STAFF HEALTH INSURANCE

SHI ONLINE

Organización Panamericana de la Salud
Organización Mundial de la Salud
Oficina Regional para las Américas

OPS

SHI ONLINE: Important Reminders

Important to Remember

Check that your profile is complete

- Correct name and surname
- Email
- National identifcation number, if required to process payments and/or electronic transfers in your country
- Bank information in local currency and in US dollars (if applicable)

Bank transfer is the only form of payment in countries where the Organization has this payment method enable

Only for retiress: send your email address to nieveso@paho.org to update your information in our systmem

Important to Remember

Read and familiarize with the Health Insurance Rules

What does the insurance cover and does not cover?

- Prescription drugs – covered
- Massages – not covered

What requirements are necessary for each service ?

- Surgeries – medical report, estimated costs

Which benefits have a limit?

- Dental
- Optical
- Therapies

Important to Remember

No advances will be processed at the country offices so:

- Submit your claims as soon as possible
- Minimum amount to file a claim is US$50.00 – Rule C.11
- Invoices are valid for reimbursement for 12 months form the date of service – Rule C.11

Be sure to submit all established documents and make a claim with a maxium of 5 bills/invoices, same patient and same currency

Cases of services that require authorization must be submitted 2 weeks in advance

Important to Remember

- Scanned documents must be legible
  - 5 bills/invoices per claim
    - Same patient
    - Same currency

- Medicines
  - Documents required for reimbursement
    - Prescription
    - Bill/Invoice
      - Maximum of 3 bills/invoices per prescription

Important to Remember

All prescriptions must include:

- Date
- Name of patient
- Diagnosis (if applicable)
- Medication name
- Indication of how to take the medicine
- For how long you should take the medicine

Over-the-counter medicines:

- Are not reimbursable
- What to do when in our country the medicine is sold with prescription only?
  - Send: literature / medicine package

Important to Remember

- Scanned documents must be legible
- Physical exams every 2 years are not covered
- Preventive measures – covered at 100% (with limits and requirements)
    - Vaccines – Rule B.150
    - Mammography – Rule B.152
    - Colonoscopy – Rule B.155.1

Write in the comments box of the online claim: preventive measures so that 100% can be reimbursed, if aplicable.

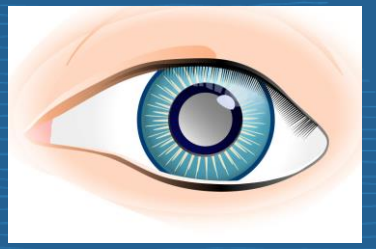
Important to Remember

<u>Glasses / Contact lenses</u>

- Prescription / Diopter
- Bill / invoice

<u>Cataract surgery</u> – Maximum – **US$3,500.00** per eye

- Rule B.113
- Medical report



<u>Hearing aids</u> – Maximum **US$ 2,750.00** per ear (every 4 years)

- Rule B.212
- Medical report
- Audiogram

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Important to Remember

Physicians bills/invoices must include:

- Name of the doctor
  - Specialty
- Patient's full name
  - Date
  - Diagnosis (if applicable)

Important to Remember

Supplementary benefit: Catastrophic Limit

- What is it?
- How is is calculated?

Catastrophic Limit

SUPPLEMENTARY BENEFIT (CATASTROPHIC LIMIT)

C.2 An additional reimbursement will be paid if, during the 12-month period prior to the date of reimbursement, the share borne by a staff member or former staff member themselves in the cost of the services enumerated in Part B – Benefits, as included in the catastrophic expenses calculation on behalf of themselves and their eligible family members, calculated on the amounts and dates on which the reimbursements were made, exceeds their catastrophic limit.

C.3 This additional reimbursement will be paid at 100% of the difference between that share borne by the staff member or former staff member and his/her catastrophic limit. The catastrophic limit is computed as follows:

Catastrophic Limit

C.3.1 for staff members, 5% of their annual remuneration for purposes of contribution as per these rules, calculated on the basis of 100% fixed-term equivalent even if the staff member is working part-time;

C.3.2 for former staff members with more than 25 years of service, or their surviving dependants, 5% of the actual full pension benefit;

C.3.3 for former staff members with less than 25 years of service, or their surviving dependants, whose pension benefit is referred to in Part E - Eligibility, 5% of the full pension benefit payable after 25 years of service.

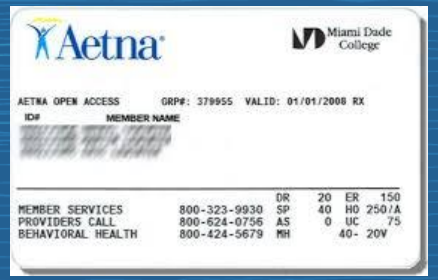
Important to Remember

When we travel abroad

Proof of coverage – Letter provided by SHI/WDC

AETNA & CVS/CAREMARK (US) – When we travel to the US for medical reasons or for a stay of 3 months or more (**prior authorization is required**)

- Requirements
  - Postal address in the US
  - Period: arrival and departure dates
  - Purpose (medical reason, visit, etc.)



Blue Card - WHO/OMS

- When travelling outside of your place of residence
- Only for emergencies

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Important to Remember

What to do when a member, dependent pass away:

- Notify – Local office and/or central office (WDC)
  - Omarys Nieves – nieveso@paho.org WDC
- Important information:
  - Date of death
  - Copy of death certificate (when available)

Survivor:

- Complete form WHO90.3, if interested in continuing having health insurance coverage
  - Include copy of your national identity card / document

This information is sent to WHO for relevant changes related to health isnurance and pension benefits

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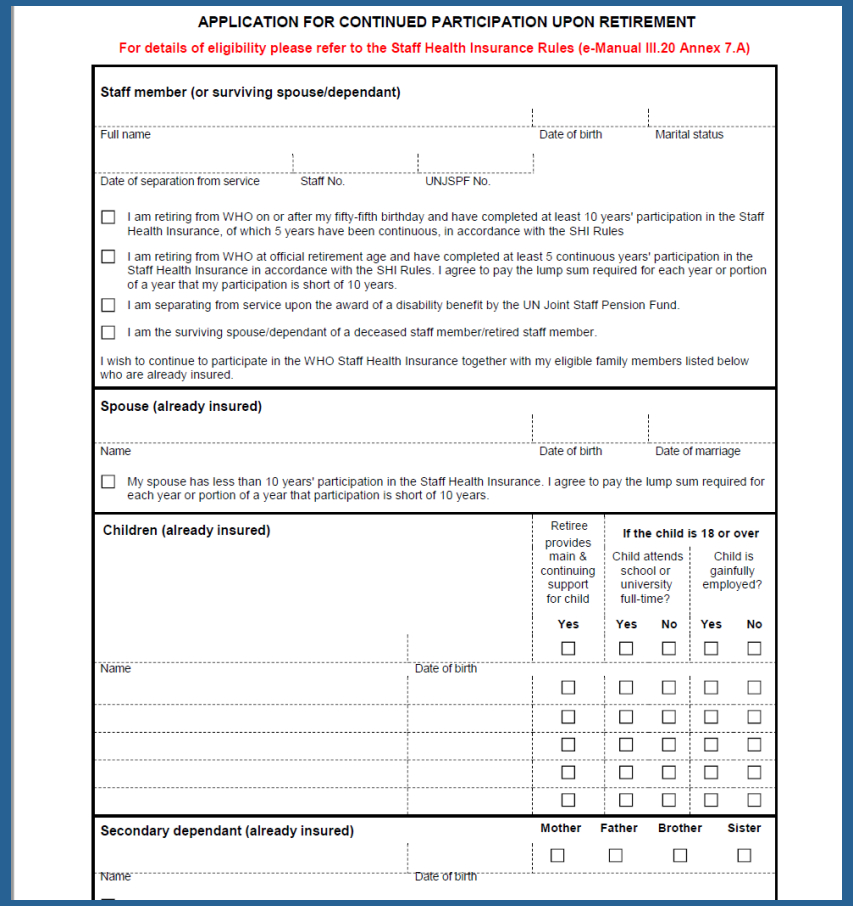
Form WHO90.3E



APPLICATION FOR CONTINUED PARTICIPATION UPON RETIREMENT

For details of eligibility please refer to the Staff Health Insurance Rules (e-Manual III.20 Annex 7.A)

Staff member (or surviving spouse/dependant)

Full name | Date of birth | Marital status

Date of separation from service | Staff No. | UNJSPF No.

- ☐ I am retiring from WHO on or after my fifty-fifth birthday and have completed at least 10 years' participation in the Staff Health Insurance, of which 5 years have been continuous, in accordance with the SHI Rules
- ☐ I am retiring from WHO at official retirement age and have completed at least 5 continuous years' participation in the Staff Health Insurance in accordance with the SHI Rules. I agree to pay the lump sum required for each year or portion of a year that my participation is short of 10 years.
- ☐ I am separating from service upon the award of a disability benefit by the UN Joint Staff Pension Fund.
- ☐ I am the surviving spouse/dependant of a deceased staff member/retired staff member.

I wish to continue to participate in the WHO Staff Health Insurance together with my eligible family members listed below who are already insured.

Spouse (already insured)

Name | Date of birth | Date of marriage

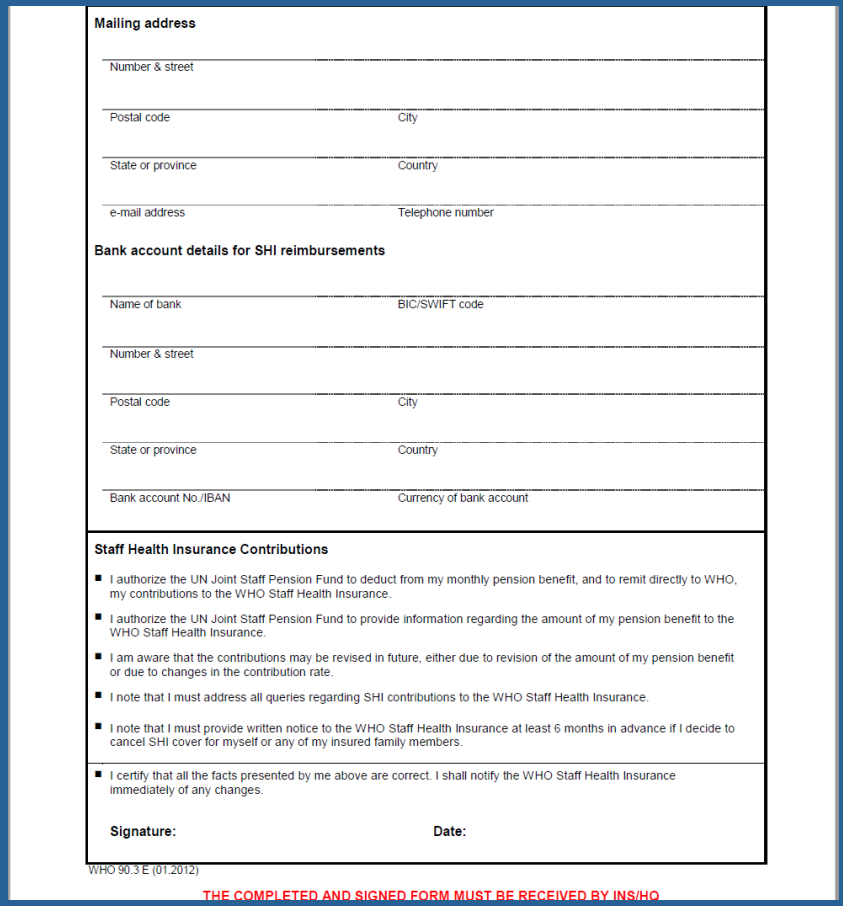
- ☐ My spouse has less than 10 years' participation in the Staff Health Insurance. I agree to pay the lump sum required for each year or portion of a year that participation is short of 10 years.

Children (already insured)

Name	Date of birth	Retiree provides main & continuing support for child	If the child is 18 or over: Child attends school or university full-time?		Child is gainfully employed?	
		Yes	Yes	No	Yes	No
		☐	☐	☐	☐	☐
		☐	☐	☐	☐	☐
		☐	☐	☐	☐	☐
		☐	☐	☐	☐	☐
		☐	☐	☐	☐	☐

Secondary dependant (already insured)

Name	Date of birth	Mother	Father	Brother	Sister
		☐	☐	☐	☐



Mailing address

Number & street

Postal code | City

State or province | Country

e-mail address | Telephone number

Bank account details for SHI reimbursements

Name of bank | BIC/SWIFT code

Number & street

Postal code | City

State or province | Country

Bank account No./IBAN | Currency of bank account

Staff Health Insurance Contributions

- I authorize the UN Joint Staff Pension Fund to deduct from my monthly pension benefit, and to remit directly to WHO, my contributions to the WHO Staff Health Insurance.
- I authorize the UN Joint Staff Pension Fund to provide information regarding the amount of my pension benefit to the WHO Staff Health Insurance.
- I am aware that the contributions may be revised in future, either due to revision of the amount of my pension benefit or due to changes in the contribution rate.
- I note that I must address all queries regarding SHI contributions to the WHO Staff Health Insurance.
- I note that I must provide written notice to the WHO Staff Health Insurance at least 6 months in advance if I decide to cancel SHI cover for myself or any of my insured family members.
- I certify that all the facts presented by me above are correct. I shall notify the WHO Staff Health Insurance immediately of any changes.

Signature: **Date:**

WHO 90.3 E (01.2012)

THE COMPLETED AND SIGNED FORM MUST BE RECEIVED BY INS/HQ