Rules of the CERN Health Insurance Scheme

Version: 1 September 2017
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, as far as possible and under conditions to be agreed upon, insures 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 illness and accidents, disability and old age in accordance with the provisions of the social protection scheme it has set up;

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” and the provisions for its implementation;

Considering that the Council of the Organization, in accordance with the Staff Rules, sets the contributions of the Organization as well as the benefits and contributions of the members of the personnel relating to the 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 authorise the Director-General to take timely measures to contain the increase of the Scheme’s expenses, such as incentives to use healthcare providers and treatments that provide the best value for money;

Considering the Council decision of 16 December 2016 relating to the conditions of membership and the basis for the calculation of contributions, and specifying the conditions governing the application of certain benefits;

Hereby adopts the “Rules of the CERN Health Insurance Scheme”, as amended on 1 September 2017.
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Chapter I - The CERN Health Insurance Scheme

Section 1 - General framework

1.01 OBJECTIVE OF THE SCHEME

The objective of the CERN Health Insurance Scheme (hereinafter the “Scheme”), in accordance with Article S IV 2.01, paragraph a) of the CERN Staff Rules and Regulations, is to safeguard its Members against the financial consequences of illness, accidents and maternity by providing for the reimbursement of the expenses arising from medical treatment.

The Scheme also safeguards certain Members against the financial consequences of dependence and, in accordance with Article S IV 2.02 of the Staff Rules and Regulations, of disability.

1.02 MANAGEMENT OF THE SCHEME

The Director-General is responsible for the management of the Scheme and determines and implements the necessary structures as defined in Chapter XIII Section 1 of these Rules.

1.03 RULES

The Rules of the CERN Health Insurance Scheme (hereinafter the “Rules”) specify the social insurance measures provided by the Scheme and the associated terms and conditions. They are adopted by the Director-General following discussion in the Standing Concertation Committee (SCC), on the basis of:

- the decisions of the Council of the Organization setting the benefits and contributions, in accordance with the provisions of Article S IV 2.07 of the Staff Rules and Regulations; or
- the authorisation given to the Director-General by the Council of the Organization in 2010 to take timely measures to contain the increase of the Scheme’s expenses.

1.04 INTERPRETATION OF THE RULES

The provisions of the Rules are interpreted by the Director-General in accordance with their terms and purpose.

The Rules are interpreted with reference to the CERN Staff Rules and Regulations and the provisions for their implementation.

Moreover, in the event of difficulty in interpreting or applying the Rules, in particular where they are silent on an issue, reference may be made subsidiarily and by analogy to Swiss and/or French legislation governing social security and health insurance matters.

Both the English and French texts of the Rules are authentic.

1.05 DECISIONS TAKEN IN APPLICATION OF THE RULES

All decisions taken in application of the Rules are taken in the name of the Director-General.

1.06 IMPLEMENTING DIRECTIVES

The Rules may give rise to implementing directives, which are adopted by the Director-General following discussion in the SCC; the SCC’s discussions are prepared by the CHIS Board.

Section 2 - Categories of benefits of the Scheme

The Scheme includes the following categories of benefits:

- insurance against the financial consequences of illness, accidents and maternity (hereinafter “health insurance”), based on two types of cover:
  - normal health insurance (Chapter VII);
  - reduced health insurance (Chapter VIII);

- insurance against the financial consequences of occupational accidents and illness (hereinafter “occupational insurance”) (Chapter IX);
insurance against the financial consequences of dependence (hereinafter “long-term care benefits”) (Chapter X);

• insurance against the reduced earning capacity of a family member (hereinafter “reduced earning capacity allowance”) (Chapter XI).

Section 3 - General principles of the Scheme

I 3.01 MUTUALITY
The Scheme, to which the Organization and the Members contribute, is based on the principle of mutuality.

I 3.02 FAMILY COVER
Normal health insurance, long-term care benefits and the reduced earning capacity allowance may apply to all family members of the Main Members concerned, depending on their status.

The contribution to the Scheme is not based on the composition of the family. However, a supplementary contribution may be payable for the spouse of a Compulsory Main Member or Post-Compulsory Main Member (Article IV 1.05).

I 3.03 PRIMARY HEALTH INSURANCE
The Scheme serves as the primary health insurance of its Members, except in the case of those who are members of another adequate primary health insurance scheme, in which case the Scheme serves as supplementary insurance.

I 3.04 GLOBAL COVER
Members are covered for the cost of medical treatment carried out anywhere in the world.

I 3.05 FREE CHOICE OF HEALTHCARE PROVIDER
Members are free to choose any healthcare provider, as long as it is recognised by the competent authorities of the State in which it operates. However, the amount of reimbursement paid in application of these Rules may vary according to the choice made.

I 3.06 ADMISSIBILITY OF TREATMENT
In order to be covered by the Scheme, treatments must be:

• appropriate;

• dispensed by providers and/or in establishments that are recognised by the competent authorities of the State in which they operate; and

• recognised by the competent authorities of the State in which they are dispensed.

I 3.07 CONFIDENTIALITY
All documents and data containing the personal administrative or medical details of Members must be treated confidentially.

Persons having access to such personal information 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 unauthorised persons.

In addition, professional medical secrecy must be preserved.
Chapter II - Definitions

Section 1 - Members

II 1.01 MAIN MEMBER
The following are Main Members of the Scheme:

- any member of the CERN personnel for whom membership of the Scheme is compulsory by virtue of his or her contract of employment or association with the Organization, as specified in the Staff Rules and Regulations;
- any person who has opted for post-compulsory membership in accordance with the provisions of these Rules;
- any person who meets the conditions for voluntary membership and has joined the Scheme before the date specified in Article III 3.01.

II 1.02 SUBSIDIARY MEMBER
The following are Subsidiary Members of the Scheme:

- any family member of a Compulsory or Post-Compulsory Main Member;
- any family member of a Voluntary Main Member with normal health insurance.

The membership of Subsidiary Members who meet the above criteria is compulsory and automatic.

However, a family member of a Main Member is him- or herself a Main Member if he or she belongs to a category of the CERN personnel for which membership is compulsory under Article III 1.01 or can apply to be a Post-Compulsory Member under Article III 2.01.

II 1.03 MEMBER
All Main and Subsidiary Members are considered Members of the Scheme.

II 1.04 GENDER
In drafting these Rules, every effort has been made to use gender-neutral language in accordance with CERN’s commitment to diversity.

II 1.05 SPOUSE
In the framework of these Rules, the term “marriage” includes registered civil partnerships; the term “spouse” includes registered partners, and the term “divorce” includes the dissolution of a registered civil partnership.

II 1.06 FAMILY
The family of a Main Member is defined in accordance with CERN’s Staff Rules and Regulations.

II 1.07 CERN PENSIONER
All beneficiaries of the CERN Pension Fund whose pension rights derive from an employment contract with CERN are CERN pensioners, provided that they actually receive payments from the Fund.

II 1.08 CERN RETIREMENT AGE
In these Rules, all references to “CERN retirement age” are to be understood as the highest age limit for a staff member, as defined in CERN’s Staff Rules and Regulations.

1 Pursuant to the CERN Council’s decision of 17 December 2015, according to which registered civil partnerships are recognised as equivalent to marriage.
Section 2 - Health conditions

II 2.01
ILLNESS, ACCIDENT, CERTIFICATION, CONSOLIDATION, RECOVERY AND RELAPSE

These terms are defined in Administrative Circular No. 14 “Protection of members of the personnel against the financial consequences of illness, accident and incapacity for work”.

II 2.02
MATERNITY

The physical condition of a woman from the conception to the birth of a child and all medically related occurrences resulting therefrom.

II 2.03
DEPENDENCE

Permanent or long-term inability to perform the ordinary functions of everyday life unaided, as detailed in Chapter X.

Section 3 - Healthcare providers

II 3.01
RECOGNISED HEALTHCARE PROVIDERS

In order to be recognised by the Scheme, the healthcare providers used by the Members must be recognised, qualified and licensed to practice medicine and/or to provide the healthcare or medical treatment concerned by the competent national authorities of the country where they operate.

II 3.02
MEDICAL TREATMENT

All examinations and treatments carried out with a view to restoring or preserving health and/or physical integrity. Vaccination is also considered to be a medical treatment. Medical treatment must be recognised as such by the competent health authorities of the State in which it is dispensed.

II 3.03
HOSPITAL

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

II 3.04
PUBLIC HOSPITAL

Any hospital, or part thereof, recognised as public by the competent health authorities of the State concerned.

II 3.05
PRIVATE HOSPITAL

Any hospital, or part thereof, that does not correspond to the definition in Article II 3.04.

II 3.06
APPROVED HOSPITAL

Any public hospital as defined in Article II 3.04, or any private hospital as defined in Article II 3.05 provided that it is established:

• in Switzerland and has concluded a tariff agreement with the Scheme;
• outside Switzerland and has concluded a tariff agreement with the relevant national social security scheme and applies to the Scheme’s members similar tariffs to those stipulated in the aforementioned agreement for medical treatment and accommodation.

II 3.07
UNAPPROVED HOSPITAL

Any hospital that does not correspond to the definition in Article II 3.06.

II 3.08
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 3.09
MEDICAL AUXILIARY

Any person qualified and licensed, by the competent national authority of the State in which the treatment is provided, to provide services on the basis of a medical prescription and assist the medical profession in administering treatment and care following maternity, illness or accidents.

II 3.10
AUXILIARY APPLIANCES

Any device or item of equipment that needs to be purchased or rented by Members in order to improve their state of health, for example prostheses other than dental prostheses, dialysis machines, equipment to enhance personal autonomy (wheelchairs, hospital beds, etc.).
II 3.11 ALTERNATIVE THERAPIES
The alternative therapies recognised by the Scheme are acupuncture, Chinese medicine, chiropractic medicine, osteopathy and etiopathy, provided that they are dispensed by healthcare providers recognised for these specific treatments in accordance with Article II 3.01.

II 3.12 HOME NURSE
Any person qualified to assist dependent persons in performing the ordinary functions of everyday life.

II 3.13 CURE
Stay, prescribed by a physician, in a residential medical establishment, a thermal centre or a similar establishment, which is part of a course of treatment of an existing pathology. High-altitude, rejuvenation, rest and change-of-air therapy and any other such therapy is not considered as a “cure” within the meaning of these Rules.

Section 4 - Contributions

II 4.01 CONTRIBUTION RATE
Members’ contributions are calculated based on the multiplication of the Reference Salary by a contribution rate. The contribution rates are defined in Annex III.

II 4.02 REFERENCE SALARY
The Reference Salary used to calculate the contribution of each Member depends on the type of membership. The Reference Salaries to be used are set out in Chapter VII Section 2 and the Reference Salaries themselves are set out in Chapter XII.

Section 5 - Reimbursements

II 5.01 GENERAL REIMBURSEMENT RULE
Rule defining the reimbursement rates according to the costs borne by the insured member (referred to hereinafter by the French acronym FCA) cumulated by the Member over a calendar year, as detailed in Article A II 1.01.

II 5.02 COSTS BORNE BY THE INSURED MEMBER (FCA)
The part of the expenses not reimbursed by the Scheme, up to the applicable ceiling if relevant, for the benefits covered by the General Reimbursement Rule.

Section 6 - Governance and administration

II 6.01 STRATEGIC ADVISOR TO THE DIRECTOR-GENERAL
The CERN staff member appointed by the Director-General of the Organization to advise him or her on health insurance matters.

II 6.02 CERN HEALTH INSURANCE SCHEME BOARD (CHIS BOARD)
The CERN Health Insurance Scheme Board (CHIS Board) is the joint committee in which discussion on health insurance matters takes place. Its role and composition are defined in Article XIII 1.03.

II 6.03 MANAGER OF THE HEALTH INSURANCE SCHEME
The CERN staff member appointed by the Director-General to manage the operation of the CERN Health Insurance Scheme.

II 6.04 THIRD-PARTY ADMINISTRATOR
The Director-General appoints a Third-Party Administrator for the day-to-day administration of the Scheme.
Chapter III - Insurance of Main Members

Section 1 - Compulsory Main Members

Membership of the Scheme as a Main Member is compulsory for:

- staff members and fellows;
- students participating in one of CERN’s student programmes, as defined in Administrative Circular No. 11 (Categories of members of the personnel).

Compulsory Main Members are entitled to the following categories of benefits:

- normal health insurance;
- occupational insurance;
- long-term care benefits;
- insurance against the reduced earning capacity of a family member.

Membership as a Compulsory Main Member extends from the first to the last day of the contract of employment or association with the Organization. Compulsory membership is interrupted during any period of unpaid special leave or unpaid authorised absence of one month or more, except in the case of parental leave.

Section 2 - Post-Compulsory Main Members

The following Members may apply to remain Main Members of the Scheme when the condition making their membership compulsory comes to an end either temporarily or definitively:

- CERN pensioners who have remained Members of the Scheme without interruption since the end of their compulsory membership;
- beneficiaries of a deferred pension from the CERN Pension Fund who have remained Members of the Scheme without interruption since the end of their compulsory membership;
- Compulsory Members, for any period of unpaid special leave or unpaid authorised absence of one month or more.

The following persons may apply to remain Main Members of the Scheme as Post-Compulsory Members:

- former staff members in receipt of unemployment benefits from the Organization, throughout the period during which they receive these benefits;
- Compulsory Members who have been Members of the Scheme for one year or more and who are not entitled to membership under the terms of Article III 2.01, for a maximum period of 12 months;
- Compulsory Members who have been Members of the Scheme for less than one year, for a maximum period of one month;
- the children of a Compulsory or Post-Compulsory Main Member who are no longer dependent, within the meaning of the CERN Staff Rules and Regulations and are aged under 26 years, at their request. Their membership remains dependent on the continued membership of the parent. They become a Main Member and pay their own contribution. They alone are covered: members of their family cannot be Subsidiary Members;
- in the event of the divorce of a Compulsory or Post-Compulsory Member who has been a Member for one year or more, the ex-spouse and his or her dependent children (who were considered as family members on the final date of the divorce), for a maximum period of 12 months;
- in the event of the death of a Compulsory or Post-Compulsory Member, the
members of his or her family on the date of death, if they do not become CERN pensioners, for a maximum period of 12 months.

III 2.03
PENSIONERS WHO ARE THE SPOUSES OF MAIN MEMBERS

Where the spouse of a Compulsory or Post-Compulsory Main Member is a CERN pensioner, his or her membership as a Main Member is compulsory.

III 2.04
APPLICATION FOR MEMBERSHIP

Applications to become a Post-Compulsory Member must be submitted within the 30 calendar days following the first day after the end of compulsory membership.

III 2.05
DURATION OF MEMBERSHIP

Insurance terminates, where applicable:
- at the end of the period defined in Articles III 2.01 to III 2.02, or
- when the Member ceases to meet the conditions that allowed him or her to be a member, or
- when the Member cancels his or her membership, or
- when the Member is excluded from the Scheme in accordance with Article V 5.04.

III 2.06
CANCELLATION OF MEMBERSHIP

Post-Compulsory Members may cancel their membership by giving 30 days’ notice. This cancellation is irrevocable and takes effect at the end of a calendar month.

However, Post-Compulsory Members may cancel their membership without notice if they are required to become compulsory members of another health insurance scheme pursuant to a legal provision of the State in which they reside or work. In such cases, cancellation is effective from the day on which the cover of the other health insurance scheme enters into force.

III 2.07
CATEGORIES OF BENEFITS

Post-Compulsory Main Members are entitled to the following categories of benefits:
- normal health insurance;
- long-term care benefits;
- allowance for the reduced earning capacity of a family member, in accordance with the conditions defined in Chapter XI.

Section 3 - Voluntary Main Members

III 3.01
END OF NEW VOLUNTARY MEMBERSHIP

Under these Rules, it will no longer be possible for associated members of the personnel (MPA) to join the Scheme as Voluntary Members as of 1 September 2017.

However, Members who are already Voluntary Members on this date may remain so, including in cases where their contract is renewed, provided that they meet the conditions defined in Article III 3.02.

III 3.02
CONDITIONS AND DURATION OF VOLUNTARY MEMBERSHIP

Voluntary Members must be in possession of a carte de légitimation issued by the Swiss authorities.

Their membership of the Scheme terminates automatically and definitively when this condition is no longer met, or when their membership is cancelled pursuant to a provision of these Rules.

III 3.03
CHANGE OF TYPE OF COVER

An application to change the type of cover can be accepted only if it is justified by:
- the age of the Main Member, as specified in Article III 3.05; or
- a change in the family status of the Voluntary Member, in particular marriage, divorce, or the birth or adoption of a child.

Applications to change the type of cover must be submitted within the 30 calendar days following the event giving entitlement to the change.
III 3.04
CANCELLATION OF THE INSURANCE

Voluntary Members may cancel their membership subject to 30 calendar days’ notice. The cancellation takes effect at the end of a calendar month.

Notice is not required if the Voluntary Member is required to become a compulsory member of another health insurance scheme pursuant to a legal provision of the State in which he or she resides or works. In such cases, cancellation is effective from the day on which the cover of the other health insurance scheme enters into force.

All cancellations are irrevocable.

III 3.05
CATEGORIES OF BENEFITS

Voluntary Members are entitled only to the health insurance benefit and may choose between normal health insurance, provided that they are younger than the CERN retirement age, and reduced health insurance, for which there is no age limit.
Chapter IV - Insurance of Subsidiary Members

Section 1 - Cover for Subsidiary Members

IV 1.01 SUBSIDIARY MEMBERS

Article II 1.02 defines the conditions under which the family members of a Main Member are insured as Subsidiary Members.

Subsidiary Members are insured until the day on which they are no longer recognised as family members, unless they opt to continue cover in accordance with Article III 2.02.

The type of cover of Subsidiary Members depends on whether or not they are members of another health insurance scheme, as described below.

IV 1.02 PRIMARY OR SUPPLEMENTARY INSURANCE

As a general rule, the Scheme serves as primary insurance for Subsidiary Members.

However, when a Main Member has declared that his or her spouse is covered by another adequate health insurance scheme, the Scheme serves as supplementary insurance. In this case, the spouse must submit his or her bills for reimbursement to the other health insurance scheme in the first instance.

If one or more children are covered by the spouse’s health insurance, the Scheme may also serve as their supplementary insurance.

IV 1.03 ADEQUATE HEALTH INSURANCE

The following are considered to be adequate health insurance for a spouse:

- any health insurance provided by the national system of a Member State of the Organization, provided that it is valid in the spouse’s State of residence;

- any private or public, individual or collective health insurance that provides benefits and reimbursement levels in the spouse’s State of residence that are at least broadly equivalent to those guaranteed under the Swiss federal law on health insurance (LAMal).

IV 1.04 SUPPLEMENTARY REIMBURSEMENT

Any difference between the amount reimbursed by the primary health insurance and the actual expenses incurred may be submitted to the Scheme for reimbursement, in accordance with the provisions of these Rules.

However, if the reimbursement under the spouse’s other health insurance is subject to an annual deductible, this is not reimbursed by the Scheme.

IV 1.05 SUPPLEMENTARY CONTRIBUTION

As a general rule, no supplementary contribution is required for Subsidiary Members.

However, where a Compulsory or Post-Compulsory Main Member who is or has been a staff member or fellow or is a CERN pensioner has a spouse who is in receipt of income or a retirement pension, as defined in Articles IV 2.04 and IV 2.05, but is not a member of an adequate health insurance scheme, a supplementary contribution is payable if the spouse uses the Scheme as his or her primary insurance.

To this end, the Main Member concerned is required to provide information about the spouse in accordance with Section 2 of this chapter. No supplementary contribution is required for dependent children who are Subsidiary Members.
Section 2 - Obligation to furnish information

IV 2.01
DECLARATION OF FAMILY STATUS

By extension of the provisions of Article R V 1.38 of the Staff Rules and Regulations, all Main Members must declare the following within 30 calendar days:

- any change in their personal status or that of members of their family (in particular marriage, divorce, death, birth or adoption);
- the end of full-time education or start of employment of a dependent child;
- any change in their usual address, e-mail address and/or telephone number.

Subsidiary Members are determined as a function of these declarations and by analogy with the practices deriving from the relevant provisions of the Staff Rules and Regulations.

IV 2.02
DECLARATION OF SPOUSE’S HEALTH INSURANCE AND FINANCIAL SITUATION

Each Main Member is required to declare in writing the situation of his or her spouse with respect to:

- any other primary health insurance scheme of which the spouse is a member; and
- in the event that the spouse does not have adequate primary health insurance, the amount of any income deriving from a professional activity and/or a retirement pension received by the spouse.

This declaration must be made within the 30 calendar days following:

- the date on which the spouse joins the Scheme;
- the date of a change (or of the notification of a change) of the health insurance scheme of which the spouse is a member or of the spouse’s professional or pension income resulting in a change in the income category as defined in Article XII 1.06;
- each request by the Scheme (including in the context of annual renewal).

The effective date of a declaration of a change is the day on which the change occurs, even if the notification is late.

IV 2.03
DECLARATION OF A MAIN MEMBER’S INCOME

As a general rule, a Main Member is not required to make a specific declaration of his or her own income, unless he or she is a CERN pensioner and the spouse of another Main Member.

In this case, in order to determine his or her Reference Salary V as per Article XII 1.05, if

- his or her spouse is a Main Member, or
- his or her Reference Salary III is lower than that of the spouse, if the spouse is a CERN pensioner,

the Member is required to declare to the CERN Pension Fund the total amount of his or her own professional and/or retirement pension income (including the CERN pension).

In addition, the Member is required to declare, within 30 calendar days, any change in such income resulting in a change in the income category calculated according to Article XII 1.06.

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2 This declaration must be made to the Human Resources department by Main Members, to the CERN Pension Fund by beneficiaries of the Pension Fund, to the Third-Party Administrator by Voluntary Members and to the CHIS Manager by all other persons.
IV 2.04 PROFESSIONAL INCOME

Any form of remuneration, salary, fee or payment deriving from a professional activity, including any replacement salary received during periods of leave.

The following are not considered as income:

• unemployment benefits;
• disability pensions;
• dependent child allowances;
• maternity benefits if they are not a replacement salary;
• adoption benefits; and
• reimbursement by the employer of professional expenses incurred.

IV 2.05 RETIREMENT PENSION

Any payment from an old-age insurance scheme, including the CERN Pension Fund, is considered to be a retirement pension. The following are not considered as retirement pensions:

• disability pensions;
• payments received from a voluntary interest-bearing savings product, contracted privately and for a fee.

IV 2.06 AMOUNT TO BE DECLARED

The amount to be declared is the monthly gross total professional income and retirement pension paid to the Member in question.

Where the income concerned is not known by the deadline stipulated in Article IV 2.03, for example in the case of non-salaried activities, the Main Member must declare an estimated income. The actual gross income must be declared within 30 calendar days of its becoming known.

Where only a multi-month (for example annual) income of the spouse is known, the monthly income to be declared is the average monthly income for the period concerned, for example 1/12 of the annual income.

IV 2.07 SUPPORTING DOCUMENTATION

On request, the Main Member must provide supporting documentation for the information provided in accordance with Articles IV 2.02 and IV 2.03.

IV 2.08 LATE OR INACCURATE DECLARATIONS

In the event of a late or inaccurate declaration, any supplementary contributions due will be collected retroactively, up to a limit of five years.

IV 2.09 CONSEQUENCES OF A FAILURE TO DECLARE

In the event of a failure to declare a change in family status (Article IV 2.01) by the specified deadline, where such a declaration would result in the end of the Subsidiary Member status of one or more members of the family and as soon as the Organization is informed of the change, each person concerned will retroactively be made a Post-Compulsory Member with effect from the date on which the status giving entitlement to Subsidiary Membership ended. In such cases, the Main Member must pay the corresponding contributions in arrears.

Any failure to make a declaration in accordance with Articles IV 2.02 or IV 2.03 will result in a deduction, from the salary, allowance or pension received from CERN, of a flat-rate supplementary contribution based on the highest value of Reference Salary VI (Article XII 1.06). This measure will continue to be applied until the change has been duly declared or the supporting documentation has been provided.
Chapter V - General provisions

Section 1 - Contributions

V 1.01 CONTRIBUTIONS
Main Members pay a monthly contribution corresponding to the categories of benefits applicable to them.

Unless otherwise specified in these Rules, the Organization also pays a contribution in accordance with the procedures defined in Annex III.

V 1.02 PRO RATA CONTRIBUTIONS
The amount of the main contribution is calculated pro rata temporis based on the actual number of days of membership of the Scheme.

The amount of the supplementary contribution due for a part of a month is zero in the first month of the period for which the contribution is due and full for the last month of the period.

Section 2 - Benefits

V 2.01 CEILING OF PRO RATA BENEFITS
Any annual ceilings applicable are reduced pro rata temporis based on the duration of membership of the Scheme, except in the event of death.

V 2.02 NON-CONCURRENCE OF BENEFITS
The amount of any benefit received as a result of compulsory membership of a national, public or equivalent social-security scheme (health insurance and/or compulsory supplementary mutual insurance) will be deducted from the benefits provided by the Scheme. Members are required to inform the Third-Party Administrator if they are in receipt of such benefits. This provision does not apply to benefits resulting from membership of a scheme to which the Member has opted to contribute, such as voluntary supplementary insurance.

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

Where medical expenses have been partly paid or reimbursed, for example by another insurance scheme, the Member may submit a reimbursement claim to the Scheme only for the amount remaining at his or her expense.

V 2.03 EXCLUDED BENEFITS
No reimbursement will be made in the event of fraud or abuse, as defined in Articles V 4.05 and V 4.06.

The following are also excluded:

- costs resulting from a failure to attend an appointment;
- rejuvenating therapy;
- cosmetic treatments, except in the case of disfigurement of the face or serious burns to the hands, as well as reparatory or reconstructive surgery, unless agreed beforehand (prior approval) and if the surgery is made necessary due to the materialisation of an insured risk, the occurrence of an accident or the onset of an illness less than two calendar years before the Member joined the scheme.

V 2.04 REIMBURSEMENT AT THE END OF COVER
All medical costs incurred up to the last day of insurance cover for non-occupational accidents and illnesses may be submitted for reimbursement in accordance with the provisions and deadlines specified in these Rules.

Where a hospital stay extends beyond the last day of insurance cover, the Member concerned may remain a Voluntary Member of the Scheme (Article III 2.02) until such time as he or she is able to join another primary health insurance scheme or to leave the hospital, whichever comes first.
Section 3 - Responsibility and representation

V 3.01 RESPONSIBILITY
Except in exceptional circumstances, the Main Member is responsible for all declarations and reimbursement claims made by the Subsidiary Members in his or her family.

V 3.02 REPRESENTATION OF A MEMBER
A Member may arrange to be represented by a third party, if necessary, in all actions relating to the Scheme.

The Third-Party Administrator may require the third party to provide evidence of his or her power of representation in the form of a written authorisation or a court decision.

Section 4 - Specific situations

V 4.01 RECOVERY OF UNDUE PAYMENTS
Any amount paid by the Scheme and to which the Member is not entitled must be repaid. The Scheme is entitled to claim the repayment of sums unduly received by the Member up to five years after the payment is made, unless the payment resulted from a fraudulent declaration, in which case no deadline applies. The undue payment will be recovered in accordance with the Organization’s usual procedures.

In the event of the death of the Member, the daily long-term care allowances already received for the month in which the death occurs do not have to be repaid.

V 4.02 RECOVERY OF DEBTS
In the event of non-payment by the Main Member of any contribution to the Scheme, contribution to medical costs incurred, repayment of sums unduly received or any other payment due to the Scheme, and after formal notice from the Third-Party Administrator proves unsuccessful, an amount will be withheld from the salary, indemnity, allowance or pension paid by the Organization. The amounts concerned may also be recovered by deduction from reimbursements or by recourse to the competent national jurisdiction.

In cases involving Voluntary Members where it has not been possible to recover debts in accordance with the paragraph above, the case will be reported to the Voluntary Member’s home institute, which will be responsible for paying the amounts due.

V 4.03 REFUND OF OVER-PAYMENT OF CONTRIBUTIONS
In the event of over-payment of contributions to the Scheme, a refund will be made as soon as possible after the facts have been established.

Over-payments will be refunded for a maximum period of:

- two years if the Scheme is responsible for the error;
- three months if the Member is responsible for the error.

Where the over-payment is made as a result of a fraudulent declaration, it will not be refunded.

V 4.04 EXCESSIVE RATES
If the Third-Party Administrator observes that the rate charged for a healthcare service is significantly higher than the usual and reasonable rate for that service, the amount refunded may be limited to the usual rate applicable in the region where the service is provided.

V 4.05 ABUSE
Excessive use of a treatment, a right or a practice above and beyond a level which is acceptable and/or necessary for its stated aims constitutes an abuse of the system.

V 4.06 CERN’s Staff Rules and Regulations define fraud as “any intentional act or omission designed to deceive others and to achieve a gain for the perpetrator or a third party, resulting
FRAUD  

in the Organization suffering a loss of funds, property or reputation”.

The provisions of Operational Circular No. 10 “Principles and procedures governing investigation of fraud” apply by extension to all Members of the Scheme.
Section 5 - Suspension and exclusion from the Scheme

V 5.01 SUSPENSION OR REFUSAL OF BENEFITS

The Third-Party Administrator may suspend, with the consent of the Scheme’s Manager, all or part of the benefits:

- of a Member who fails to comply with the provisions of these Rules;
- of a Member who refuses to undergo a medical examination requested by the Third-Party Administrator’s consulting medical practitioner;
- of a Member who fails to pay the amounts due to the Scheme in the event of third-party payment;
- of a Voluntary or Post-Compulsory Member who is late in paying the contribution due;
- of a Member suspected of fraud.

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

V 5.02 GROUNDS FOR REFUSAL, REDUCTION OR WITHDRAWAL OF BENEFITS

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

The treatment of the after-effects of a treatment not eligible for reimbursement by the Scheme is also not eligible for reimbursement.

V 5.03 DISCIPLINARY OR ADMINISTRATIVE SANCTIONS

Any member of the personnel of CERN who is a Member of the Scheme and who fails to comply with the provisions of these Rules shall be liable for disciplinary action, in accordance with the CERN Staff Rules and Regulations.

V 5.04 EXCLUSION FROM THE SCHEME

After holding a hearing with the Member concerned, the Organization may exclude a Post-Compulsory or Voluntary Member for one of the following reasons:

- failure to pay the contribution within the 30 calendar days following a third reminder by the Third-Party Administrator;
- fraud or proven attempt to defraud.

The decision to exclude a Member from the Scheme is taken by the Manager, after consulting the Strategic Advisor.
Chapter VI - Reimbursement of medical expenses

Section 1 - Requests for reimbursement

VI 1.01 DEADLINE
Claims for the reimbursement of expenses arising from medical treatment must be submitted within the twelve months following the date of the bill.

VI 1.02 SUPPORTING DOCUMENTATION
Claims for the reimbursement of medical expenses must be accompanied by the originals of the prescriptions, bills and proofs of payment.

Claims for supplementary reimbursement by the Scheme must be accompanied by the reimbursement statement received from the primary health insurance scheme, indicating the initial total amount of the medical expenses and the sums already reimbursed by that insurance scheme.

VI 1.03 BREAKDOWN OF THE BILL
Bills submitted for reimbursement must clearly indicate:

- the first and last name of the patient,
- the name, qualification and address of the medical practitioner or medical service provider,
- details of the treatment provided,
- the date or period of the treatment,
- the amount payable and the currency of payment.

VI 1.04 MEDICAL PRESCRIPTION
The purchase of medicines or medical equipment is reimbursed if they are supplied on the basis of a medical prescription.

Acts performed by medical auxiliaries must be performed in accordance with a medical prescription. However, acts performed by osteopaths, etiopathy therapists and chiropractors may be reimbursed without a medical prescription, up to a maximum of five sessions per calendar year.

VI 1.05 THIRD-PARTY PAYMENT
In some cases, bills from healthcare providers may be paid directly by the Third-Party Administrator as a third-party payer, particularly in the case of hospitalisation in an approved hospital (Article VI 5.01).

In cases where the Third-Party Administrator pays the healthcare provider directly, a bill is sent to the Member for his or her share of the expenses. This bill must be paid within 30 calendar days of issue.

VI 1.06 PAYMENT OF BILLS
Where the Third-Party Administrator does not act as a third-party payer, the Member must make sure that he or she receives and pays the bills for medical expenses in order to be able to submit them for reimbursement.

VI 1.07 OCCUPATIONAL ACCIDENTS AND ILLNESSES
Reimbursement in accordance with the provisions concerning occupational accidents and illness can be made only once the illness or accident concerned has been recognised as occupational by the Organization.

Where reimbursement is claimed for medical expenses resulting from an occupational accident or illness, the reimbursement claim must include a reference to the Organization’s decision to classify the accident or illness as such.

Where reimbursements have already been made when this decision is taken, the Member should contact the Third-Party Administrator to ensure that his or her rights are taken into account. If necessary, the Third-Party Administrator can help the Member to assemble the documents needed to claim the shortfall.
Section 2 - Procedures for the payment of benefits

VI 2.01 MEDICAL INFORMATION
The Member concerned must provide any information requested by the Third-Party Administrator regarding the illness contracted or the treatment followed. The Third-Party Administrator may also communicate directly with healthcare providers. If confidential information is involved, it must be sent in a sealed envelope to the Third-Party Administrator’s consulting medical practitioner. The consulting medical practitioner will forward to the service that handles the claims only information relevant to the reimbursement.

VI 2.02 MEDICAL EXAMINATION
The Third-Party Administrator may appoint a doctor to examine a Member who is undergoing treatment. At the request of the Member concerned, his or her own medical practitioner may be present at such an examination.

VI 2.03 PAYMENT OF BENEFITS TO MAIN MEMBERS
Benefits are usually paid to the Main Member, to the bank account held on record by the Organization, including in the case of benefits relating to a Subsidiary Member.

VI 2.04 PAYMENT OF BENEFITS TO SUBSIDIARY MEMBERS
Under certain defined conditions and in accordance with a procedure approved by the Director-General, the following may be reimbursed or paid directly to the Subsidiary Member concerned or his or her legal representative:

- certain medical treatments that have been dispensed or prescribed to the Subsidiary Member;
- services paid for or due to be paid for by the Subsidiary Member or by a third-party, except the Main Member;
- long-term care or reduced earning capacity allowances.

In such cases, claims for benefits must be made by the Subsidiary Member concerned and he or she is responsible for their accuracy. These claims and the corresponding medical information will be treated confidentially, including with respect to the Main Member.

VI 2.05 CURRENCIES USED
All payments in respect of contributions, reimbursements and allowances are made in Swiss francs. Any bank or exchange fees are borne by the Member.

If the costs to be reimbursed are not expressed in Swiss francs, the rate of exchange to Swiss francs is the official rate in force at CERN on the date on which the reimbursement claim is submitted.

Where a guarantee for the direct payment of bills is granted in accordance with Article VI 5.01, bills submitted directly to the Third-Party Administrator by the hospital concerned are paid in the currency of the State in which the treatment was dispensed.

Section 3 - Prior approvals and opinions

VI 3.01 PRIOR APPROVAL
Prior approval by the Third-Party Administrator is required for:

- transport (except in the case of emergency transport);
- refractive surgery;
- thermal spa therapy, convalescence stays, rehabilitation stays, stays 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, whose presence is required by the hospitalisation of a child of less than ten years of age.
VI 3.02
TIME LIMIT FOR THE
SUBMISSION OF
REQUESTS FOR PRIOR
APPROVAL

Requests for prior approval must be submitted in writing to the Third-Party Administrator at
least 14 calendar days before the medical expenses concerned are incurred, except in
exceptional circumstances. This deadline is increased to 30 calendar days for expenses for
thermal spa therapy.

In the absence of a response from the Third-Party Administrator within 14 or 30 calendar
days, as applicable, the request is deemed to have been accepted.

VI 3.03
SUPPORTING
DOCUMENTATION

Each request for prior approval must be supported by a medical prescription indicating the
treatment, its purpose, 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.

VI 3.04
PRIOR APPROVAL NOT
OBTAINED

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

VI 3.05
PRIOR OPINION ON
DENTAL TREATMENT

Except in cases of emergency, any planned dental treatment, prostheses or orthodontic
devices scheduled to cost more than 25% of the annual ceiling requires a prior opinion from
the Third-Party Administrator, who makes a medical and financial evaluation of the
treatment.

Section 4 - Cures and convalescence stays

VI 4.01
PRIOR APPROVAL

All courses of cures (see Article II 3.13) and convalescence stays, including the related
treatment costs, are subject to prior approval in accordance with Article VI 3.01.

VI 4.02
CONVALESCENCE
STAYS

Convalescence stays are accepted if they follow medical surgery involving hospitalisation,
or after a stay in hospital of a least ten calendar days, provided that the convalescence stay
commences within the 30 calendar days following the end of the hospital stay.

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

VI 4.03
CURES

The prescription for a course of cure must be accompanied by a medical case history setting
out the results obtained by the medical treatment preceding the therapy, the programme of
medical treatment during the therapy and the expected result with respect to the recovery or
consolidation of the state of health of the person concerned.

In the event of a course of therapy being repeated and commencing less than 12 months after
the previous course began, the medical practitioner must submit a detailed supporting
document to justify the effectiveness of the therapy.

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

Therapy must be provided by establishments recognised by the competent authorities of the
State in which they are located.

VI 4.04
REFUSAL OF CURE

Where a course of therapy is refused, the Third-Party Administrator will inform the Member
concerned of the decision and the grounds for it.
Section 5 - Hospital guarantee

VI 5.01  THIRD-PARTY PAYMENT GUARANTEE

Where hospitalisation is in an approved hospital pursuant to Article II 3.06, the Third-Party Administrator will, at the request of the hospital or the patient, issue a third-party payment guarantee at least three working days before the start of the hospitalisation, except in emergencies.

An initial guarantee is issued for a hospital stay of 14 calendar days. Any request for extension of the guarantee must be submitted by the hospital to the Third-Party Administrator for approval.

The Member must provide the hospital with all the information needed for it to submit the request to the Third-Party Administrator.

Where the Third-Party Administrator grants a third-party payment guarantee, the Member must not make payments directly to the hospital. However, even in cases where the Third-Party Administrator grants a third-party payment guarantee, certain non-medical expenses (e.g. for increased comfort) may be billed directly to the Member by the hospital. These expenses must be paid directly by the Member as they are not eligible for reimbursement by the Scheme.

VI 5.02  GUARANTEE AS THIRD-PARTY GUARANTOR

Where hospitalisation is in an unapproved hospital pursuant to Article II 3.07, the Third-Party Administrator will issue a guarantee as third-party guarantor. The Member must pay the bills for the hospital stay directly and then claim reimbursement.

Section 6 - Exceptional procedures

VI 6.01  ADVANCE REIMBURSEMENT

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

The Member must subsequently submit proof of payment of the bill. Failure to settle a bill for which advance reimbursement has been granted constitutes an infringement of the Rules and may lead to the application of Articles V 5.01, V 5.03 and V 5.04.

VI 6.02  EX GRATIA PAYMENTS

In exceptional circumstances, a Member may request that a benefit exceeding a reimbursement ceiling or a benefit not listed in these Rules be granted. A request for an ex gratia payment must be submitted in writing to the Third-Party Administrator, and a decision will be made by the Scheme’s Manager, in agreement with the Strategic Advisor.

Notwithstanding the provisions of Article XIV 1.01, decisions with regard to ex gratia payments are not subject to review in principle. Only in exceptional circumstances will they be subject to a reassessment or appeal and only for reasons such as a failure to take account of essential facts, a material error not involving a value judgement, a failure to rule on a conclusion, or the discovery of essential facts that the Member was not able to declare at the time of submitting the request.
Chapter VII - Normal health insurance

Section 1 - General description

VII 1.01
GENERAL DESCRIPTION

Normal health insurance provides for the reimbursement of a major portion of the reasonable and customary expenses resulting from medical treatment that are incurred by Members benefitting from this cover, under the conditions specified in these Rules.

VII 1.02
ELIGIBLE PERSONS

Compulsory and Post-Compulsory Main Members and the Subsidiary Members who are their dependents benefit from this cover.

Voluntary Main Members, provided that they have opted for normal health insurance cover before the date specified in Article III 3.01, and the Subsidiary Members who are their dependents, also benefit from this cover.

Section 2 - Contributions

VII 2.01
MEMBER CONTRIBUTIONS

Each Main Member pays a main contribution calculated in accordance with Article VII 2.05, except in cases where both spouses are Main Members (see Article VII 2.02).

A Main Member may also be required to pay a supplementary contribution for his or her spouse as a Subsidiary Member, calculated in accordance with Article VII 2.07.

Both the main and supplementary contributions are calculated by multiplying the Member’s Reference Salary (Chapter XII) by a contribution rate. The same rate is used for the spouse’s supplementary contribution as for the main contribution of the Main Member.

Where both spouses are Main Members of the Scheme, a main contribution is paid only by the spouse whose contribution is the highest. A supplementary contribution is paid by the other spouse.

VII 2.03
CONTRIBUTION BY THE ORGANIZATION

For Compulsory Main Members and CERN pensioners, the Organization pays a contribution based on the same Reference Salary as the Member’s contribution.

The Organization does not pay a contribution for Subsidiary Members.

VII 2.04
CONTRIBUTION RATES

The contribution rates for Members and for the Organization are defined in Annex III.

VII 2.05
REFERENCE SALARY FOR THE MAIN CONTRIBUTION

The main contribution, except in the case of continuation of cover, is based on the following reference salaries:

- Compulsory Main Members: Reference Salary I;
- Post-Compulsory Main Members who are CERN pensioners: Reference Salary III;
- Voluntary Members: Reference Salary II.

VII 2.06
AMOUNT OF THE CONTRIBUTION FOR CONTINUATION OF INSURANCE

The main contribution required for the continuation of normal health insurance, as set out in Articles III 2.01 and III 2.02, is based on the following reference salaries:

- children who are no longer dependents of a Main Member: 40% of Reference Salary II;
- beneficiaries of a deferred pension from the CERN Pension Fund who are not yet CERN pensioners: Reference Salary II;
- members of the personnel no longer in post or on special leave: the Reference Salary used in their last month of service;
- ex-spouses of Main Members: Reference Salary II.

The contribution rate used is the total rate defined in Article A II 1.01. The total amount of the contribution is paid by the Member.
The supplementary contribution for the spouse of a Main Member is based on the following Reference Salaries:

- if the spouse is a Compulsory Main Member: Reference Salary IV;
- if the spouse is a Post-Compulsory Main Member and a CERN pensioner: Reference Salary V;
- if the spouse is a Subsidiary Member: Reference Salary VI.

The main contribution payable by a Compulsory Main Member or by a CERN pensioner 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 Member pays the main contribution to the Scheme’s bank account each month in advance.

The supplementary contribution payable by a Compulsory Main Member or by a CERN pensioner in accordance with Article VII 2.07 is deducted each month from the remuneration or payment received from the Organization or from the pension received from the CERN Pension Fund.

The supplementary contribution payable for a Subsidiary Member who is a dependent of a Compulsory or Post-Compulsory Member, in accordance with Article VII 2.07 paragraph 3, is deducted each month from the remuneration or payment received by the Main Member from the Organization or from the pension received from the CERN Pension Fund.

It is payable directly by the Main Member in all other cases.

Section 3 - Benefits

All benefits, as well as the rates for reimbursement and the ceilings for expenses, are specified in Annex I of these Rules.

The cost of medical treatment and accommodation in a hospital is reimbursed in accordance with the general reimbursement rule, except:

- in the case of hospitalisation in a public ward of a public hospital, in which case the cost is 100% reimbursed;
- in the case of hospitalisation in an unapproved hospital, in which case the cost is 80% reimbursed.

Doctors’ fees and the costs of laboratory analyses and medical imaging during hospitalisation are reimbursed according to the conditions in force for the hospital concerned.

In all cases, the supplement for board and accommodation in a one-bed room invoiced by the hospital is borne exclusively by the Member.

Certain preventive examinations and treatments are 100% reimbursed, as defined in Article A II 1.03.

Other preventive examinations and treatments (e.g. vaccinations) are reimbursed in accordance with the general reimbursement rule.

The reimbursement rates under the general reimbursement rule are specified in Article A II 1.01 as a function of the accumulated FCA for the calendar year in which the expenses were incurred.

Certain benefits are subject to a maximum ceiling, which generally applies per calendar year and in certain cases can be cumulated over several years. Details of these ceilings are given in Annex I.

Under Article VI 6.02, these ceilings may be exceeded with the prior approval of the Third-Party Administrator, in particular in the case of children or the elderly whose state of health requires prolonged medical treatment.
VII 3.06
DETERMINATION OF CEILINGS
The maximum amounts of expenses that are reimbursable per benefit category (ceilings) are set annually by CERN, for application as of 1 January of the following year.

VII 3.07
REIMBURSEMENT BONUS
The reimbursement rate may be increased for certain benefits covered by the general reimbursement rule, provided that the total reimbursement rate does not exceed 100%.
The amount of this bonus and the applicable conditions are defined by the Director-General and reviewed annually (Article A II 1.02).

VII 3.08
SERIOUS CASE
Expenses under categories B1 to B5 of Annex I that are incurred for a given illness or accident after the point where the expenses cumulated for that illness or accident during membership of the Scheme exceed 80000 CHF are 100% reimbursed. The Member must contact the Third-Party Administrator to ensure that his or her rights to this benefit are taken into account. If necessary, the Third-Party Administrator can help the Member to compile the file required to claim this benefit.

VII 3.09
INDEMNITY IN THE EVENT OF DEATH
In the event of the death of a CERN staff member or a member of his or her family, an indemnity will be paid to the staff member’s estate in accordance with the conditions set out in Annex I.
Chapter VIII - Reduced health insurance

Section 1 - General description

VIII 1.01 GENERAL DESCRIPTION
Reduced health insurance cover provides certain categories of associated members of the CERN personnel (see Chapter III Section 3) with reduced benefits compared to the cover provided by normal health insurance.

VIII 1.02 ELIGIBLE PERSONS
Voluntary Main Members are entitled to this cover provided that they have opted in before the date specified in Article III 3.01 or if they previously had normal health insurance cover and request a change of cover.

The family members of a Main Member are not covered by reduced health insurance cover and may not opt into it.

Section 2 - Contributions

VIII 2.01 CONTRIBUTION
The contribution for reduced health insurance is 50% of Reference Salary II, multiplied by the total health insurance contribution rate indicated in Article A III 1.01.

The Organization does not pay a contribution.

VIII 2.02 PAYMENT OF THE CONTRIBUTION
The contribution is paid to the Scheme’s bank account by the Member each month in advance.

Section 3 - Benefits

VIII 3.01 BENEFITS
Reduced health insurance cover provides the same benefits as normal health insurance cover (Chapter VII Section 3) except in the case of:

- treatment dispensed 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 a unit for those waiting for space to become available in a suitable institution;
- infertility treatment.

All other medical expenses subject to reimbursement, as well as the applicable rates and ceilings, are specified in Annex I of these Rules.
Chapter IX Insurance against the consequences of occupational illness and accidents

Section 1 - General description

IX 1.01 GENERAL DESCRIPTION
Accidents and illnesses recognised as occupational by the Organization in accordance with the provisions of Administrative Circular No. 14 give entitlement to specific cover for the expenses for medical treatment directly associated with them.

IX 1.02 ELIGIBLE PERSONS
Only Compulsory Main Members are entitled to this cover.

IX 1.03 END OF COVER
This cover ends when the Member ceases to be a Compulsory Main Member. However, benefits arising from:
- an occupational accident recognised by CERN as having occurred during the membership period, or
- an occupational illness recognised by CERN as having been contracted during the membership period
are payable until recovery from or consolidation of the condition.

Section 2 - Contributions

IX 2.01 CONTRIBUTION
The Organization pays 100% of the contribution for this cover.

IX 2.02 CONTRIBUTION RATE
The contribution rate, as indicated in Article A III 1.01, is a percentage of the applicable Reference Salary.

Section 3 - Benefits

IX 3.01 BENEFITS
Subject to obtaining the applicable prior opinion or approval, medical expenses and treatments directly linked to an occupational illness or accident are 100% reimbursed, without any limit or ceiling.

Medical treatment for the condition concerned will cease to be reimbursed under the occupational scheme in the event of recovery or consolidation. The right to such reimbursement may resume in the event of a relapse.

No medical treatment resulting from an occupational accident sustained or an occupational illness contracted before the start of the insurance cover provided for in this Chapter is reimbursed by the Scheme as an occupational accident or illness.

IX 3.02 TIME LIMIT
The time limit for submitting a reimbursement claim for medical expenses or treatments resulting from an occupational accident or illness is the same as under Article VI 1.01. This time limit starts on the date on which the accident or illness was recognised as occupational by the Organization or on the date of the bill, whichever is the later.

If reimbursements have already been made before the accident or illness is recognised as occupational, the Member must inform the Third-Party Administrator.
Chapter X - Long-term care benefits

Section 1 - General description

X 1.01 GENERAL DESCRIPTION

Long-term care benefits are granted to eligible Members who are recognised as being in a state of dependence, i.e. unable to perform the ordinary functions of everyday life unaided. These benefits are aimed, among other things, at allowing these Members to live with their disability under decent conditions without necessarily having recourse to stays in a hospital or a specialised institution.

These benefits are also referred to by the acronym LTC (Long-Term Care).

X 1.02 ELIGIBLE MEMBERS

Compulsory and Post-Compulsory Main Members and the Subsidiary Members who are their dependents are eligible for these benefits.

Section 2 - Procedure for the award of the benefit

X 2.01 APPLICATION FOR THE BENEFIT

Any eligible Member who considers him- or herself to be unable to perform the ordinary functions of everyday life unaided may apply to receive long-term care benefits.

The application must be submitted to the Third-Party Administrator in writing. It must specify whether the Member concerned lives at home or in a specialised institution, as well as the full name and address of his or her medical practitioner.

X 2.02 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 CERN’s Social Affairs Service, the Third-Party Administrator’s consulting medical practitioner specialising in geriatrics and long-term care, appointed in agreement with CERN, and a representative of the Third-Party Administrator.

The panel’s assessment of the Member’s state of dependence is based upon two questionnaires: a medical questionnaire completed by the Member’s medical practitioner and a medico-social questionnaire completed by the Member concerned and/or his or her family members, friends or others close to him or her. If necessary, the panel may request any additional information it deems necessary.

The medico-social panel distinguishes between three levels of dependence (low, moderate or high) according to the Member’s degree of ability to perform the following functions unaided:

- getting up, sitting down and getting into bed;
- moving around;
- washing and grooming;
- getting dressed and undressed;
- eating and drinking;
- going to the toilet;
- coherence and ability to communicate;
- orientation in space and time.

The panel also determines the date on which the state of dependence began.

The decision to recognise a state of dependence is taken by the Third-Party Administrator on the advice of the medico-social panel and is communicated in writing to the Member.

X 2.03 EFFECTIVE DATE

Long-term care benefits are granted from the date on which the application was submitted, provided that it is medically recognised that the Member concerned was in a state of dependence on that date.

Where the date of onset of the state of dependence (as determined by the panel) is later than that of the application, the long-term care benefits are paid only from the date of onset onwards.
X 2.04
REASSESSMENT OF THE STATE OF DEPENDENCE

The medico-social panel may, at any time, conduct a reassessment of the Member’s state of dependence.

The Member concerned is required to inform the Third-Party Administrator of any lasting change (deterioration or improvement) that may affect his or her state of dependence. Such a notification also triggers a reassessment of the state of dependence of the Member concerned.

The reassessment is conducted in the same way and on the same basis as the assessment described in Article X 2.02. The decision as to whether or not to recognise a change in the state of dependence is taken by the Third-Party Administrator on the advice of the medico-social panel and is communicated in writing to the Member concerned. The effective date of a change in the state of dependence is determined by analogy with Article X 2.03.

X 2.05
RULE CONCERNING NON-CONCURRENCE OF BENEFITS

In accordance with Article V 2.02, the amount of any benefit of the same nature received as a result of compulsory membership of a national social security scheme will be deducted from the long-term care allowance set out in Section 4.

Members are required to inform the Third-Party Administrator if they are in receipt of such benefits as soon as possible.

Section 3 - Contributions

X 3.01
CONTRIBUTIONS

The contributions by the Member and the Organization for long-term care benefits are calculated by multiplying the Member’s Reference Salary by the rates defined in Article A III 1.01.

Section 4 - Benefits

X 4.01
BENEFITS

In the event of recognition of a state of dependence, a daily allowance, the amount of which is defined in Article A IV 1.01, will be paid monthly to the Member concerned.

The ceilings for the paramedical benefits listed in Annex I B 6 c (home nurse) and B 6 d (medical auxiliaries other than those mentioned in points 6 a to 6 c) are modified in accordance with Article A IV 1.02.
Chapter XI - Allowance for the reduced earning capacity of a family member

Section 1 - Eligibility

XI 1.01 DEFINITION OF REDUCED EARNING CAPACITY

The term “reduced earning capacity” is defined as a reduction in earning capacity, assumed to be permanent or long-term, resulting from the effects of a physical, mental or psychological condition caused by congenital anomaly, illness or accident, preventing the person concerned from carrying out paid work in spite of treatment and rehabilitation measures appropriate to the situation.

XI 1.02 ELIGIBLE PERSONS

An application for the payment of an allowance for reduced earning capacity may be made for a family member (hereinafter “eligible person”) of an active employed member of the personnel, a former member of the personnel who is a pensioner or a deceased member of the personnel (hereinafter “the member or former member of the personnel”), provided that the following conditions are all met at the time of the application:

- the member or former member of the personnel must be, or have been, a staff member or fellow;
- the member or former member of the personnel must have served the Organization for at least two uninterrupted years in this capacity;
- the member or former member of the personnel and the eligible person must have been Members of the Scheme with normal health insurance for at least one year;
- the eligible person must not be a Compulsory Main Member of the Scheme;
- all attempts to restore the earning or working capacity of the eligible person must have proven either completely or partially ineffective;
- the eligible person must have reached the age of 18 but must not have reached the CERN retirement age.

XI 1.03 CONDITIONS FOR ENTITLEMENT TO THE ALLOWANCE

The application may be made where the eligible person’s earning capacity:

- is permanently reduced by at least 50%; or
- has been reduced by an average of at least 50% for 360 days without an interruption of more than 30 consecutive days, and remains below 50%.

Section 2 - Procedure for applying for the allowance

XI 2.01 APPLICATION FOR THE ALLOWANCE

The allowance for reduced earning capacity may be applied for at any time provided that the conditions set out in this Chapter are met. The application may be submitted by the eligible person him- or herself or by a third-party representing him or her.

If the application is accepted, the effective date will be the first day of the month in which the application was submitted. 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 met continuously.

XI 2.02 ASSESSMENT OF THE APPLICATION

Anyone applying for the allowance must, at his or her own cost, provide the Third-Party Administrator with a detailed medical report, by the competent national authority, setting out the cause, nature, start date and probable duration of the reduced earning capacity, as well as details of the physical injuries or intellectual or physical deterioration of the person concerned. This report must also indicate the level of reduced earning capacity as determined by the person’s medical practitioner, and a statement on the chances of recovery.
XI 2.03 RECOGNITION OF ENTITLEMENT TO THE ALLOWANCE

Within the six weeks following receipt of the application in the form set out above, the Third-Party Administrator informs the person concerned and, where applicable, the Scheme’s Manager, of its decision in writing. If the decision is favourable, the level of the allowance and the date from which it is payable are specified.

The Third-Party Administrator is entitled to defer the decision by a maximum of one year after medical treatment is completed if the medical report leaves doubts as to whether the reduced earning capacity is permanent and as to its extent.

Section 3 - Contributions

XI 3.01 CONTRIBUTIONS

No additional contribution is required for this benefit.

Section 4 - Benefits

XI 4.01 FULL ALLOWANCE

The eligible person is entitled to the full reduced earning capacity allowance if he or she is diagnosed as having at least a two-thirds reduction in earning capacity.

XI 4.02 HALF ALLOWANCE

The eligible person is entitled to half the reduced earning capacity allowance if he or she is diagnosed as having at least a 50% reduction in earning capacity.

XI 4.03 AMOUNT OF THE ALLOWANCE

The reduced earning capacity allowance is equal to the minimum allowance that the disability insurance scheme of the Swiss Confederation would pay in the same circumstances, regardless of the State of residence of the eligible person.

XI 4.04 NON-CONCURRENCE OF BENEFITS

In accordance with Article V 2.02, the amount of any benefit of the same nature received as a result of compulsory membership of a national social security scheme will be deducted from the reduced earning capacity allowance.

Members are required to inform the Third-Party Administrator if they are in receipt of such benefits as soon as possible.

However, the disabled orphan’s pension, granted under the Rules of the CERN Pension Fund, may be paid concurrently with the benefits covered by this Chapter.

Section 5 - Modifications to or termination of benefits

XI 5.01 CHANGE IN WORKING OR EARNING CAPACITY

The Third-Party Administrator must be notified immediately of any change in working or earning capacity. Such a notification will give rise to a new assessment in accordance with the procedure set out in Article XI 2.02.

A recognised restoration of or improvement in working capacity will result in a corresponding reduction in or termination of the reduced earning capacity allowance. Any allowance paid to which the person concerned is not entitled must be repaid in accordance with Article V 4.01.

A recognised deterioration in working capacity will result in a corresponding increase in the allowance. Where the reduction in earning capacity is at least two-thirds, a full allowance will be paid.

XI 5.02 EFFECTIVE DATE OF A CHANGE

A change in the level of reduced earning capacity will take effect from the day on which the change was medically certified.

XI 5.03 PROOF AND MEDICAL EXAMINATION

The Third-Party Administrator may at any time request any proof it deems necessary and have the Member concerned examined at the Scheme’s expense by a medical practitioner of the Third-Party Administrator’s choice. At the request of the Member concerned, the Member’s own medical practitioner may be present at such an examination.
XI 5.04
REFUSAL TO UNDERTAKE REHABILITATION MEASURES

The reduced earning capacity allowance may be withdrawn temporarily or permanently if the Member concerned evades or objects to rehabilitation measures that he or she may reasonably be expected to undergo and that are likely to bring about a significant improvement in his or her earning or working capacity.

XI 5.05
TERMINATION OF ENTITLEMENT

The reduced earning capacity allowance will be paid as long as the person concerned remains a Member and as long as the conditions set out in Articles XI 1.02 and XI 1.03 are met. Payment will cease on the last day of the month in which the entitlement ceases and, in all cases, as soon as the person concerned has reached the CERN retirement age.
**Chapter XII - Reference Salaries**

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

XII 1.02 REFERENCE SALARY II
Reference Salary II is the salary at the mid-point of Grade 6 in CERN’s salary grid.

XII 1.03 REFERENCE SALARY III
Reference Salary III is the Member’s last Reference Salary I at the time of his or her departure from the Organization. It is indexed annually at the same rate as the indexing of pensions.

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

XII 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.

XII 1.05 REFERENCE SALARY V
Reference Salary V is:
- for the calculation of the Member’s contribution, Reference Salary VI as set out in Article XII 1.06 below, taking into account all income, including the CERN pension;
- for the calculation of the Organization’s contribution, the amount of the CERN pension of the Member concerned.

XII 1.06 REFERENCE SALARY VI
If the monthly income is less than 2500 CHF, Reference Salary VI is 0 CHF.

If the monthly income is more than or equal to 2500 CHF, Reference Salary VI is the mid-point of the 2000-CHF income bracket into which the monthly income, as defined in Article IV 2.06, falls. For example, for a monthly income of between 6500 CHF (inclusive) and 8500 CHF (exclusive), Reference Salary VI is 7500 CHF.

The income bracket into which the highest salary in CERN’s salary grid falls is applicable to all higher incomes, and thus constitutes the highest Reference Salary VI.
Chapter XIII - Operation of the Scheme

Section 1 - Governance

XIII 1.01 MANAGER

The Manager is appointed by the Director-General to manage the day-to-day operation of the Scheme. To this end, the Manager:

- monitors and supervises the performance of the contract between the Organization and the Third-Party Administrator;
- negotiates healthcare tariffs with providers;
- in collaboration with the CERN department responsible for finance, monitors the financial position of the Scheme and its funds and reports on it to the Strategic Advisor;
- checks the benefits and contributions data submitted to and received from the Third-Party Administrator and reports on it to the CHIS Board;
- deals with any membership issue;
- handles declarations of spouses’ health insurance and financial situation (Article IV 2.02) and checks that they comply with the Rules;
- in agreement with the Strategic Advisor, decides on the award of ex-gratia benefits pursuant to Article VI 6.02, and reports these decisions to the CHIS Board;
- monitors developments in the health insurance systems in the Member States and other intergovernmental organisations and reports on them to the CHIS Board;
- performs any other tasks required for the day-to-day operation of the Scheme.

XIII 1.02 STRATEGIC ADVISOR

The Strategic Advisor is appointed by the Director-General to assist him or her in drawing up the medium- and long-term health insurance strategy. To this end, the Strategic Advisor:

- analyses the reports on the financial position of the Scheme and its reserve fund and the associated long-term projections, as well as the contributions and benefits statistics, submitted by the Manager;
- in collaboration with the Manager, analyses developments in the health insurance systems in the Member States and other intergovernmental organisations;
- draws up proposals for adjustments to 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, submits these adjustment proposals to the CHIS Board in preparation for subsequent discussion at the Standing Concertation Committee (SCC).

XIII 1.03 CHIS BOARD

The CHIS Board is a sub-group of the SCC responsible for the preparatory work preceding discussion at the SCC on the adjustment proposals submitted to the Board by the Strategic Advisor in accordance with Article XIII 1.02.

The CHIS Board is chaired by the Strategic Advisor and also comprises:

- four members appointed by the Director-General from among the members of the personnel, one of whom must be the Manager;
- four members appointed by the Staff Association from among the members of the personnel and the beneficiaries of the CERN Pension Fund.

To allow it to successfully fulfil its mandate, the CHIS Board shall be regularly informed of, among other matters, statistics relating to the Scheme’s expenses, its financial position, the quality of service provided by the Third-Party Administrator and any significant issues arising in the course of the Scheme’s operation.

The CHIS Board establishes its own working procedures.
Section 2 - Reserve Fund

XIII 2.01
RESERVE FUND

CERN has set up a reserve fund for its Health Insurance Scheme. The capital of this reserve fund is formally separate from the rest of the Organization’s assets.

For accounting reasons, the reserve fund is divided into the following two separate headings:

1. Provisions and reserves of the Health Insurance Scheme. These provisions and reserves comprise at least the following:
   - 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 a possible future deficit of the Scheme (at least 20% of all anticipated reimbursements for the year, with no upper limit).

2. Capitalised reserves of the long-term care fund.

Actuarial studies must be conducted regularly in order to monitor the evolution of the Scheme’s resources and expenditure, taking into account the contributions, the anticipated expenditure and the assets of the reserve fund.

Section 3 - Auditing

XIII 3.01
INTERNAL AND EXTERNAL AUDITORS

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 are given access to all documents and supporting documentation, confidential or otherwise, required to verify the transactions shown in the Third-Party Administrator’s financial records.

On request, the auditors will also be given access to the Third-Party Administrator’s internal written instructions.

The auditors are not given access to the Members’ personal medical data.
Chapter XIV - Settlement of disputes

Section 1 - Challenging a decision

XIV 1.01 GENERAL

Where a decision relating to the application of the Rules has an adverse effect on a Member, he or she may challenge it by:

- following the review procedure, and, if applicable, the subsequent appeal procedure, as described below;
- lodging a complaint with the Administrative Tribunal of the International Labour Organization (ILOAT) once the decision is final, i.e. when the review and appeal procedures have been exhausted.

All decisions concerning disputes relating to the Health Insurance Scheme are taken by the Director-General.

Requests for review and internal appeals are handled individually. Several individual requests for review or several individual internal appeals may nonetheless be submitted and handled collectively if they are identical.

XIV 1.02 NON-SUSPENSION

Application of the challenged decision is not suspended pending the outcome of the review or appeal.

XIV 1.03 EXTENSION OF DEADLINES

The Director-General may extend the deadlines provided for in the procedures set out below if he or she deems this necessary for the proper administration of justice. He or she immediately informs the Member concerned of the new deadlines.

Section 2 - Requesting a review

XIV 2.01 PROCEDURE FOR REQUESTING A REVIEW

In order to reach an amicable agreement, a Member may request a review of a decision relating to the application of these Rules.

Such requests must be submitted:

- within the 60 calendar days following notification of the challenged decision;
- to the Third-Party Administrator if the challenged decision was taken by the latter, or otherwise to the Director-General.

The request for a review must be signed by the Member concerned, or by his or her representative if the Member is incapacitated, and sent by registered mail.

It must include:

- a copy of the challenged decision;
- a brief summary of the facts, the grounds for the request and the conclusions.
When the party who took the challenged decision receives a request for a review, he or she first examines its admissibility and may declare it inadmissible if, in particular, it:

- concerns a decision that does not meet the conditions set out in Article XIV 1.01;
- is not in the form stipulated in Article XIV 2.02;
- is submitted after the deadline;
- is submitted neither by the Member concerned nor by a person authorised to represent him or her in accordance with Article V 3.02;
- concerns a final decision or a decision relating to a matter having the force of *res judicata*.

The party who took the challenged decision must issue an opinion on the admissibility of the request for a review within the 30 calendar days following receipt of the request.

If the party who took the challenged decision rejects a request for a review on the grounds that it is inadmissible, he or she must justify this decision in writing and inform the Member and the Manager of the Scheme accordingly. The challenged decision thus becomes final.

If the request for a review is deemed admissible, the party who took the challenged decision must consult the Manager of the Scheme and take a decision on the merits in the 60 calendar days following receipt of the request. This new decision, which cancels and replaces the challenged decision, indicates the grounds for the new decision and, in the event that the challenged decision has not been changed, the possibility of lodging an appeal in accordance with Article XIV 3.01.

### Section 3 - Appeal

**XIV 3.01**

**PROCEDURE FOR LODGING AN APPEAL**

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

The Member concerned must lodge the appeal in writing to the Director-General within the 60 calendar days following notification of the new decision taken, in accordance with Article XIV 2.04.

**XIV 3.02**

**FORM OF THE APPEAL**

The letter of appeal must be signed by the Member concerned, or by his or her representative if the Member is incapacitated, and sent to the Director-General by registered mail.

It must include:

- a copy of the challenged decision;
- a summary of the facts, the grounds for the appeal and the conclusions.

**XIV 3.03**

**ADMISSIBILITY OF THE APPEAL**

When the Director-General receives a letter of appeal, he or she first examines its admissibility and may declare the appeal inadmissible if, in particular, it:

- concerns a decision that does not meet the conditions set out in Article XIV 1.01 or that has not been reviewed;
- is not in the form stipulated in Article XIV 3.02;
- is lodged after the deadline;
- is lodged neither by the Member concerned nor by a person authorised to represent him or her in accordance with Article V 3.02;
- concerns a final decision or a decision relating to a matter having the force of *res judicata*.

The Director-General must rule on the admissibility of the appeal within 30 calendar days of receiving the letter of appeal.

If the Director-General rejects an appeal on the grounds that it is inadmissible, he or she must justify this decision in writing. The challenged decision thus becomes final.
If the appeal is deemed to be admissible, the Director-General determines whether the dispute is of an administrative or a medical nature.

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

In disputes of an administrative nature, the Director-General convenes the Health Insurance Litigation Board, in accordance with Article XIV 3.05, within the 30 calendar days following receipt of the letter of appeal.

In disputes of a medical nature, a medical practitioner is appointed in accordance with Article XIV 3.08.

The Health Insurance Litigation Board, hereinafter referred by its French acronym “CLAM”, is competent to examine any appeal against a decision of an administrative nature concerning health insurance matters.

The CLAM is composed of three members, who are normally members of the CHIS Board.

Two permanent members and their alternates are appointed for a renewable term of two years, as follows:

- one member and one alternate appointed by the Director-General;
- one member and one alternate appointed by the Staff Association.

Within the 10 calendar days after the CLAM has been convened, the two permanent members choose, by mutual agreement, the Chair of the CLAM, who is normally also a member of the CHIS Board.

If no agreement has been reached within the set time limit, the third member of the CLAM is the Chair of the CHIS Board or any other member of that Board chosen by the Chair.

The CLAM begins to examine the case within the 30 calendar days after its composition has been finalised.

The procedure is conducted in writing. However, at its discretion, the CLAM may hear the Member or any other person able to give the CLAM the benefit of his or her expertise.

The CLAM may initiate any investigation procedures that it deems necessary for examination of the case.

The Chair represents the CLAM in all procedural steps.

The CLAM:

- examines the documents that are submitted to it by the parties;
- consults the Third-Party Administrator, the Manager or any expert, if it deems this necessary.

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

Where an expert assessment requested by the CLAM entails expenses, the Chair of the CLAM informs the Director-General beforehand. The Director-General decides whether such expenses must be borne by the Scheme.

When the Chair of the CLAM deems that all the relevant information has been obtained, he or she closes the investigation procedure and informs the parties thereof.

The CLAM draws up a report and forwards it to the Director-General within the 30 calendar days following the closure of the investigation procedure.

This report includes the following elements:

- the main arguments of the parties;
- a summary of the conclusions of any experts consulted;
- the CLAM’s considerations;
- the recommendation of the CLAM, approved by the majority of its members.
XIV 3.08  SETTLEMENT OF DISPUTES OF A MEDICAL NATURE

If the Director-General has determined that the dispute is of a medical nature, it will be examined, within the 30 calendar days after the appeal is lodged, 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 the choice of medical practitioner, the appointment will be made by any competent medical authority in the Canton of Geneva.

The medical practitioner begins to examine the case within the 30 calendar days following his or her appointment.

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

The medical practitioner:

- examines the documents that are submitted to it by the parties;
- consults the Third-Party Administrator, the Manager or any expert, if it deems this necessary.

In the event of a dispute concerning the allowance for reduced earning capacity or recognition of a state of dependence, the medical practitioner must consult, respectively, a rehabilitation specialist with a good knowledge of Swiss federal legislation on disability or a practitioner specialising in geriatrics and long-term care.

Communication of information and documents of a medical nature is strictly limited to the minimum required for the proper handling of the dispute.

The fees of the medical practitioner and of any expert consulted are borne by the Scheme.

XIV 3.09  REPORT BY THE MEDICAL PRACTITIONER

The medical practitioner draws up a report and forwards it to the Director-General within the 30 calendar days following the closure of the investigation procedure.

This report includes the following elements:

- the main arguments of the parties;
- a summary of the conclusions of any experts consulted;
- the considerations of the medical practitioner;
- a recommendation.

XIV 3.10  FINAL DECISION BY THE DIRECTOR-GENERAL

The Director-General notifies the Member concerned of his or her decision in writing, enclosing a copy of the report submitted by the CLAM or by the medical practitioner, within the 30 calendar days following receipt of the report. If the decision is not in line with the recommendation of the CLAM or of the medical practitioner, the Director-General will indicate the reasons. The Director-General will inform the CHIS Manager and the Strategic Advisor of his or her decision.

The decision of the Director-General is final.

XIV 3.11  APPEAL TO THE ILOAT

A complaint against a final decision taken in accordance with Article XIV 3.10 may be lodged with the ILOAT in accordance with the latter’s Statute and Rules.
Chapter XV – Final and transitory provisions

XV 1.01
ENTRY INTO FORCE

The present edition of the Rules shall come into force on 1st September 2017. It shall supersede the previous edition.

XV 1.02
APPRENTICES

Apprentices whose contracts started before 1 August 2016 may remain Members with normal health insurance, under the conditions in force at that date.

XV 1.03
CONTINUATION OF MEMBERSHIP OF VOLUNTARY MEMBERS

Voluntary Members who were already Members on 31 August 2017 may remain so, including if their contract is renewed, provided that:

a) they are in possession of a carte de légitimation issued by the Swiss authorities (Article III 3.02);

b) they specifically request the Third-Party Administrator to continue their membership by 31 December 2017 and, at the same time, to update the personal information held about them (Article IV 2.01).

Their membership of the Scheme expires automatically and definitively on 31 December 2017 if either of these two conditions is not met, or any time thereafter if condition (a) is no longer met.

XV 1.04
REFERENCE SALARY VI

Until 28 February 2018, Reference Salary VI will be determined on the same basis as Reference Salary V was previously determined, i.e. in accordance with the following table:

<table>
<thead>
<tr>
<th>Monthly income bracket</th>
<th>Reference Salary</th>
</tr>
</thead>
<tbody>
<tr>
<td>Up to 2500 CHF inclusive</td>
<td>0 CHF/month</td>
</tr>
<tr>
<td>Above 2500 CHF and up to 4250 CHF inclusive</td>
<td>3 333 CHF/month</td>
</tr>
<tr>
<td>Above 4250 CHF and up to 7500 CHF inclusive</td>
<td>5 833 CHF/month</td>
</tr>
<tr>
<td>Above 7500 CHF and up to 10 000 CHF inclusive</td>
<td>9 167 CHF/month</td>
</tr>
<tr>
<td>Above 10 000 CHF</td>
<td>12 498 CHF/month</td>
</tr>
</tbody>
</table>
### Annex I - List of benefits

<table>
<thead>
<tr>
<th>BENEFITS</th>
<th>REIMBURSEMENT RATE</th>
<th>REIMBURSEMENT BONUS</th>
<th>PRIOR AUTHORIZATION OR OPINION BY THE THIRD-PARTY ADMINISTRATOR</th>
<th>CEILING FOR EXPENSES</th>
<th>OTHER CONDITIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>A. CONSEQUENCES OF OCCUPATIONAL ILLNESSES AND ACCIDENTS</strong></td>
<td>100%</td>
<td></td>
<td></td>
<td></td>
<td>Only for members of the personnel who are Compulsory Members of the Scheme. Without limit or ceiling, but subject to prior approval or opinion for the benefits concerned, as set out in B below. Any supplements for hospitalisation in a single-bed ward are borne exclusively by the Member.</td>
</tr>
<tr>
<td><strong>B. HEALTH INSURANCE</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Doctors' fees</td>
<td></td>
<td>General rule</td>
<td>YES</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Pharmaceutical costs</td>
<td></td>
<td>General rule</td>
<td>YES</td>
<td></td>
<td>Medication must be prescribed and must be recognised in the State where it was 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>3. Medical imaging</td>
<td></td>
<td>General rule</td>
<td>YES</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Laboratory work and analyses</td>
<td></td>
<td>General rule</td>
<td>YES</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Medical treatment and miscellaneous examinations</td>
<td></td>
<td>General rule</td>
<td>YES</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 therapists</td>
<td></td>
<td>General rule</td>
<td>YES</td>
<td></td>
<td>13 300 CHF per calendar year Excluded from the Reduced Health Insurance cover.</td>
</tr>
</tbody>
</table>
## BENEFITS

<table>
<thead>
<tr>
<th></th>
<th>REIMBURSEMENT RATE</th>
<th>REIMBURSEMENT BONUS (pursuant to Article A II 1.02)</th>
<th>PRIOR AUTHORISATION OR OPINION BY THE THIRD-PARTY ADMINISTRATOR (Chapter VI Section 3)</th>
<th>CEILING FOR EXPENSES (Article VII 3.05)</th>
<th>OTHER CONDITIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>b) Psychotherapists for children aged up to 18 years</td>
<td>General rule</td>
<td>YES</td>
<td>25 000 CHF per calendar year</td>
<td></td>
<td>Excluded from the Reduced Health Insurance cover.</td>
</tr>
<tr>
<td>c) Home nurses</td>
<td>General rule</td>
<td>YES</td>
<td>YES</td>
<td>68 CHF per day</td>
<td>In the case of recognised long-term dependence, the daily limit is replaced by the monthly limit (see Article A IV 1.02). Excluded from the Reduced Health Insurance cover.</td>
</tr>
<tr>
<td>d) Medical auxiliaries other than those mentioned in points 6 a) to c)</td>
<td>General rule</td>
<td>YES</td>
<td>3 300 CHF per calendar year</td>
<td></td>
<td>On prescription, pursuant to Article VI 1.04. In the case of recognised long-term dependence, the annual limit is replaced by the monthly limit (see Article A IV 1.02). Excluded from the Reduced Health Insurance cover.</td>
</tr>
</tbody>
</table>

### 7. Prevention

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th>Exclusively for the examinations and treatments listed in Article A II 1.03.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>100%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th>Supplement for a single-bed ward borne exclusively by the Member.</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) Hospitalisation in a public hospital, other than in a private or semi-private ward</td>
<td>100%</td>
<td></td>
<td></td>
<td></td>
<td></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) All other hospitalisations</td>
<td>General rule</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>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 seven years of age</td>
<td>70%</td>
<td></td>
<td></td>
<td>132 CHF per day</td>
<td></td>
</tr>
<tr>
<td>BENEFITS</td>
<td>REIMBURSEMENT RATE</td>
<td>REIMBURSEMENT BONUS (pursuant to Article A II 1.02)</td>
<td>PRIOR AUTHORISATION OR OPINION BY THE THIRD-PARTY ADMINISTRATOR (Chapter VI Section 3)</td>
<td>CEILING FOR EXPENSES (Article VII 3.05)</td>
<td>OTHER CONDITIONS</td>
</tr>
<tr>
<td>------------------------------------------------------------------------</td>
<td>--------------------</td>
<td>-----------------------------------------------------</td>
<td>----------------------------------------------------------------------------------</td>
<td>------------------------------------------</td>
<td>--------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>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 seven years of age</td>
<td>70%</td>
<td>YES</td>
<td></td>
<td>132 CHF per day</td>
<td>In the absence of prior approval, the Third-Party Administrator may exceptionally grant reimbursement if the attending doctor at the hospital considers the presence of this family member necessary.</td>
</tr>
<tr>
<td>9. Courses of thermal spa therapy and stays 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</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>In accordance with Chapter VI Section 4.</td>
</tr>
<tr>
<td>a) Cost of board and accommodation for thermal spa therapy</td>
<td>100%</td>
<td>YES</td>
<td></td>
<td>10 CHF per day</td>
<td></td>
</tr>
<tr>
<td>b) Cost of board and accommodation for a convalescence stay</td>
<td>100%</td>
<td>YES</td>
<td></td>
<td>80 CHF per day</td>
<td></td>
</tr>
<tr>
<td>c) Cost of board and accommodation in a rehabilitation facility</td>
<td>100%</td>
<td>YES</td>
<td></td>
<td>120 CHF per day</td>
<td>Cost of board and accommodation in a specialised social rehabilitation facility, e.g. in an alcohol or drug abuse rehabilitation centre.</td>
</tr>
<tr>
<td>d) Cost of board and 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></td>
<td>Benefit cannot be cumulated with the daily long-term care allowance Excluded from the Reduced Health Insurance cover.</td>
</tr>
<tr>
<td>e) Medical and pharmaceutical costs</td>
<td>General rule</td>
<td>YES</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. Optical and ophthalmological expenses</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a) Corrective glasses (lenses and frame) and contact lenses, including disposable lenses</td>
<td>General rule</td>
<td></td>
<td></td>
<td>500 CHF per calendar year, which can be cumulated over 3 years</td>
<td>On prescription Excluded from the Reduced Health Insurance cover.</td>
</tr>
</tbody>
</table>
### BENEFITS

<table>
<thead>
<tr>
<th></th>
<th>REIMBURSEMENT RATE</th>
<th>REIMBURSEMENT BONUS (pursuant to Article A II 1.02)</th>
<th>PRIOR AUTHORISATION OR OPINION BY THE THIRD-PARTY ADMINISTRATOR (Chapter VI Section 3)</th>
<th>CEILING FOR EXPENSES (Article VII 3.05)</th>
<th>OTHER CONDITIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>b) Refractive surgery</td>
<td></td>
<td></td>
<td>YES</td>
<td>2,000 CHF per eye for the entire period of cover</td>
<td>No reimbursement within the first 12 months of membership of the Scheme. Excluded from the Reduced Health Insurance cover.</td>
</tr>
<tr>
<td></td>
<td>General rule</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11. Hire or purchase of auxiliary appliances such as orthopaedic appliances, prostheses other than dental prostheses, hearing aids, oxygen extractors, dialysis machines, etc.</td>
<td>General rule</td>
<td>YES</td>
<td>11,000 CHF per calendar year, which can be cumulated over 2 years</td>
<td>On prescription. Excluded from the Reduced Health Insurance cover: prostheses, orthopaedic appliances and hearing aids.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>General rule</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| 12. Hire or purchase of auxiliary appliances designed to foster personal autonomy in the case of recognised disability, reduced earning capacity or dependence. | General rule | YES | 11,000 CHF per calendar year, which can be cumulated over 2 years | On prescription. This includes the following appliances:  
  - wheelchairs;  
  - supplementary automatic sanitary installations where the Member is unable to wash himself or herself without one;  
  - stair lifts for use by patients at 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 doorsteps, construction of ramps over doorsteps, modification of door frames, installation of luminous signals for the deaf and those suffering from serious hearing impairment, emergency call systems for the deaf and blind;  
  - adaptation of a vehicle to allow the Member to travel. |
<table>
<thead>
<tr>
<th>BENEFITS</th>
<th>REIMBURSEMENT RATE</th>
<th>REIMBURSEMENT BONUS (pursuant to Article A II 1.02)</th>
<th>PRIOR AUTHORIZATION OR OPINION BY THE THIRD-PARTY ADMINISTRATOR (Chapter VI Section 3)</th>
<th>CEILING FOR EXPENSES (Article VII 3.05)</th>
<th>OTHER CONDITIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>13. Dental treatment, prostheses and orthodontics</td>
<td>General rule</td>
<td></td>
<td>YES*</td>
<td>3 300 CHF per calendar year, which can be cumulated over 3 years</td>
<td>* Subject to prior opinion if the total costs exceed 25% of the annual ceiling, except in emergencies. Dental prostheses excluded from the Reduced Health Insurance cover.</td>
</tr>
<tr>
<td>14. Infertility treatment</td>
<td>General rule</td>
<td></td>
<td>YES</td>
<td>30 000 CHF for the entire period of membership</td>
<td>Excluded from the Reduced Health Insurance cover.</td>
</tr>
<tr>
<td>15. 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>d) any other medically essential transport</td>
<td>General rule</td>
<td></td>
<td>YES</td>
<td></td>
<td></td>
</tr>
<tr>
<td>16. 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>14 000 CHF</td>
<td>3 times the basic salary of the Member</td>
<td></td>
</tr>
<tr>
<td>b) of a family member</td>
<td>NA</td>
<td></td>
<td></td>
<td>1600 CHF</td>
<td></td>
</tr>
<tr>
<td>C. LONG-TERM CARE (LTC) ALLOWANCE</td>
<td>See Chapter I and Annex IV.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>D. ALLOWANCE FOR REDUCED EARNING CAPACITY OF A FAMILY MEMBER</td>
<td>See Chapter XI.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Annex II - Reimbursement rate

A II 1.01  
REIMBURSEMENT RATE UNDER THE GENERAL RULE
The reimbursement rates, which depend on the costs borne by the member (FCA) as defined in Article II 5.02, cumulated by the Member over a calendar year, are as follows:

<table>
<thead>
<tr>
<th>Cumulated Costs Borne by the Member (FCA)</th>
<th>Reimbursement rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>up to 500 CHF inclusive</td>
<td>80%</td>
</tr>
<tr>
<td>over 500 CHF, up to 3 000 CHF inclusive</td>
<td>90%</td>
</tr>
<tr>
<td>3 000 CHF</td>
<td>100%</td>
</tr>
</tbody>
</table>

A II 1.02  
REIMBURSEMENT BONUS
To encourage the use of healthcare providers in Member States where health costs are the least onerous, the 80% and 90% reimbursement rates are increased by 5 percentage points for certain outpatient treatments (defined in the table in Annex I) 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.

A II 1.03  
REIMBURSEMENT OF PREVENTIVE MEASURES
Certain preventive examinations and treatments are reimbursed at the rate of 100%, namely:

- vaccination against the human papilloma virus, on prescription
- mammography (screening for breast cancer) for women from the age of 50 onwards, once every two years
- occult blood test in stools (colon cancer screening) for men and women from the age of 50 onwards, once every two years.

A II 1.04  
REIMBURSEMENT OF SERIOUS CASES
Expenses under categories B1 to B5 of the table in Annex I are reimbursed at the rate of 100% if they are associated with a serious case, as defined in Article VII 3.08.
Annex III - Contribution rates

A III 1.01 CONTRIBUTION RATES

The contribution rates to be applied to the reference salary of the Main Member are shown in the table below, together with the breakdown of the contribution between the Main Member (M) and the Organization (O).

The contribution rate applicable to any supplementary contributions payable for a Subsidiary Member is the same as the rate applicable to the Main Member concerned.

<table>
<thead>
<tr>
<th></th>
<th>Normal health insurance</th>
<th>Reduced health insurance</th>
<th>Insurance for occupational illnesses and accidents</th>
<th>Long-term care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total rate</td>
<td>11.77%</td>
<td>5.885%</td>
<td>0.12%</td>
<td>Pensioners: 1.60%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Non-pensioners: 0.80%</td>
</tr>
<tr>
<td>Compulsory Main Member</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>M:</td>
<td>4.06%</td>
<td></td>
<td>O: 0.12%</td>
<td>M: 0.80%</td>
</tr>
<tr>
<td>O:</td>
<td>7.71%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CERN pensioner</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>M:</td>
<td>1.60%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>O:</td>
<td>0.80%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other Post- Compulsory Main Member</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>M:</td>
<td>11.77%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Voluntary Member</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>M:</td>
<td>5.885%</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

A III 1.02 ADJUSTMENT OF THE CONTRIBUTION RATE

The contribution rates defined above may be examined in the framework of each five-yearly review of CERN’s employment conditions, taking into account the past and anticipated future evolution of:

- cost factors such as demographic trends, price variations, new medical treatments, etc.
- the estimated total contributions base for the Members
- the Scheme’s reserve fund
- any other relevant factor.

If necessary, a proposal to adjust the contribution rates is submitted to the CERN Council.
### Annex IV - Long-term care benefits

**A IV 1.01  
DAILY ALLOWANCE**

The amount of the daily allowance, which depends on the level of dependence, is as follows:

- Low-level dependence: 48 CHF
- Moderate dependence: 72 CHF
- High-level dependence: 120 CHF

The daily allowance is not paid during hospital stays.

**A IV 1.02  
CEILINGS FOR PARAMEDICAL BENEFITS**

The ceilings applicable to the paramedical benefits referred to in paragraphs B.6.c) and B.6.d) of Annex I are increased to the following levels for those in receipt of the long-term care allowance:

- Low-level dependence: 1 100 CHF per month
- Moderate dependence: 1 650 CHF per month
- High-level dependence: 2 750 CHF per month

**A IV 1.03  
REVIEW OF BENEFITS**

The amounts of the daily allowances may be reviewed by the Director-General each year in accordance with the evolution of the cost of stays in a specialised institution.

The specific ceilings may be reviewed at the same time as the ceilings for the other benefits.