the patient the Third-Party Administrator will guarantee direct payment of bills at least three working days before commencement of the hospitalisation, except in emergencies.

An initial guarantee is given for 14 calendar days of hospitalisation.

Any request for an extension of the guarantee must be submitted by the hospital to the Third-Party Administrator for approval.

Where hospitalisation is in an unapproved hospital pursuant to Article II 1.11, the Third-Party Administrator will grant a guarantee as third-party guarantor. The Member must then settle the hospitalisation bill directly and claim reimbursement in accordance with the provisions of Chapter VIII, Section 1 of these Rules.

**VII 4.14 SUBROGATION**

Up to the amount of the reimbursement made by the Third-Party Administrator, the latter shall, on behalf of the Scheme, be subrogated to the rights which a victim of an accident or illness may have against any third parties who are liable. The Member may forfeit his right to reimbursement in accordance with Article VII 4.09 if he does not confirm in writing such subrogation when so requested by the Third-Party Administrator.

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**Section 5 – Duration of Membership**

Compulsory Members are covered by the Normal Health Insurance from the first to the last day of their contract of employment or association with the Organization, except during periods of special unpaid leave of one complete calendar month or more.

Applications for voluntary membership of the Normal or Reduced Health Insurances must be made within 30 calendar days:
- for members of the personnel: from the first day of the contract of association with the Organization; or from the first day of their renewed contract of association where their annual working hours have increased from 50% or less under the previous contract to over 50% under the new one; or from the first day of their renewed contract of association under the responsibility of a new employer who does not provide similar health insurance;
- from the first day following the termination of compulsory membership as a member of the CERN personnel or membership as a family member.

Provided that the application for voluntary insurance is accepted, the insurance cover commences on the first day of the month in which the Member becomes entitled to subscribe to it.

Members of personnel must subscribe to voluntary membership for the duration of the contract with CERN. Any extension of the contract with CERN automatically extends voluntary membership, except where annual working hours under the renewed contract of association have decreased from over 50% under the previous contract to 50% or less under the new one; or where renewal of the contract of association is under the responsibility of a new employer who is under the obligation to cover the member of the personnel with a similar health insurance.
VII 5.04 TERMINATION OF VOLUNTARY MEMBERSHIP

Voluntary Members may terminate the insurance at any time subject to a minimum of 30 calendar days’ notice. The termination of voluntary insurance cover is irrevocable and effective at the end of a calendar month.

VII 5.05 SHORT-TERM HEALTH INSURANCE

The Short-Term Health Insurance shall be subscribed to for the duration of the Main Member’s contract with CERN without possibility of early termination and is for a maximum of three months.

VII 5.06 TERMINATION OF NON-OCCUPATIONAL INSURANCE COVER

All medical expenses incurred up to the last day of the insurance cover for non-occupational illnesses and accidents may be submitted for reimbursement according to the provisions and time limits indicated in these Rules.

Where a stay in hospital exceeds the last day of insurance cover, the Member concerned is entitled to maintain his voluntary membership of the Scheme until he is able to subscribe to another basic health insurance or until he is discharged from hospital, whichever is earlier.

VII 5.07 APPLICATION FOR A CHANGE OF COVER

An application for a change from reduced cover to normal cover or vice versa will be accepted only if it is justified by the change in the family situation of the Main Member, notably as a result of marriage, divorce or the birth or adoption of a child.

Chapter VIII – Procedures

Section 1 – Medical Expense Reimbursement Claims

VIII 1.01 TIME LIMIT

Any claim for reimbursement of expenses resulting from medical treatment must be submitted within 12 months from the date of issue on the bill.

VIII 1.02 SUPPORTING DOCUMENTATION

The originals of the prescriptions, bills and proofs of payment of the bills must be attached to the medical expense claim.

Members are advised to keep photocopies of these documents and of the associated reimbursement statements.

When submitting a request to the Scheme for a complementary reimbursement, the Member concerned must attach the original of the reimbursement statement received from the primary health insurance stating the amounts already reimbursed by that insurance.

VIII 1.03 HIGH MEDICAL COSTS

Under special circumstances, and upon prior written request by the Member, the Third-Party Administrator may grant reimbursement of a bill containing high medical costs before the Member has paid the said bill.

The Member must subsequently submit proof of payment of this bill. Failure to settle a bill for which prior reimbursement has been granted shall constitute an infringement of the Rules and may lead to application of Articles VII 4.09, VII 4.10 et VII 4.11.

VIII 1.04 BREAKDOWN OF THE BILL

The bills submitted for reimbursement must indicate the full name of the patient, a breakdown of the treatment undergone, the date or period of the said treatment, the amount payable and the currency of payment of the bill.

The bills shall clearly indicate the name, qualification and address of the attending medical practitioner or the medical service provider concerned.

VIII 1.05 PAYMENT OF BILLS

The Member himself is responsible for ensuring that he receives and pays the bills for medical expenses in such a way as to be able to submit them for reimbursement within the deadlines specified in these Rules.

This provision is not applicable where a guarantee of direct payment of the bills has been given by the Third-Party Administrator.
VIII 1.06
ACCURACY OF REIMBURSEMENT CLAIMS
Except in exceptional circumstances, the Main Member shall assume responsibility for the accuracy of claims sent for reimbursement in his name or in the name of a member of his family. The Main Member must also, as far as possible, check that the bills correspond to the treatment undergone.

VIII 1.07
MEDICAL INFORMATION
The Member concerned must provide all the information required by the Third-Party Administrator on the illness suffered or the treatment followed.

The Third-Party Administrator may also contact those administering medical treatment directly. Confidential information may be sent under sealed cover to the Third-Party Administrator's Medical Adviser. The latter shall forward to the service for the settlement of claims only such information as is necessary for the reimbursement.

VIII 1.08
MEDICAL EXAMINATION
Any Member receiving treatment may be required by the Third-Party Administrator to undergo a medical examination by a medical practitioner designated by the Third-Party Administrator. Upon request of the Member concerned, the latter's medical practitioner may be present during such an examination.

VIII 1.09
OCCUPATIONAL ILLNESSES AND ACCIDENTS
Where reimbursement is claimed for medical expenses resulting from an occupational illness or accident, a copy of the official declaration made to CERN of the occupational illness or accident must be attached to the medical expense claim.

No reimbursement under the provisions for occupational illnesses and accidents is granted unless the illness or accident has been recognized as such by CERN.

VIII 1.10
REIMBURSEMENT OF CLAIMS
Reimbursement of medical expense claims shall normally be made within 14 calendar days following receipt of a duly completed medical expense claim including the requisite supporting documents.

VIII 1.11
APPLICABLE CURRENCY REIMBURSEMENT CLAIMS
All payments in respect of contributions, reimbursements and allowances shall be made in Swiss francs. Any bank charges shall be borne by the Member.

Where expenses to be reimbursed are not expressed in Swiss francs, the applicable rate of exchange with the Swiss franc shall be the official rate in force at CERN on the date of submission of the reimbursement claim.

In cases where a guarantee of direct payment of bills has been given pursuant to Article VII, 4.13, bills submitted directly to the Third-Party Administrator by the hospital concerned shall be paid in the currency of the State where treatment was provided.

Section 2 – Prior Approvals and Opinions
VIII 2.01
PRIOR APPROVAL
Prior approval by the Third-Party Administrator is required for reimbursement of the following items:
- transport costs (except in the case of emergency transport);
- refractive surgery;
- cures, convalescence and rehabilitation cures, in a respite care home or in a unit for those waiting for space to become available in a suitable establishment;
- home nurses;
- hire or purchase of auxiliary appliances;
- cost of accommodation in a hospital for a family member other than one of the two parents and whose presence is required by the hospitalisation of a child of less than 7 years of age.

VIII 2.02
TIME LIMIT FOR PRIOR APPROVAL
Requests for prior approval must be made on the appropriate official form and submitted to the Third-Party Administrator at least 14 calendar days before the medical expenses subject to prior approval are incurred. This deadline is increased to 30 calendar days for expenses for cures and convalescence cures.

VIII 2.03
SUPPORTING DOCUMENTATION
Each request for prior approval must be supported by a medical prescription indicating the treatment, its justification, its duration and the expected result. An estimate must be attached to any request for prior approval of the hire or purchase of auxiliary appliances.
VIII 2.04 PRIOR APPROVAL NOT OBTAINED

Expenses incurred without obtaining the requisite prior approval are not reimbursed by the Scheme.

VIII 2.05 PRIOR OPINION ON DENTAL TREATMENT

A prior opinion on the medical evaluation and financial estimate must be obtained from the Third-Party Administrator for any planned dental treatment, prostheses and orthodontics scheduled to cost in excess of 800 CHF, except in cases of emergency.

VIII 2.06 SUBMISSION OF ESTIMATE FOR DENTAL TREATMENT

The estimate for a prior opinion on dental treatment must be submitted to the Third-Party Administrator at least 14 calendar days before the commencement of the treatment.

Section 3 – Cures and Convalescence Cures

VIII 3.01 PRIOR APPROVAL

All cures and convalescence cures, including related treatment costs, are subject to prior approval in accordance with Article VIII 2.01.

VIII 3.02 CONVALESCENCE CURES

Convalescence cures are accepted following medical surgery involving a stay in hospital, or after a stay in hospital of at least 10 calendar days without medical surgery, provided that the cure commences within 30 calendar days after the end of the hospital stay.

Wherever possible, requests for prior approval must be submitted seven calendar days before commencement of the convalescence cure.

VIII 3.03 OTHER CURES

The prescription for a cure, other than convalescence cures, shall be accompanied by a medical case history setting out the results obtained by the medical treatment preceding the cure, the schedule for medical treatment during the cure and the expected result with respect to curing or consolidating the state of health of the person concerned.

In the event of a cure being repeated with the following cure commencing less than 12 months after the previous cure began, the medical practitioner shall submit a detailed supporting document to justify the effectiveness of the cure.

In the event of a third or further cure for the same condition, the medical practitioner must attach to the prescription for the cure a detailed evaluation of the previous cures.

Cures must be undergone in establishments recognized by the competent authorities of the State in which the establishment is situated.

VIII 3.04 REFUSAL OF CURE

Where a cure is refused, the Third-Party Administrator will inform the Member concerned of his decision and the grounds for it.

VIII 3.05 EXCLUSION OF CURES

High-altitude, rejuvenation, rest and change-of-air cures and any other such cures shall not be considered as cures within the meaning of the present Rules.

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1 The term “cure” in Section 3 does not fall within the definition of “cure” specified in Article II 1.16.
Section 4 – Settlement of Disputes

Any decision to apply these Rules is taken on behalf of the Director-General of the Organization. The general arrangements for challenging such a decision are described in the procedure set out below.

However, the arrangements for challenging a decision relating to the recognition of a state of dependence are described in Annex V of these Rules.

During the procedure set out below, personal medical data shall be subject to confidentiality, as indicated in Article I 1.06.

The Director-General may delegate his authority to any member of the personnel within the Organization whom he deems competent to settle disputes concerning health insurance matters.

Application of the challenged decision shall not be suspended pending the outcome of the procedure set out below.

The Director-General may extend the deadlines provided for in the procedure set out below whenever the proper administration of justice so requires. He shall immediately inform the Member concerned accordingly.

In order to reach an amicable agreement, a Member of the Scheme may request a review of a decision taken in accordance with these Rules. Such a request must be made in writing within 60 calendar days after notification of the challenged decision, to the Third-Party Administrator if he has taken the challenged decision, otherwise to the Director-General.

The request for a review shall be signed by the Member concerned and sent by registered mail. It shall include a copy of the challenged decision and a written summary of the grounds for the request.

The Third-Party Administrator, or the Director-General where applicable, shall review the grounds for the challenged decision and consult the competent CERN authority. A substantiated reply, which constitutes a new decision, shall be addressed to the Member concerned within 60 calendar days after receipt of the request. This new decision, which cancels and replaces the challenged decision, shall indicate the grounds for the decision and the possibilities of lodging an appeal in accordance with Article VIII 4.04.

An appeal regarding health insurance matters may be lodged only after completion of the review procedure.

The Member concerned shall lodge the appeal in writing to the Director-General within 60 calendar days after notification of the decision taken in accordance with Article VIII 4.03.

The letter of appeal shall be signed by the Member concerned and sent by registered mail. It shall include a copy of the challenged decision and a summary of the grounds for the appeal.

Upon receipt of the appeal, the Director-General shall first examine the receivability.

If the appeal is irreceivable, the Member concerned shall be informed of the grounds in writing within 30 calendar days after receipt of the appeal.

If the appeal is receivable, the Director-General shall determine whether the dispute is of an administrative or medical nature.

Any dispute concerning the allowance for reduced earning capacity is deemed to be of a medical nature.

In disputes of an administrative nature, the Director-General shall convene the Health Insurance Litigation Board in accordance with Article VIII 4.06 within 30 calendar days after receipt of the appeal.

In disputes of a medical nature, a medical practitioner shall be appointed in accordance with Article VIII 4.09.
VIII 4.06
SETTLEMENT OF DISPUTES
OF AN ADMINISTRATIVE
NATURE

The Health Insurance Litigation Board, hereafter referred to as "the Board", is competent to hear any appeal against a decision of an administrative nature concerning health insurance matters taken in accordance with Article VIII 4.03.

The Board shall be composed of three members who shall normally be members of the CHIS Board, as referred to in Article X 1.03.

Two permanent members and their alternates shall be appointed for a renewable period of two years, as follows:

- one member and one alternate, appointed by the CERN Management;
- one member and one alternate, appointed by the Staff Association.

Within 10 calendar days after the Board has been convened, the two permanent members shall choose, by mutual agreement, the Chairman of the Board who shall normally also be a member of the CHISB.

If no agreement has been reached within the set time limit, the third member of the Board shall be the Chairman of the CHISB.

When the composition of the Board has been finalized, the Board shall begin to examine the case within 30 calendar days.

VIII 4.07
PROCEDURE OF THE
BOARD

The procedure is conducted entirely in writing. However, at its discretion, the Board may hear the member or any person who may give the Board the benefit of his expertise.

The Board may initiate any investigation procedures which it deems necessary for examination of the case.

The Chairman represents the Board for all legal proceedings.

The Board shall:

- examine the documents which are presented to it by the parties;
- consult the Third-Party Administrator or any expert, if it deems this necessary.

The conclusions of any expert consulted shall be communicated to the parties for comments.

Where an expert assessment requested by the Board entails expenses, the Chairman of the Board shall inform the Director-General beforehand and he shall decide whether such expenses should be borne by the Scheme.

When the Chairman of the Board deems that he has obtained all the relevant information, he shall close the investigation procedure and inform the parties thereof.

VIII 4.08
REPORT BY THE BOARD

The Board shall draw up a report which it shall forward to the Director-General within 30 calendar days after the closure of the investigation procedure.

This report shall include the following elements:

- the main arguments of the parties;
- a summary of the conclusions by any possible experts consulted;
- the considerations of the Board;
- the recommendation of the Board, approved by the majority of its members.
Where the Director-General has determined that the dispute is of a medical nature, it shall be examined, within 30 calendar days after the lodging of the appeal, by a medical practitioner jointly appointed by the medical practitioner chosen by the Member concerned and the one chosen by the Organization.

If the parties fail to agree on a choice of medical practitioner, the appointment shall be made by any competent medical authority in the Canton of Geneva.

Once the medical practitioner has been appointed, he shall begin to examine the case within 30 calendar days.

The medical practitioner may initiate any investigation procedures that he deems necessary for examination of the case.

The medical practitioner shall:
- examine the documents which are presented to him by the parties;
- consult the Third-Party Administrator or any expert, if he deems this necessary.

In the event of a dispute concerning the allowance for reduced earning capacity, the medical practitioner shall consult a rehabilitation specialist familiar with Swiss Federal legislation on disability.

Communication of information and documents of a medical nature, including within the context of Article VIII 4.10, shall be strictly limited to the minimum required for a proper administration of the dispute.

The fees due to the medical practitioner and to any expert consulted shall be borne by the Scheme.

The medical practitioner shall draw up a report which he shall forward to the Director-General within 30 calendar days after the closure of the investigation procedure.

This report shall include the following elements:
- the main arguments of the parties;
- a summary of the conclusions by any possible experts consulted;
- the considerations of the medical practitioner;
- a recommendation.

The Director-General shall notify the Member concerned of his decision in writing, enclosing a copy of the report submitted by the Board or by the medical practitioner, within 30 calendar days after receipt of the report. Where applicable, he shall indicate his reasons for not following the recommendation of the Board or of the medical practitioner.

The decision of the Director-General shall be final.

A complaint against the final decision pursuant to Article VIII 4.11 may be filed with the Administrative Tribunal of the International Labour Organization (ILOAT) in accordance with the latter’s Statute and Rules.
Chapter IX – Financial Provisions

Section 1 – Reference Salaries

IX 1.01 REFERENCE SALARY I
Reference Salary I is the basic monthly remuneration specified in the contract of employment or association with the Organization on the basis of a 40-hour working week.

This Reference Salary is used to calculate the main contributions of staff members, fellows and students.

IX 1.02 REFERENCE SALARY II
Reference Salary II is the weighted average basic monthly remuneration of all staff members and fellows on the last day of the preceding calendar year, using the salary scale for the current calendar year.

This Reference Salary is used to determine the contribution of associates, users and beneficiaries of a deferred pension from the CERN Pension Fund. It is also used to determine the contribution of apprentices (50% of Reference Salary II), and of children no longer insured as dependants (40% of Reference Salary II).

IX 1.03 REFERENCE SALARY III
Reference Salary III is the monthly basic salary paid to a beneficiary of the CERN Pension Fund at the time of his departure from the Organization. It is adjusted in line with the pensions.

For beneficiaries of a surviving spouse’s pension and/or an orphan’s pension, the Reference Salary III is reduced in accordance with the Rules and Regulations of the Pension Fund.

This Reference Salary is used to determine the amount of the main contribution for beneficiaries of the CERN Pension Fund opting for membership of the Normal Health Insurance.

IX 1.04 REFERENCE SALARY IV
Reference Salary IV is the basic monthly remuneration specified in the contract of employment with the Organization on the basis of the actual duration of the working week.

This Reference Salary is used to calculate the amount of the supplementary contribution when both spouses are staff members or fellows.

IX 1.05 REFERENCE SALARY V
Reference Salary V is the mid value (except for the lowest and highest brackets) of the income bracket corresponding to the monthly gross income or retirement pension (including the CERN pension) deriving from a professional activity.

<table>
<thead>
<tr>
<th>Monthly income bracket</th>
<th>Reference Salary</th>
</tr>
</thead>
<tbody>
<tr>
<td>up to 2,500 CHF inclusive</td>
<td>0 CHF / month</td>
</tr>
<tr>
<td>Above 2,500 CHF up to 4,250 CHF inclusive</td>
<td>3,333 CHF / month</td>
</tr>
<tr>
<td>Above 4,250 CHF up to 7,500 CHF inclusive</td>
<td>5,833 CHF / month</td>
</tr>
<tr>
<td>Above 7,500 CHF up to 10,000 CHF inclusive</td>
<td>9,167 CHF / month</td>
</tr>
<tr>
<td>Above 10'000 CHF</td>
<td>Reference Salary II x 0.5 x Overall rate (Member + Organization)/ rate of Member alone</td>
</tr>
</tbody>
</table>

This Reference Salary is used to determine the contribution of spouses of Main Members covered under Article III 5.07, paragraph 2, using the CERN Health Insurance Scheme as their primary health insurance.
Section 2 – Reserve Fund

CERN has set up two funds, one for the capitalisation of its Long-Term Care (LTC) fund reserves and the other for the provisions and reserves of its Health Insurance Scheme (HIS).

The latter corresponds to the following provisions and reserves:
- provision for reimbursements incurred and not yet claimed (20% of all anticipated reimbursements for the year);
- provision for catastrophic risk (30% of all anticipated reimbursements for the year);
- reserve against any future deficit of the Scheme (at least 20% of all anticipated reimbursements for the year).

The capital of these funds is formally separate from the rest of CERN's assets.

Actuarial studies shall be regularly conducted in order to monitor the evolution of the HIS and LTC schemes, taking into account the contributions, anticipated expenditure and the assets of the funds. Any structural imbalance of these schemes shall be remedied as rapidly as possible.

Chapter X – Operation of the Scheme

Section 1 – Operation

The Director-General shall appoint a Manager to manage the daily operation of the Scheme. In this framework the Manager shall:

- monitor and supervise the performance of the contract between the Organization and the Third-Party Administrator;
- negotiate healthcare tariffs with providers;
- in collaboration with the CERN department responsible for finance, monitor the financial position of the Scheme and its funds and report to the Strategic Advisor referred to in Article X 1.02;
- check the benefits and contributions data submitted to and received from the Third-Party Administrator and report to the Strategic Advisor;
- deal with any membership issue;
- in agreement with the Strategic Advisor, decide on the award of ex-gratia benefits pursuant to Article VII 4.06
- monitor developments in the health insurance systems in the Member States and other intergovernmental organisations and report on them to the Strategic Advisor;
- perform any other tasks required for the daily operation of the Scheme.
X 1.02 STRATEGIC ADVISOR

The Strategic Advisor shall be appointed by the Director-General to assist him in drawing up the medium and long-term health insurance strategy. In this framework he shall, in particular:

- analyse the reports on the financial position of the Scheme and its funds and the associated long-term projections, as well as the contributions and benefits statistics submitted to him by the Manager;

- in collaboration with the Manager, analyse developments in the health insurance systems in the Member States and other intergovernmental organisations;

- in collaboration with the Manager, draw up and submit to the Director-General proposals for adjustments of the Scheme needed to ensure that it achieves its objectives and remains in long-term financial balance and that its conditions are competitive with those of the health insurance schemes of the intergovernmental organisations used as comparators;

- in agreement with the Director-General, submit these adjustment proposals to the CHIS Board, as referred to in Article X 1.03, in preparation for subsequent discussion at the Standing Concertation Committee (SCC).

X 1.03 CHIS BOARD

The CERN Health Insurance Scheme Board (hereafter the “CHIS Board”) is a sub-group of the SCC responsible for preparing discussion at the SCC of the adjustment proposals submitted to the Board by the Strategic Advisor pursuant to Article X 1.02.

The CHIS Board shall be chaired by the Strategic Advisor and shall also comprise:

- four members appointed by the Director-General from among the members of the personnel, including the Manager;

- four members appointed by the Staff Association from among the members of the personnel and the beneficiaries of the CERN Pension Fund.

The CHIS Board shall establish its own working procedures. To allow it to successfully complete its work, the CHIS Board shall be regularly informed by its Chairman and by the Manager of details relating to the operation of the Scheme (including quality of service, statistics, financial position, tariff negotiations, actuarial analyses). The members of the CHIS Board shall have access to the documents containing such information.
Chapter XI – Auditing

Section 1 – Auditing

CERN's internal and external auditors may on their own initiative examine all or part of the CERN Health Insurance Scheme.

In order to be able to carry out this task, the auditors shall have access to all documents, confidential or otherwise, required to verify the transactions shown in the Third-Party Administrator's financial records together with the supporting documentation.

On request, the auditors shall also have access to the Third-Party Administrator's internal written instructions.

The auditors shall not have access to personal medical data concerning the Members.

Chapter XII – Annexes

Section 1 – Annexes

The following documents form an integral part of the Rules:

- Annex I entitled "Normal Health Insurance Cover";
- Annex II entitled "Allowance for Reduced Earning Capacity";
- Annex III entitled "Short-Term Health Insurance Cover";
- Annex IV entitled "Contribution Rates";
- Annex V entitled "Long-Term Care benefits".
## Annex I – Normal Health Insurance Cover

<table>
<thead>
<tr>
<th>A I 1.01</th>
<th>REIMBURSEMENT RATES UNDER THE GENERAL RULE</th>
</tr>
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<tbody>
<tr>
<td></td>
<td>The reimbursement rates according to the Costs Borne by the Insured Member (FCA) cumulated by the Member over a calendar year are as follows:</td>
</tr>
<tr>
<td></td>
<td><strong>Cumulated Costs Borne by a Member (FCA)</strong></td>
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<tr>
<td></td>
<td>up to 499.99 CHF</td>
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<tr>
<td></td>
<td>as from 500 CHF and up to 2’999.99 CHF</td>
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<td></td>
<td>3000 CHF</td>
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<tr>
<th>A I 1.02</th>
<th>CEILINGS</th>
</tr>
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<tbody>
<tr>
<td></td>
<td>Reimbursement of some items is limited to a certain level of expenses (ceiling), which generally applies per calendar year and in certain cases can be cumulated over several years. Details of these ceilings are given in the table in this Annex.</td>
</tr>
<tr>
<td></td>
<td>Under Article VII 4.06, the ceilings below may be exceeded with the prior agreement of the Third-Party Administrator, in particular in the case of children whose state of health requires prolonged medical treatment.</td>
</tr>
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</table>

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<thead>
<tr>
<th>A I 1.03</th>
<th>BONUS FOR OUTPATIENT TREATMENT</th>
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<tbody>
<tr>
<td></td>
<td>In order to promote use of healthcare providers in Member States where health costs are less onerous, the 80% and 90% reimbursement rates are increased by 5 percentage points for certain outpatient treatments (defined in the table below) if they are dispensed in one of the following Member States: Austria, Belgium, Bulgaria, Czech Republic, Finland, France, Germany, Greece, Hungary, Israel, Italy, Netherlands, Poland, Portugal, Romania, Slovak Republic, Spain, Sweden and the United Kingdom.</td>
</tr>
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</table>

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<tr>
<th>A I 1.04</th>
<th>PREVENTION</th>
</tr>
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<tbody>
<tr>
<td></td>
<td>Certain preventive examinations and treatments are 100% reimbursed. They are:</td>
</tr>
<tr>
<td></td>
<td>- Vaccination against the human papilloma virus: with medical prescription</td>
</tr>
<tr>
<td></td>
<td>- Mammography (screening for breast cancer): women from the age of 50, once every two years</td>
</tr>
<tr>
<td></td>
<td>- Occult blood test in stool (colon cancer screening): men and women from the age of 50, once every two years</td>
</tr>
<tr>
<td></td>
<td>Other preventive examinations and treatments (e.g. vaccinations) are reimbursed in accordance with the General Rule.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>A I 1.05</th>
<th>SERIOUS CASE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Expenses under items B1 to B5 for a given illness or accident that are incurred after the point where the cumulated expenses for that illness or accident exceed 80000 CHF are 100% reimbursed.</td>
</tr>
</tbody>
</table>
The following benefits are covered by the Normal Health Insurance cover:

<table>
<thead>
<tr>
<th>BENEFITS</th>
<th>REIMBURSEMENT RATE</th>
<th>BONUS</th>
<th>PRIOR AUTHORISATION BY THE THIRD-PARTY ADMINISTRATOR (see Chapter VIII, Section 2)</th>
<th>CEILING</th>
<th>OTHER CONDITIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>A. OCCUPATIONAL ILLNESSES AND ACCIDENTS</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Without limit or ceiling, but subject to prior agreement or opinion for the items concerned, as in B below. Any supplements for hospitalisation in a single-bed ward borne exclusively by the Member.</td>
</tr>
<tr>
<td><strong>B. NON-OCCUPATIONAL ILLNESSES AND ACCIDENTS</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Doctors' fees</td>
<td>General rule</td>
<td></td>
<td>According to A I 1.03</td>
<td></td>
<td>Recognised as such in the State where prescribed. The cost of non-reimbursed medication is not included in the calculation of the Costs Borne by the Insured Member (FCA).</td>
</tr>
<tr>
<td>2. Pharmaceutical costs</td>
<td>General rule</td>
<td></td>
<td>According to A I 1.03</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Medical imaging</td>
<td>General rule</td>
<td></td>
<td>According to A I 1.03</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Laboratory and analysis work</td>
<td>General rule</td>
<td></td>
<td>According to A1.1.03</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Medical treatment and miscellaneous exams</td>
<td>General rule</td>
<td></td>
<td>According to A I 1.03</td>
<td></td>
<td>Including outpatient treatment at a hospital</td>
</tr>
<tr>
<td>6. Treatment given by:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a) Speech therapist</td>
<td>General rule</td>
<td></td>
<td>According to A I 1.03</td>
<td>13300 CHF per calendar year</td>
<td></td>
</tr>
<tr>
<td>b) Child psychotherapist</td>
<td>General rule</td>
<td></td>
<td>According to A I 1.03</td>
<td>25000 CHF per calendar year</td>
<td></td>
</tr>
<tr>
<td>c) Home nurses</td>
<td>General rule</td>
<td></td>
<td>According to A I 1.03</td>
<td>YES 68 CHF per day</td>
<td>In the case of recognised long-term dependence, the daily limit is replaced by the monthly limit (see Annex V 2.01)</td>
</tr>
</tbody>
</table>
## BENEFITS

<table>
<thead>
<tr>
<th>REIMBURSEMENT RATE</th>
<th>BONUS</th>
<th>PRIOR AUTHORIZATION BY THE THIRD-PARTY ADMINISTRATOR (see Chapter VIII, Section 2)</th>
<th>CEILING</th>
<th>OTHER CONDITIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>d) General rule</td>
<td>According to AI 1.03</td>
<td>3300 CHF per calendar year</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### 7. In-patient hospital treatment (cost of accommodation and treatment)

- **a)** Hospitalisation in a public hospital, apart from the private or semi-private sector: 100%
- **b)** Hospitalisation in an unapproved private hospital: 80%
- **c)** Any other hospitalisation: General rule
- **d)** Cost of accommodation in a hospital for one of the two parents whose presence is required by the hospitalisation of their child of less than 7 years of age: 70% (132 CHF per day)
- **e)** Cost of accommodation in a hospital for a family member, other than one of the two parents, whose presence is required by the hospitalisation of a child of less than 7 years of age: 70% (YES 132 CHF per day)

Any supplements for hospitalisation in a single-bed ward borne exclusively by the Member.

In the absence of prior agreement, the Third-Party Administrator may exceptionally accept reimbursement if the attending physician at the hospital considers the presence of this family member necessary.

### 8. Cures and accommodation in convalescence and rehabilitation facilities, in a respite care home or in a unit for those waiting for space to become available in a suitable institution

- **a)** Cost of accommodation and board for a cure: 100% (YES 10 CHF per day)
- **b)** Cost of accommodation and board for a convalescence cure: 100% (YES 80 CHF per day)
- **c)** Cost of accommodation and board in a rehabilitation facility: 100% (YES 120 CHF per day)

Cost of accommodation and board in a specialised social rehabilitation facility, e.g. in an alcohol or drug abuse rehabilitation centre.
### BENEFITS

<table>
<thead>
<tr>
<th></th>
<th>REIMBURSEMENT RATE</th>
<th>BONUS</th>
<th>PRIOR AUTHORIZATION BY THE THIRD-PARTY ADMINISTRATOR (see Chapter VIII, Section 2)</th>
<th>CEILING</th>
<th>OTHER CONDITIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>d)</td>
<td>Cost of accommodation in a respite care home or in a unit for those waiting for space to become available in a suitable institution;</td>
<td>General rule</td>
<td>YES</td>
<td></td>
<td>Benefit cannot be cumulated with the daily long-term care allowance.</td>
</tr>
<tr>
<td>e)</td>
<td>Medical and pharmaceutical costs</td>
<td>General rule</td>
<td>According to A1.1.03</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### 9. Optical and ophthalmologic expenses

- **a)** Corrective glasses (lenses and frame) and contact lenses, including disposable lenses
  - General rule
  - 500 CHF per calendar year, which can be cumulated over 3 years
  - On prescription.
  - As a transitory measure for members affiliated before 1.1.2012, the annual ceiling shall be increased as follows:
    - for 2012: by 1000 CHF minus the expenses incurred in 2010 and 2011;
    - for 2013: by 500 CHF minus the expenses incurred in 2011.
  - Article VII 4.04, which concerns the calculation of ceilings pro rata temporis shall be applied to calculate these increases.

- **b)** Refractive surgery
  - General rule
  - YES
  - 2000 CHF per eye for the entire period of cover
  - No reimbursement within the first 12 months of membership of the Scheme.

#### 10. Hire or purchase of auxiliary appliances:

- Orthopaedic appliances, prostheses other than dental prostheses, hearing aids, oxygen extractors, dialysis machines, etc.
  - General rule
  - YES
  - 11000 CHF per calendar year, which can be cumulated over 2 years
<table>
<thead>
<tr>
<th>BENEFITS</th>
<th>REIMBURSEMENT RATE</th>
<th>BONUS</th>
<th>PRIOR AUTHORISATION BY THE THIRD-PARTY ADMINISTRATOR (see Chapter VIII, Section 2)</th>
<th>CEILING</th>
<th>OTHER CONDITIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>11. Hire or purchase of auxiliary appliances designed to foster personal autonomy in the case of recognised disability, reduced earning capacity or dependence</td>
<td>General rule</td>
<td>YES</td>
<td>11000 CHF per calendar year, which can be cumulated over 2 years</td>
<td>This concerns the following appliances: - wheelchairs; - supplementary automatic sanitary installations where the Member is unable to wash himself without one; - chair lifts for use by patients in their home; - electric beds (with base, but excluding mattress and other accessories) for use at home; - adaptation of the Member’s place of residence: installation of support rails, elimination of changes in floor levels, construction of ramps over changes in floor levels, modification of door embrasures, installation of luminous signals for the deaf and those suffering from serious hearing impairment, emergency call systems for the deaf and blind; - adjustments to a vehicle to allow the Member to travel.</td>
<td></td>
</tr>
<tr>
<td>12. Dental treatment, prostheses and orthodontics</td>
<td>General rule</td>
<td>YES</td>
<td>3300 CHF per calendar year, which can be cumulated over 3 years</td>
<td>* Subject to prior opinion if the costs exceed 800 CHF, except in emergencies.</td>
<td></td>
</tr>
<tr>
<td>13. Transport costs: in an ambulance or medical vehicle (exceptionally by taxi)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a) from the place of residence or the site of the accident to the nearest suitable hospital, or any other means of transport used in an emergency</td>
<td>General rule</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b) from one hospital to another</td>
<td>General rule</td>
<td>YES</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>f) to a rehabilitation facility</td>
<td>General rule</td>
<td>YES</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>d) any other medically essential transport</td>
<td>General rule</td>
<td>YES</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>C. PREVENTION</td>
<td>100%</td>
<td>NA</td>
<td></td>
<td>Exclusively for the examinations and treatments listed in A I 1.04.</td>
<td></td>
</tr>
<tr>
<td>BENEFITS</td>
<td>REIMBURSEMENT RATE</td>
<td>BONUS</td>
<td>PRIOR AUTHORISATION BY THE THIRD-PARTY ADMINISTRATOR (see Chapter VIII, Section 2)</td>
<td>CEILING</td>
<td>OTHER CONDITIONS</td>
</tr>
<tr>
<td>----------</td>
<td>-------------------</td>
<td>-------</td>
<td>---------------------------------------------------------------------------------</td>
<td>---------</td>
<td>-----------------</td>
</tr>
<tr>
<td>D. ALLOWANCE FOR REDUCED EARNING CAPACITY of a family member</td>
<td>NA</td>
<td></td>
<td></td>
<td></td>
<td>See Annex II</td>
</tr>
<tr>
<td>E. LONG-TERM CARE ALLOWANCE</td>
<td>NA</td>
<td></td>
<td></td>
<td></td>
<td>See Annex V</td>
</tr>
<tr>
<td>F. INDEMNITY IN THE EVENT OF DEATH</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a) of a staff member</td>
<td>NA</td>
<td></td>
<td>14000 CHF</td>
<td></td>
<td>3 times the basic salary with a ceiling of 14000 CHF.</td>
</tr>
<tr>
<td>b) of a family member</td>
<td>NA</td>
<td></td>
<td>1600 CHF</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Annex II – Allowance for Reduced Earning Capacity

A II 1.01 DEFINITION

For the purpose of this Annex, the notion "reduced earning capacity" means a reduction in earning capacity, assumed to be permanent or of a long duration, resulting from the effects of physical or mental illness caused by congenital infirmity, illness or accident, preventing the person concerned from carrying out his normal work.

A II 1.02 ELIGIBLE PERSONS

A member of the family (as defined in the CERN Staff Rules and Regulations) of a member of the personnel in active employment, of a former member of the personnel in receipt of a pension or of a deceased member of the personnel or as defined in Article III 2.04 may claim payment of an allowance for reduced earning capacity provided the following conditions are fulfilled cumulatively at the time of the application:

- the member of the personnel must be (or have been, in the case of former members of the personnel) a staff member, a fellow or an apprentice;
- the member of the personnel must have, or have had, at least two years of uninterrupted service within the Organization. This two-year period includes the total period of uninterrupted contracts as a staff member, a fellow or an apprentice;
- the member of the personnel and the eligible person must be Members of the Normal Health Insurance, and must have been Members for at least one year;
- the eligible person must not be a member of the CERN personnel;
- all attempts to restore the earning or working capacity of the person concerned must have proven either completely or partly ineffective;
- the eligible person must have reached the age of 18 but not have reached the official retirement age laid down in the CERN Staff Rules and Regulations.

A II 1.03 CONDITIONS FOR ENTITLEMENT TO THE ALLOWANCE

A person is eligible to request the allowance where:

- his earning capacity is permanently reduced by at least 50%;
  or
- where his earning capacity has been reduced, with no significant interruption (i.e. more than 30 consecutive days), by an average of at least 50% over 360 days, and where his earning capacity is still reduced by at least 50%.

A II 1.04 APPLICATION FOR ALLOWANCE

The allowance for reduced earning capacity may be claimed at any time provided the conditions set out in this Annex are fulfilled.

If a claim is accepted, the effective date is the first day of the month in which the claim is made. The allowance may be paid retroactively for a maximum period of 12 months if the person concerned proves that the conditions justifying the payment were fulfilled continuously.

A II 1.05 SUPPORTING DOCUMENTATION

Anyone claiming payment of the allowance must provide the Third-Party Administrator, at his own expense, with a detailed medical report by the competent national authority setting out the cause, nature, commencement, history and probable duration of the illness, injuries or the intellectual and physical deterioration of the person concerned. The report shall also state the extent of reduced earning capacity determined by a medical practitioner and a certificate indicating the chances of recovery. The Third-Party Administrator shall be entitled to request any useful information and proof; he may himself, at the expense of the Scheme, carry out investigations and have the Member concerned examined by the medical practitioners of his choice.

A II 1.06 RECOGNITION OF ENTITLEMENT

Within six weeks following receipt of the supporting documents set out above, the Third-Party Administrator shall inform the person concerned, and, where appropriate, CERN, in writing whether it has been decided to grant an allowance for reduced earning capacity and, if this is so, giving details of the amount and the date from which it is payable.

The Third-Party Administrator shall be entitled to defer the decision by a maximum of one year after medical treatment is completed if the medical report leaves doubts concerning permanent reduced earning capacity and its extent.
A II 1.07 FULL ALLOWANCE

The entitled person shall receive a full allowance if he is diagnosed as having at least a two-thirds reduction in earning capacity.

A II 1.08 HALF ALLOWANCE

The entitled person shall receive a half allowance if he is diagnosed as having at least a 50% reduction in earning capacity.

A II 1.09 AMOUNT OF THE HALF ALLOWANCE

The allowance shall be equal to the minimum allowance which would be payable by the AI (disability insurance) of the Swiss Confederation in the same circumstances, irrespective of the State of residence of the person concerned.

A II 1.10 OBLIGATION TO FURNISH INFORMATION

Anyone receiving an allowance provided for in the present Annex is required to inform the Third-Party Administrator without delay of any allowance, pension or sum of money for reduced earning capacity, disability or old-age that is not an allowance from voluntary private insurance in return for payment.

A II 1.11 NON-CONCURRENCE OF BENEFITS

Any allowance, pension or sum of money for reduced earning capacity, disability or old age received by an entitled person shall be deducted from the allowance granted under the terms of the present Annex, provided that it is not an allowance from voluntary private insurance in return for payment. However, the handicapped orphan's pension, as granted under the Rules of the CERN Pension Fund, may run concurrently with the benefits covered by this Annex.

A II 1.12 IMPROVEMENT IN EARNING OR WORKING CAPACITY

The Third-Party Administrator must immediately be informed of any improvement in earning or working capacity. The allowance shall be cancelled or reduced following restoration of or improvement in working capacity. Any allowance to which the person concerned was not entitled must be repaid in accordance with Article VII 4.08.

A II 1.13 DETERIORATION IN EARNING OR WORKING CAPACITY

Where a person in receipt of a half allowance suffers a further deterioration that results in a reduced earning capacity of at least two thirds, the allowance becomes full.

A II 1.14 DATE OF EFFECT

The consequences of a change in the extent of the reduction in earning capacity take effect from the day on which the change is medically certified.

A II 1.15 PROOF AND MEDICAL EXAMINATION

The Third-Party Administrator may at any time request any proof he deems necessary and have the Member concerned examined by any medical practitioner of the choice of the Third-Party Administrator and at the expense of the Scheme. Upon request of the Member concerned, the latter's medical practitioner may be present during such an examination.

A II 1.16 GROUNDS FOR REFUSAL, REDUCTION OR WITHDRAWAL OF ALLOWANCE

The allowance shall be refused, reduced or withdrawn, temporarily or permanently, if the person concerned has caused or worsened his own reduced earning capacity either intentionally or by serious negligence, or by committing a crime or criminal offence.

A II 1.17 REFUSAL OF REHABILITATION MEASURES

The person concerned shall be temporarily or permanently refused an allowance if he evades or objects to rehabilitation measures which he can reasonably be expected to undergo and which are likely to bring about a significant improvement in his earning or working capacity.

A II 1.18 TERMINATION OF ENTITLEMENT

The allowance shall be paid as long as the person concerned remains insured under the Normal Health Insurance and the conditions provided for in Articles A II 1.02 and A II 1.03 remain valid. Payment shall cease on the last day of the month in which the entitlement ceases and, whatever the circumstances, as soon as the person concerned has reached the retirement age as set out in the CERN Staff Rules and Regulations.

A II 1.19 APPLICABLE LAWS

For the implementation and interpretation of the provisions of this Annex, the parties shall refer, in the following order, to:

- the provisions of this Annex;
- the Rules, without prejudice to the provisions of Article I 1.08 thereof;
- Swiss Federal legislation on disability insurance, it being understood that the notion "reduced earning capacity" used in this Annex corresponds to the notion "disability" in the LAI (Loi sur l'assurance-invalidité);
- the insurance laws and regulations in force in Switzerland.
Annex III – Short-Term Health Insurance

A III 1.01 REIMBURSEMENT RATE UNDER THE GENERAL RULE

The reimbursement rates according to the Costs Borne by the Insured Member (FCA) cumulated by the Member over a calendar year are as follows:

<table>
<thead>
<tr>
<th>Cumulated Costs Borne by a Member (FCA)</th>
<th>Reimbursement rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>up to 499.99 CHF</td>
<td>80 %</td>
</tr>
<tr>
<td>as from 500 CHF and up to 2’999.99 CHF</td>
<td>90 %</td>
</tr>
<tr>
<td>3000 CHF</td>
<td>100 %</td>
</tr>
</tbody>
</table>

A III 1.02 BONUS FOR OUTPATIENT TREATMENTS

In order to promote use of healthcare providers in Member States where health costs are less onerous, the 80% and 90% reimbursement rates are increased by 5 percentage points for certain outpatient treatments (defined in the table below) if they are dispensed in one of the following Member States: Austria, Belgium, Bulgaria, Czech Republic, Finland, France, Germany, Greece, Hungary, Israel, Italy, Netherlands, Poland, Portugal, Romania, Slovak Republic, Spain, Sweden and the United Kingdom.

<table>
<thead>
<tr>
<th>BENEFITS</th>
<th>REIMBURSEMENT RATE</th>
<th>BONUS</th>
<th>PRIOR AUTHORIZATION BY THE THIRD-PARTY ADMINISTRATOR (see Chapter VIII, Section 2)</th>
<th>CEILING</th>
<th>OTHER CONDITIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. OCCUPATIONAL ILLNESSES AND ACCIDENTS</td>
<td>100%</td>
<td>NA</td>
<td></td>
<td></td>
<td>Without limit or ceiling, but subject to prior agreement or opinion for the items concerned, as in B below. Any supplements for hospitalisation in a single-bed ward borne exclusively by the Member.</td>
</tr>
<tr>
<td>B. NON-OCCUPATIONAL ACCIDENTS AND ILLNESSES</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Doctors’ fees</td>
<td>General rule</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Pharmaceutical costs</td>
<td>General rule</td>
<td></td>
<td></td>
<td></td>
<td>Recognised as such in the State where prescribed. The cost of non-reimbursed medication is not included in the calculation of the Costs Borne by the Insured Member (FCA).</td>
</tr>
<tr>
<td>BENEFITS</td>
<td>REIMBURSEMENT RATE</td>
<td>BONUS</td>
<td>PRIOR AUTHORIZATION BY THE THIRD-PARTY ADMINISTRATOR</td>
<td>CEILING</td>
<td>OTHER CONDITIONS</td>
</tr>
<tr>
<td>----------</td>
<td>-------------------</td>
<td>-------</td>
<td>-----------------------------------------------------</td>
<td>---------</td>
<td>------------------</td>
</tr>
<tr>
<td>3. Medical imaging</td>
<td>General rule</td>
<td>According to A III 1.02</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Laboratory and analysis work</td>
<td>General rule</td>
<td>According to A III 1.02</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. In-patient hospital treatment (cost of accommodation and treatment)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a) Hospitalisation in a public hospital apart from the private or semi-private sector</td>
<td>100%</td>
<td></td>
<td></td>
<td></td>
<td>Any supplements for hospitalisation in a single-bed ward borne exclusively by the Member.</td>
</tr>
<tr>
<td>b) Hospitalisation in an unapproved private hospital</td>
<td>80%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>c) Any other hospitalisation</td>
<td>General rule</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Urgent dental treatment (excluding prostheses and orthodontics)</td>
<td>General rule</td>
<td></td>
<td>300 CHF</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Transport costs: in an ambulance or medical vehicle (exceptionally by taxi)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a) from the place of residence or the site of the accident to the nearest suitable hospital, or any other means of transport used in an emergency</td>
<td>General rule</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b) from one hospital to another</td>
<td>General rule</td>
<td></td>
<td>YES</td>
<td></td>
<td></td>
</tr>
<tr>
<td>c) to a rehabilitation facility</td>
<td>General rule</td>
<td></td>
<td>YES</td>
<td></td>
<td></td>
</tr>
<tr>
<td>g) any other medically essential transport</td>
<td>General rule</td>
<td></td>
<td>YES</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Annex IV – Contribution Rates

Section 1 – Contributions and Contribution Rates

In accordance with Articles III 5.09 and IV 5.01, the contribution rate for non-occupational illnesses and accidents is the following percentage of the Member’s reference salary defined in Chapter IX Section 1 for (a) beneficiaries of the CERN Pension Fund and (b) all other Members:

<table>
<thead>
<tr>
<th>Year</th>
<th>(a)</th>
<th>(b)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011</td>
<td>11.66%</td>
<td>10.86%</td>
</tr>
<tr>
<td>2012</td>
<td>12.07%</td>
<td>11.27%</td>
</tr>
<tr>
<td>2013</td>
<td>12.48%</td>
<td>11.68%</td>
</tr>
<tr>
<td>2014</td>
<td>12.91%</td>
<td>12.11%</td>
</tr>
<tr>
<td>2015</td>
<td>13.37%</td>
<td>12.57%</td>
</tr>
</tbody>
</table>

For the year 2011,

(a) the Member pays 4.27% of the reference salaries defined for staff members, fellows, students and for beneficiaries of the CERN Pension Fund;

(b) the Organization pays

1. 6.59% of the reference salaries defined for staff members, fellows and students, and,

2. 7.39% of the reference salaries defined for beneficiaries of the CERN Pension Fund.

Thereafter, this apportionment will be increased to the following percentage of the respective reference salary:

<table>
<thead>
<tr>
<th>Year</th>
<th>(a)</th>
<th>(b1)</th>
<th>(b2)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2012</td>
<td>4.41%</td>
<td>6.86%</td>
<td>7.66%</td>
</tr>
<tr>
<td>2013</td>
<td>4.55%</td>
<td>7.13%</td>
<td>7.93%</td>
</tr>
<tr>
<td>2014</td>
<td>4.70%</td>
<td>7.41%</td>
<td>8.21%</td>
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<tr>
<td>2015</td>
<td>4.86%</td>
<td>7.71%</td>
<td>8.51%</td>
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</table>

The Organization pays 100% of the contribution payable for apprentices.

When a supplementary contribution is calculated on Reference Salary V, the contribution is paid by the Member alone at the rate as specified under (a).

During periods of special leave of one complete calendar month or more, the apportionment of the contributions are determined in each individual case by mutual agreement between the Organization and the member of the CERN personnel concerned.

In all other cases, unless otherwise specified, the Member concerned pays 100% of the contribution.

The contribution for the Short-Term Health Insurance is 13 CHF per Member per full day of insurance cover (0.00 to 24.00) or 330 CHF per month (30 consecutive days) per Member.

In accordance with Article VI 5.02, the contribution rate for occupational illnesses and accidents is 0.12% of the reference salaries defined in Chapter IX, Section 1.
Annex V – Long-Term Care Benefits

Section 1 – Conditions of Award and Procedural Aspects

A V 1.01 GENERAL CONDITIONS

Unless otherwise specified, the conditions of the Health Insurance Scheme shall apply to the provisions of this Annex.

A V 1.02 ELIGIBLE PERSONS

Any Member of the Normal Health Insurance considering himself to be in a state of dependence may apply to receive the long-term care benefits set out in Section 2 of this Annex.

A V 1.03 « MEMBER CONCERNED »

Within the meaning of this Annex, “Member concerned” shall signify the Member himself or any person expressly empowered to represent him, except where it is clear from the context that the provisions in question relate exclusively to the Member himself.

A V 1.04 FORM OF THE APPLICATION

The application shall be addressed to the Third-Party Administrator in writing. It shall specify whether the Member concerned resides at home or in a specialised institution, as well as the name and address of the attending physician.

A V 1.05 PROCEDURE FOR THE RECOGNITION OF A STATE OF DEPENDENCE

The recognition of a state of dependence is based upon an assessment by a Medico-Social Panel comprising a representative of the CERN Social Affairs Service, the Third-Party Administrator's consulting medical practitioner specialising in geriatrics and dependence, appointed in agreement with CERN and a representative of the Third-Party Administrator. The Panel's assessment of whether a state of dependence exists shall be based upon two questionnaires: a medical questionnaire completed by the Member's attending physician and a medico-social questionnaire completed by the Member concerned and/or his family members, friends or others close to him. Wherever appropriate, the Panel may request any additional information it deems necessary.

The Medico-Social Panel shall distinguish between three levels of dependence (low, moderate or high) according to the Member's degree of ability to perform the following functions of everyday life unaided:

- getting up, sitting down, getting into bed;
- mobility;
- washing and grooming;
- dressing and undressing;
- taking food and drink;
- going to the lavatory;
- coherence and ability to communicate;
- orientation in space and time.

The Panel shall also determine the date on which the state of dependence began.

A V 1.06 RECOGNITION OF A STATE OF DEPENDENCE

The Third-Party Administrator's recognition of a level of dependence, on the advice of the Medico-Social Panel, shall be the subject of written notification sent to the Member concerned and shall give him entitlement to the corresponding long-term care benefits set out in Section 2 of this Annex.

A V 1.07 DATE OF EFFECT

The long-term care benefits shall be granted from the date on which the application was submitted provided that it is medically recognised that the Member concerned was in the state of dependence on this date.

Where the date of recognition of the state of dependence falls later than the date of application, the long-term care benefits shall be paid only from the date of recognition onwards.
A V 1.08
CHANGE IN THE STATE OF DEPENDENCE

The Member concerned shall be required to inform the Third-Party Administrator of any lasting change (deterioration or improvement) that may affect the state of dependence. This change shall be substantiated by a medical certificate.

The Medico-Social Panel may, at any time, conduct a new assessment of the Member's state of dependence.

A V 1.09
DATE OF EFFECT OF A CHANGE IN THE STATE OF DEPENDENCE

The Third-Party Administrator's recognition of a change in the state of dependence shall take effect from the day on which this change is medically recognised.

A V 1.10
RULE CONCERNING NON-CONCURRENCE OF BENEFITS

Any benefit of the same nature for the same purpose received as a result of compulsory membership of a national social-security scheme shall be deducted from the long-term care allowance provided for under Section 2 of this Annex.

The Member concerned is required to inform the Third-Party Administrator that he is in receipt of any such benefit.

A V 1.11
APPEAL AGAINST A DECISION CONCERNING THE RECOGNITION OF A STATE OF DEPENDENCE

Any decision concerning the recognition of a state of dependence shall be taken on behalf of the Director-General of the Organization and may be challenged according to the appeal procedure set out below.

During the procedure set out below, personal medical data shall be subject to confidentiality, as indicated in Article I 1.06.

The Director-General or the person to whom he has delegated his authority may extend the time limits specified in the procedure set out below whenever circumstances so require. He shall immediately inform the Member concerned accordingly.

The Member concerned shall lodge the appeal with the Director-General in writing within 60 calendar days following the notification of the challenged decision.

The letter of appeal shall be signed by the Member concerned and sent by registered mail. It shall include a copy of the challenged decision and a summary of the grounds for the appeal.

The dispute shall then be examined by a medical practitioner specialising in geriatrics and dependence, jointly appointed by the Member concerned and the Organization within 15 calendar days following the lodging of the appeal.

If the parties fail to agree on the choice of the specialist medical practitioner, the appointment shall be made by any competent medical authority in the Canton of Geneva.

When the specialist medical practitioner has been appointed, he shall begin to examine the case within 15 calendar days.

The specialist medical practitioner may initiate any investigation procedures which he deems necessary for examination of the case.

The specialist medical practitioner shall:
- examine the documents which are presented to him by the parties;
- consult the Third-Party Administrator or any expert, if he deems this necessary.

The specialist medical practitioner’s fees and those of any expert consulted shall be borne by the Scheme.

The specialist medical practitioner shall draw up a report which he shall forward to the Director-General within 15 calendar days following the closure of the investigation procedure. This report shall include the following elements:
- main arguments of the parties;
- a summary of the conclusions of the experts consulted;
- considerations of the specialist medical practitioner;
- a recommendation.
The Director-General shall notify the Member concerned of his decision in writing, enclosing a copy of the report submitted by the specialist medical practitioner, within 15 calendar days of receiving the report.

The decision of the Director-General shall be final.

A complaint against this decision may be filed with the Administrative Tribunal of the International Labour Organization (ILOAT), in accordance with the latter's Statute and Rules.

Section 2 – Benefits

In the event of recognition of a state of dependence in accordance with the procedure described in Section 1 of this Annex, the following benefits shall be granted in addition to those of the Normal Health Insurance Cover provided for in Annex I of these Rules, with the exception of points 6 c) [home nurses] and 6 d) [other medical auxiliaries].

PARAMEDICAL BENEFITS

- 6 c) home nurses
- 6 d) Medical auxiliaries other than those mentioned in points 6 a) to c) of Annex I.

<table>
<thead>
<tr>
<th>Rate of reimbursement</th>
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<tr>
<td>low level of dependence</td>
<td>general rule</td>
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<tr>
<td>moderate level of dependence</td>
<td>general rule</td>
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<tr>
<td>high level of dependence</td>
<td>general rule</td>
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LONG-TERM CARE ALLOWANCE

<table>
<thead>
<tr>
<th>Amount</th>
<th>Conditions</th>
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<tbody>
<tr>
<td>low level of dependence</td>
<td>48 CHF / day the long-term care allowance</td>
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<tr>
<td>moderate level of dependence</td>
<td>72 CHF / day shall not be paid during periods of hospitalisation.</td>
</tr>
<tr>
<td>high level of dependence</td>
<td>120 CHF / day</td>
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