Staff Health Insurance Rules

Effective 1 January 2015

Attached is the complete text of the WHO Staff Health Insurance Rules, dated 1 January 2015 (eManual III.7.4, Annex 7.A), incorporating all amendments to date, which cancels and supersedes all previous versions.

In case of discrepancy between the different language versions, the English language version will prevail.

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Appendices

Objective

10 The objective of the WHO Staff Health Insurance plan (hereinafter referred to as the Insurance) is to provide for the reimbursement of a major portion of the expenses for medically recognized health care incurred by staff members and other persons admitted as participants to the Insurance.

Definitions

20 For the purposes of these rules:

20.1 "Physician" means a person who holds a medical degree from a medical school of university level recognized by the government of the country in which the physician is licensed to practise medicine.

20.2 "Responsible physician" means a practising physician (either a general practitioner or a specialist) attending a patient or referring the patient elsewhere for treatment.

20.3 "Dental services" means the dental and stomatological services rendered by or under the responsibility of a registered dentist.

20.4 "Health care" covers health protection (including disease prevention and reproductive health care) and care provided by reason of accident, illness or impairment.

Participation

Staff members on fixed-term or continuing appointments

30 All staff members on fixed-term or continuing appointments participate in the Insurance as a condition of their employment by WHO [see Staff Rule 720.1].

Staff members on temporary appointments

50 Staff members on temporary appointments, excluding staff members on temporary appointments of 60 days or less and paid on a daily basis ("temporary staff under paragraph 50"), participate in the insurance as a condition of their employment by WHO [see paragraph 186 in policies and procedures on "Temporary appointment under Staff Rule 420.4"].

50.1 Coverage under paragraph 50 is compulsory for the temporary staff member and eligible insured family members up to the end of the uninterrupted period of WHO Staff Health Insurance contributions.

50.2 Temporary staff under paragraph 50 may continue participation under the provisions of paragraph 110 or 150, provided that they agree to pay the required contribution, including the Organization's share for self and each insured family member.

The rates of contributions are set out in paragraph 10 of Appendix A of these rules.

55 Staff members on temporary appointments of 60 days or less and paid on a daily basis participate in the Insurance as a condition of their employment by WHO [see paragraph 26 in policies and procedures on "Temporary appointments of 60 days or less"] and to the extent set out in Appendix C, Appendix C1, paragraphs 10–20, 340–380 and 490–580 of these rules.

Former staff members

60 As per paragraph 100, coverage ceases at the date of separation from the Organization. However, subject to paragraphs 60.1 and 60.2, staff members, including temporary staff insured under paragraph 50, who leave the service of the Organization on or after their 55th birthday (or 58th birthday for staff members who joined the United Nations Joint Staff Pension Fund as from 1 January 2014) may choose to continue to participate in the Insurance. Staff members, including temporary staff under paragraph 50, may also choose to continue participation for their insured family members recognized under paragraphs 80 and 90.

60.1 On separation, the staff members must have participated in the Insurance in accordance with paragraph 30 and/or 50:

(a) for at least ten years, five years of which must be continuous; or

(b) for at least five continuous years, if they leave at official age of separation (60, 62 or 65) or above at the date of separation, provided the required lump sum has been paid by the staff member on separation. The lump sum is equivalent to 8.06% of the staff member's last annual remuneration for purposes of contribution [see paragraphs 400 and para 405 for each year or portion of a year that pre-retirement or pre-termination participation is short of ten years. (For details of the lump sum required for spouses and secondary dependants of staff members covered under this provision, see paragraph 90.2 (d) (ii)); or

(c) be in receipt of a disability pension from the United Nations Joint Staff Pension Fund.

60.2 The decision to continue participation must be notified to the Staff Health Insurance Officer at Headquarters (through the regional budget and finance officer) no later than 90 days after the date of separation from the Organization. If the (former) staff member decides to continue participation, and subject to the payment of the corresponding contribution, his/her participation will be deemed to have continued uninterrupted from the date of separation.

65 The former staff members may at any time discontinue participation, but may not thereafter resume it.

70 If, immediately before being appointed by WHO, a staff member who is insured under paragraph 30 of these rules has been employed by the United Nations or another specialized agency, any period of participation in the health insurance plan of the other organization may be credited towards the periods of participation mentioned in paragraphs 60 and 90.2, provided that that organization has a similar rule under which its retired staff, dependants and other eligible insured family members are given credit for previous participation with WHO.

Dependants

80 The following dependants are covered by the Insurance:

80.1 the spouse of a staff member recognized by the Organization as a dependant as defined in Staff Rule 310.5;

80.2 a child recognized by the Organization as a dependant as defined in Staff Rule 310.5;

80.3 a parent, brother or sister of a staff member recognized by the Organization as a dependant as defined in Staff Rule 310.5 and subject to 171 of these rules.

Other persons

90 The following persons may be covered by the Insurance:

90.1 subject to paragraph 171 of these rules, a spouse:

(a) who is not recognized as a dependant, if the staff member concerned applies for his/her admission and pays the required contribution [see Appendix A, paragraph A.10];

(b) for general service staff at official stations where the local employment conditions established under Staff Rule 1310.3 do not provide for recognition of a dependent spouse, a spouse who meets the conditions of Staff Rule 310.5, if the staff member applies for his/her admission and pays the required contribution [see Appendix A, paragraph A.10].

90.2 the dependants and other eligible family members of a staff member who has opted, under the provisions of paragraph 60, to continue to participate in the Insurance on retirement, if the staff member so chooses, provided that:

(a) they were insured at the date of the staff member's separation; and

(b) the definition of dependency contained in Staff Rule 310.5 is met, or the conditions of paragraph 90.1 of these rules apply; and

(c) a spouse or secondary dependant has participated in the Insurance for at least ten years; or

(d) the staff member pays a lump sum on separation, which is calculated as follows:

(i) in the case of staff members eligible to participate under paragraph 60.1 (a):

4.24% for a spouse and 5.95% for a secondary dependant of the staff member's last annual remuneration for purposes of contributions for each year or portion of a year that participation is short of ten years;

(ii) in the case of staff members eligible to participate under paragraph 60.1 (b):

8.06% of the staff member's last annual remuneration for purposes of contributions for each year or portion of a year that participation is short of ten years for a spouse and/or secondary dependant;

(e) the staff member has been awarded a disability benefit by the United Nations Joint Staff Pension Fund, in which case the lump sum referred to in paragraph 90.2 (d) is waived.

On separation, staff members are notified of this possibility and must inform the Staff Health Insurance Officer within 90 days of receiving the notification whether they wish to continue participation or not.

If retiring staff members decide not to retain protection for their dependants and other eligible insured family members, they are excluded from participation in the Insurance at a later date.

90.3 the surviving spouse and/or children, a surviving parent, brother or sister of a staff member or of a retired staff member after the death of the staff member or retired staff member, provided that:

(a) they were insured at the date of his/her death;

(b) application for continued participation is made within 90 days of being informed by the Staff Health Insurance Officer that insurance protection may be continued. Failure to apply or renunciation of insurance protection excludes the dependants and other eligible family members from participation at a later date.

Participation of dependants and eligible family members ceases when the definition of dependency in Staff Rule 310.5 is no longer met.

90.4 A child of a staff member insured under paragraph 30 or paragraph 50 not covered under paragraph 80.2, from the age of 18 up to the end of the month in which he/she reaches the age of 25, in accordance with the conditions set out in Appendix D.

90.5 for general service staff at official stations where the local employment conditions established under Staff Rule 1310.3 do not provide for recognition of a secondary dependant, a parent, brother or sister (but not more than one such person), provided that:

(a) the staff member demonstrates that he/she provides more than half the total support and in any case at least twice the amount of the standard allowance payable for a second dependent child;

(b) the staff member's spouse is not a participant in the Insurance under paragraphs 80.1 or 90.1 (b);

(c) a brother or sister fulfils the age and school attendance conditions of Staff Rule 310.5.2;

(d) the staff member applies for his/her admission and pays the required contribution.

Period of protection

Staff members

100 Staff members are insured from the date of their appointment and, subject to the provisions of paragraph 150 below, remain insured until the date on which their employment ceases.

110 Staff members, including temporary staff members insured under paragraph 50, who are not eligible to benefit from the provisions of paragraph 60 may elect, up to the date of separation from the Organization, to continue their participation for a further period not exceeding six months, provided that they pay both their own and the Organization's contributions for the whole period in one payment in advance or by deduction from terminal emoluments or through a combination of these.

115 Staff members whose employment ceases after the completion of at least 20 years of service on or after their 50th birthday (or 53rd birthday for staff members who joined the United Nations Joint Staff Pension Fund as from 1 January 2014), but before their 55th birthday (or 58th birthday for staff members who joined the United Nations Joint Staff Pension Fund as from 1 January 2014), may elect to continue participation. The contributions are calculated as follows:

115.1 from the date of separation until the 55th birthday (or 58th birthday for staff members who joined the United Nations Joint Staff Pension Fund as from 1 January 2014), as for leave without pay [see paragraphs 150 and 405];

115.2 from the 55th birthday (or 58th birthday for staff members who joined the United Nations Joint Staff Pension Fund as from 1 January 2014) onwards, as for retired staff members [see paragraph 410].

Former staff members

120 Subject to the provisions of paragraphs 60 and 65, eligible former staff members who have chosen to continue their participation in the Insurance under the provisions of paragraph 60 remain insured for as long as they pay the required contributions. Non-payment of contributions for a period of 12 months ends participation. Readmission thereafter is not allowed.

Dependants and other persons

130 Eligible dependants are insured from the date on which they have acquired dependency status under Staff Rule 310.5. Eligible newborn children (0–28 days) who are registered as dependent and recognized by the Organization are covered from the date of birth. Other persons as defined in paragraph 90 are covered from the date of registration.

140 Subject to the provisions of paragraph 150 below, dependants and other persons remain insured until their eligibility as defined in paragraphs 80–90 ceases, until the staff member concerned ceases to be a participant [see paragraph 110], or, for those surviving dependants and eligible family members who have maintained insurance contributions under paragraph 90, until they elect to discontinue. Non-payment of contributions for a period of 12 months also ends participation. Readmission thereafter is not allowed.

145 In the case of divorce of a retired staff member, the Staff Health Insurance Officer at Headquarters may approve a request for continued participation of the former spouse, provided that:

145.1 the retired staff member continues to pay the contributions;

145.2 the retired staff member continues to submit the claims;

145.3 the retired staff member continues to receive the reimbursements.

Non-payment of contributions for a period of 12 months ends participation. Readmission thereafter is not allowed.

Leave without pay and secondment

150 Staff members, their dependants and eligible family members can be covered during leave without pay or secondment periods, provided that the staff member pays full contributions (his/her own and that of the Organization) for the whole period of the leave without pay or secondment in one payment in advance.

Exclusions

160 The benefits of the Insurance are not applicable to accidents that took place before the day protection commenced, i.e. for staff members, from the date of their appointment until the date on which their employment ceases; for dependents and other persons from the date on which they have acquired dependency status under Staff Rule 310.5; or during a leave without pay or secondment period, provided that the staff member paid full contributions.

170 [Deleted]

171 Except in case of emergency or accident, the benefits of the Insurance are limited to a maximum amount of US$ 10 000 (ten thousand dollars) per year for the first three calendar years of coverage of any insured non-dependent spouse or non-dependent child, or secondary dependant (dependant father, mother, brother or sister). This clause does not apply to a non-dependent spouse or non-dependent child entering the Insurance:

1. at the time of recruitment of staff holding a fixed-term appointment;
2. at the date of the staff member's affiliation under the provisions of Annex 7A of the Staff Rules, up to the end of the uninterrupted period of WHO Staff Health Insurance contributions for staff holding temporary appointments; or
3. within three months of a life event (a life event is defined as marriage, birth, adoption of a child or change in dependency status of a spouse or child).

175 [Deleted]

180 [Deleted]

190 The benefits of the Insurance do not extend to any expenses incurred after the date when participation ceases. However, if dependants are under treatment when they reach the age limit for participation, reimbursement is allowed of expenses for such treatment that are incurred within 90 days of the date when their participation ceased.

Benefits

General provisions

200 Details of benefits are included in the Benefits Table and Appendix C1 as follows:

200.1 benefits for staff members, excluding staff members on temporary appointments of 60 days or less and paid on a daily basis: Benefits Table;

200.2 benefits for staff members on temporary appointments of 60 days or less and paid on a daily basis: Appendix C1.

Claims procedure

Excessive charges

201 If the SHI Officer in Headquarters finds the charges for any service clearly excessive after consultation with the regional SHI officer when relevant, he/she may authorize reimbursement on the basis of the usual charge in the locality for similar services.

Supplementary benefit (catastrophic limit)

202 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 retired staff member themselves in the cost of the services enumerated in the Benefits Table 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.

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

203.1 for staff members, 5% of their annual remuneration for purposes of contribution [see paragraphs 400 and 405];

203.2 for retired staff members with more than 25 years of service, or their surviving dependants, 5% of the actual full pension benefit;

203.3 for retired staff members with less than 25 years of service, or their surviving dependants, whose pension benefit is referred to in paragraphs 410.1 and 415, 5% of the full pension benefit payable after 25 years of service.

Reimbursement from other sources

204 Where another insurance, social security or similar scheme exists, reimbursement is made for that part of the cost not reimbursed by the other scheme up to a maximum of 80% of the total cost that would normally be paid; in no case shall the amount reimbursed, added to the reimbursement from another source, exceed 100% of the total cost of treatment.

205 If there is reason to believe that a third party may be under a legal liability to reimburse medical expenses for an illness or injury for which reimbursement from Staff Health Insurance would normally be due, the paying member must inform the relevant Staff Health

Insurance Officer. The paying member must submit all relevant medical bills directly to the third party insurance. If the paying member is reimbursed any medical expenses from a third party insurance that have already been reimbursed by the WHO Staff Health Insurance, he/she must reimburse the WHO Staff Health Insurance. In exceptional cases, the Director-General or, in the regions, the regional director may require the staff member concerned to take action to enforce such liability. In such cases, costs arising out of legal proceedings will be borne by the Staff Health Insurance.

Place of treatment

207 Active or former staff members, other than those whose recognized (by the Organization) nationality/place of residence or duty station is within the WHO Region of the Americas, who choose to seek medical care in the United States of America or in Canada, are entitled to reimbursement up to 80% of 75% of their reimbursable medical expenses. Exceptional cases can be reviewed by the Global Standing Committee/relevant regional surveillance committee, which may decide that the circumstances justify a waiver of this restriction, provided that costs are not expected to exceed US$ 200 000. If the estimated costs of an exceptional case are greater than US$ 200 000, and in emergency cases (life-threatening situation or situation where the patient must start treatment within a maximum of 48 hours and for whom travel is not possible for medical reasons), approval of the Global Standing Committee is required, through the regional surveillance committee.

208 Dependants and eligible family members are covered in the same way as the active or former staff member to whom they are related.

Submission of claims

340 Claims for reimbursement should be made on form WHO 339, to which should be attached original bills, prescriptions (when appropriate) and proof of payment satisfactory to the relevant Staff Health Insurance for the services rendered. Claims should be sent in an envelope marked “Confidential – Staff Health Insurance” to the Staff Health Insurance Officer at Headquarters (regional budget and finance officer). Retired staff members should send their claims to the regional office relevant to their country of residence.

341 By signing the claim form WHO 339, the staff member or retired staff member confirms that:

341.1 the bills for which reimbursement is claimed have been paid in full and that all information on any discounts and/or any payments received or expected to be received from other sources has been provided;

341.2 the bills submitted have been verified and correspond to medical treatment received;

341.3 [Deleted]

341.4 the Staff Health Insurance is authorized to query or seek clarification directly with the health care provider or another insurance company when appropriate;

341.5 the bills do not relate to an accident that took place during a break in participation.

345 Claim forms must be signed by the staff member (or survivor under paragraph 90.3), except if as a consequence of a serious accident or illness staff members (or survivors under paragraph 90.3) are not in a position to attend to their personal affairs. Claims may then be

made by their legal personal representative, or in exceptional cases by a person acting in a fiduciary capacity on their behalf.

350 Claims must be submitted for reimbursement within 12 months of the date of the bill for the services rendered, and must be translated into English, French or the main working language of the relevant regional office. In the interest of avoiding unnecessary administrative costs, bills for small sums are not to be submitted individually. They should be accumulated and submitted for reimbursement only when the total represents a significant sum as per table below.

Threshold of minimum amounts allowed for claims submission by region:

Regional office	Amount in US$	Accumulation period
HQ / IARC / EURO / EMRO / SEARO / WPRO	100	3 months
AFRO / AMRO / PAHO / GSC	50	3 months

However, an accumulation over a period of three months may be submitted irrespective of the amount. In cases where additional information is required, the complement must be provided within 3 months from the date of the request thereof in order for reimbursement to be made.

Direct Payment

351 For active staff members (whose contract is not due to expire within three months of the date of receipt of the request) and their participating family members, direct payment may be made to a health care provider for the full amount of an individual medical bill, where the full amount of the medical bill equals at least 15% of a staff member's net monthly salary (plus post adjustment for staff in the Professional and Director categories). The direct payment form WHO 843 (yellow envelope) shall be completed and submitted to the office administering the staff member's claims together with the relevant original bill(s) as soon as possible after receipt from the health care provider – normally within 30 days and in any case not later than 3 months from the date of the bill for the services rendered. The staff member's share of expenses (normally 20% plus non-reimbursable expenses) is recovered from the next month's salary and up to three months' salaries.

352 A direct payment can also be made for up to 80% of the amount of an individual medical bill on behalf of a retiree or an active staff member whose contract is due to expire within three months of the date of receipt of the request. In such cases, the 20% plus non-reimbursable expenses must be paid directly to the health care provider by the retiree/staff member. For retirees, the full amount of the individual medical bill must equal at least 15% of the full monthly pension benefit that would have been payable after 30 years of service. The direct payment form WHO 843 (yellow envelope) must be completed and submitted to the office administering the staff member's claims together with the relevant original bill(s) as soon as possible after receipt from the health care provider and in any case not later than 3 months of the date of the bill for the services rendered.

Letter of Guarantee

355 Letter of guarantee: In case of hospitalization, at the request of the paying member or the hospital, the Staff Health Insurance will guarantee, up to its liability, direct payment of bills at least three working days before commencement of the hospitalization, except in emergencies. An initial guarantee is given for 30 calendar days of hospitalization. Any extension of the guarantee is subject to a request from the hospital or the staff member supported by a medical report to the Staff Health Insurance for approval. Letters of guarantee may be issued for treatments other than hospitalization, on a case by case basis.

Advance Payment

356 The SHI Officer is authorized to make advance payments to health care providers on an exceptional basis up to a maximum amount of US$ 20 000 (twenty thousand US dollars) in cases when a letter of guarantee has been refused for admittance for hospitalization and in order to facilitate access to treatment. The staff member's share of expenses shall be recovered as per paragraph 351 of the SHI Rules.

Bank account used for reimbursement

357 Reimbursements will be made to the paying member as follows:

357.1 In the case of staff members, reimbursements will normally be made to the bank account into which their salary is paid. Where more than one bank account is registered in the Global Management System, staff members may inform the Staff Health Insurance Officer at Headquarters which account is to be used for all claims.

357.2 Retired staff members must inform the Staff Health Insurance Officer at Headquarters of any change in their banking details with the following information:

Name and address of bank
Account number/IBAN
SWIFT code/BIC
Currency of the account

357.3 It is not possible for WHO to make payment through an intermediary bank.

360 If the claim conforms to the requirements of these rules, the relevant Staff Health Insurance Officer arranges for the computation of the amount of the claim and pays the claimant the sum to which he/she is entitled in the currency in which the costs were incurred or, if this is not convenient to the Organization, in any freely convertible currency at the Organization's rate of exchange.

361 Benefits that have a ceiling in United States Dollars are calculated on the basis of a unique floor rate, in order to avoid exchange rate fluctuations against the dollar. The floor rate is calculated using the average exchange rate of the last 24 months each January for every currency. The floor rate is used only if it is beneficial for the participant. In other cases, the UN operational rate of exchange at the date of reimbursement is used.

370 If any part of the claim does not conform to the requirements of these rules, the relevant Staff Health Insurance officer makes payment accordingly and informs the claimant of the

reason why full payment cannot be made.

375 The Insurance may deduct from any benefit payable to a participant under these rules the amount of any indebtedness to the Insurance on the part of the participant when payment has been made otherwise than in accordance with these rules.

380 In case of doubt as to the interpretation of these rules or the genuineness of any claim, the relevant Staff Health Insurance officer refers the claim to the Global Standing Committee/relevant regional surveillance committee.

Financing

390 The income of the Insurance consists of:

390.1 contributions from the Organization and the participants to the first tier;

390.2 contributions to the second tier, where required to meet the provisions of paragraph 395;

390.3 any incidental revenue, including investment earnings.

393 The first tier of contributions consists of a set of rates [see Appendix A, paragraph A.10] that is applicable to all participants in the Insurance, both active and retired staff members, irrespective of their duty station or place of residence. First-tier contributions are financed in the ratio of two thirds by the Organization to one third by the participants.

395 A region,[i] or any other office administered by WHO, shall be required to add a second tier of contributions to the Insurance throughout the year following any calendar year in which the claims reimbursed to its active staff total more than 75% [see paragraph 470.3 of these rules] of the first tier contributions by the staff members concerned and the Organization. The amount by which these claims exceed the 75% ceiling is defined as the regional deficit. It is this amount that must be recovered by the Insurance through the second tier of contributions.

397 During the first year that a second tier is required, its cost shall be borne by the Organization in the region concerned, provided that the regional deficit does not exceed either 10% of the first tier contributions by active staff and the Organization, or US$ 50 000, whichever is lower. If the regional deficit exceeds either of these amounts, or if there is a regional deficit for two or more consecutive years, the second tier shall be financed in the ratio of two thirds by the Organization to one third by the participants in the region concerned, excluding retired staff members, surviving dependants and temporary staff.

Contributions by staff members

400 The contributions of staff members are computed on the basis of their remuneration, which, for the purposes of this Insurance, is considered to consist of net salary together with post adjustment or any non-resident's allowance.

405 The contributions of staff members employed on a part-time basis and of those who are granted special leave with partial pay are also based on the remuneration for full-time

[i] "Region" meaning any one of the following: Headquarters (including IARC), AFRO (including APOC), AMRO/PAHO, EMRO, EURO, SEARO and WPRO.

employment. Contributions of staff members on leave without pay are based on their last net salary together with post adjustment or any non-resident allowance, where applicable.

Contributions by retired staff members or surviving dependants

410 The contributions of former staff members [see paragraph 60] are computed on the basis of the higher amount of:

410.1 the full benefit granted to the retired staff members under the Regulations of the United Nations Joint Staff Pension Fund based on a minimum length of service of 30 years; staff members retiring with less than 30 years of service contribute on the basis of the full pension benefit payable after 30 years of service; staff members with 30 years or more of service contribute on the basis of their full pension benefit;

410.2 an amount equal to one third of the annual net salary payable to the staff members at the date of their retirement or death.

415 The contributions of surviving dependants [see paragraph 90.3] are computed on the basis of 50% of the full pension benefit granted to the staff member under the Regulations of the United Nations Joint Staff Pension Fund based on a minimum length of service of 30 years.

Categories of persons insured

420 Contributions vary in relation to the number or category of persons insured. The rates of contribution, expressed in percentages of remuneration, are shown in Appendix A.

430 In the light of the financial experience of the Insurance, the rates in Appendices A, C and D may be changed by decision of the Director-General on the recommendation of the Global Oversight Committee after consultation with the Global Standing Committee/relevant regional surveillance committee.

440 If both spouses are fixed-term staff members, both contribute separately to the Insurance as staff members. The spouse with the higher remuneration contributes at the appropriate rate for the children.

441 Where one spouse is a fixed-term staff member and the other is a temporary staff member covered by the insurance under paragraph 50, the children remain as dependants of the staff member covered under paragraph 30, even if the temporary staff member has the higher remuneration.

450 The contributions of staff members are deducted monthly from their remuneration. The contributions of retired staff members and surviving spouses and children shall be deducted one month in advance from the monthly United Nations Joint Staff Pension Fund benefit. It is only in cases where there is no United Nations Joint Staff Pension monthly benefit that direct payment of contributions will be accepted.

460 In application of paragraph 25 of the WHO International Public Sector Accounting Standards Manual, the Staff Health Insurance Fund is considered as a WHO Trust Fund, to which:

460.1 the contributions of the participants and of the Organization are credited monthly;

460.2 incidental revenue is credited, including interest earnings;

460.3 all benefits paid by the Insurance are charged;

460.4 expenses incurred by the Medical Review Committee under paragraph 540 are charged;

460.5 any administrative expenses are charged, up to a maximum of 6% of total premiums collected and other sources of income (for example reinsurance, see paragraph 465).

The Staff Health Insurance prepares annually a full set of audited financial statements in compliance with International Public Sector Accounting Standards.

465 The Global Oversight Committee may recommend to the Director-General to enter into such reinsurance arrangements as it deems necessary in the interests of the Insurance.

470 A reserve is maintained in the Trust Fund, equal to:

470.1 an amount corresponding to one third of the previous year's reimbursements, for settlement of outstanding claims should the Insurance have to be liquidated; plus

470.2 an amount that the Global Oversight Committee estimates to be required based on actuarial projections to cover the projected costs of benefits to current retirees (former staff members insured under paragraphs 60 and 90.3), to the extent that such estimated costs will not be met by contributions received in respect of such persons;

470.3 an amount that the Global Oversight Committee estimates to be required based on actuarial projections to cover the projected costs of benefits to future retirees (staff members insured under paragraphs 30 and 50), to the extent that such estimated costs will not be met by contributions received in respect of such persons;

470.4 25 % of the first-tier contributions made by active staff and the Organization in each region to meet the requirements of paragraph 470.2 and thereafter paragraph 470.3,

480 The Staff Health Insurance Officer at Headquarters prepares quarterly reports on receipts and expenditures and an annual analysis of expenditures to serve as a basis for the management of the Insurance by the Global Oversight Committee.

Surveillance

Global Oversight Committee

490 A Global Oversight Committee is established to oversee the Staff Health Insurance and advise the Director-General on Staff Health Insurance management and operations. In particular, the Global Oversight Committee shall:

490.1 review the operations and the financial status of the Staff Health Insurance, including levels of benefits and contributions consistent with the rules and guiding principles;

490.2 review the financial stability and the adequacy of the financial reserve of the Staff Health Insurance;

490.3 consider all Staff Health Insurance requests received from the Global Standing Committee;

490.4 review the annual report and overall performance of the Global Standing Committee;

490.5 organize periodic actuarial studies and approve the underlying assumptions, review the actuarial reports and recommend any required changes to the Staff Health Insurance to the Director-General after consultation with the Global Standing Committee;

490.6 review the external auditors' report, and recommend appropriate action on any recommendations in the report;

490.7 review any internal audit reports referred to it and recommend appropriate action on implementation of any recommendations concerning the Staff Health Insurance;

490.8 based on advice from the Advisory Investment Committee, review the Staff Health Insurance investment strategy and review its performance annually;

490.9 review the implementation of the recommendations from internal and external audit reports referred to it on the accounts of the Staff Health Insurance;

490.10 provide information to the Advisory Investment Committee to assist in the review of the Staff Health Insurance investments;

490.11 review and ensure the adequacy of the WHO Secretariat's direction and management of the Staff Health Insurance and review its performance annually;

490.12 keep itself informed of developments in the best practices of comparable health insurance plans;

490.13 in consultation with regional directors of administration and finance, recommend the implementation of measures to provide effective and methodical examination of claims, internal audit and fraud prevention;

490.14 advise the Director-General on the implementation of measures for cost containment;

490.15 submit an annual report on the operations, administration and accounts of the Staff Health Insurance to the Director-General and all staff committees and make an executive summary accessible to all participants;

490.16 propose amendments to the Staff Health Insurance Rules for decision by the Director-General;

490.17 review objectives and establish guiding principles and an assessment model and indicators to evaluate the performance of the Global Oversight Committee, Global Standing Committee and regional surveillance committees.

491 The Global Oversight Committee is composed of:

491.1 Assistant Director-General, General Management (ex officio, Chair); Comptroller (ex officio, non-voting) (alternate Chair);

491.2 a regional director of administration and finance;

491.3 a regional director of programme management;

491.4 a representative designated by the Staff Committee at Headquarters and a representative designated by a regional staff committee;

491.5 one member elected by the former staff members, at large, who are participants in the Staff Health Insurance as per paragraph 60 of the Staff Health Insurance Rules.

492 The Director of Administration and Finance and Director of Programme Management groups designate a member and an alternate member from within their respective groups who serve on a biennial rotating basis. Other alternate members are designated or elected in the same manner as members. An alternate member may act in the respective member's place when the member is unable to attend a meeting. Members other than the Assistant Director-General (General Management), the Comptroller and their alternates, shall serve for a renewable term of two years, with the exception of members elected by former staff members who shall serve for a term of four years. The Global Oversight Committee members and alternate members cannot serve concurrently on the Global Standing Committee or on a Regional Surveillance Committee.

493 The Global Oversight Committee is advised by:

493.1 external advisers (normally two), appointed by the Director-General;

493.2 a WHO Legal Officer from the Office of the Legal Counsel;

493.3 a WHO Medical Adviser, appointed by the Director-General on the recommendations of the Global Oversight Committee;

493.4 Director, Human Resources.

493.A The observers to the Global Oversight Committee are:

493A.1 the chair of the Global Standing Committee;

493.A.2 Director, Staff Health and Well-being Services for medical related subjects;

493.A.3 the alternate member elected by former staff members

494 External advisers to the Global Oversight Committee will be appointed by the Director-General. The external advisers will have strong experience in health insurance plans (particularly mutual plans). The external advisers shall not be employed by WHO or perform services under any contract with the Organization, nor shall they be a participant or former participant in the Staff Health Insurance. The external members will be entitled to reimbursement for travel and other expenses under the appropriate WHO policy.

495 The Director-General designates an Insurance Officer to act as Secretary of the Committee.

496 The Global Oversight Committee shall function in accordance with the rules of procedure described below and will normally meet twice a year. In fulfilling its responsibilities, the Global Oversight Committee may obtain, from any source, medical, technical and actuarial advice that it deems necessary. However, if the consultation is likely to result in a financial engagement, concurrence must be obtained from appropriate officers in application of WHO policies.

Global Standing Committee

500 A Global Standing Committee is established to decide on cases referred to it in accordance with the Staff Health Insurance Rules, and recommends to the Global Oversight Committee any proposed amendments to the Staff Health Insurance Rules and practices of the Staff Health Insurance. In particular, the Global Standing Committee shall:

500.1 apply the rules and take decisions on cases referred to it;

500.2 obtain, from any source, necessary medical or technical information in order to determine whether the care provided in a given case is medically recognized and whether the costs are excessive. However, if obtaining such information is likely to result in a financial engagement, the concurrence of the appropriate Secretariat officer must be sought in accordance with the delegation of authority from the Director-General;

500.3 propose to the Global Oversight Committee such amendments to the Staff Health Insurance Rules or practices of the Staff Health Insurance that, in the light of experience and in consultation with the regional surveillance committees, it may consider advisable;

500.4 submit an annual report to the Global Oversight Committee that analyses the results of the work and operational costs of the Global Standing Committee and the regional surveillance committees, potential changes in benefits, trends in cases reviewed and areas of opportunity for cost containment;

500.5 provide guidelines and tools to the regional surveillance committees and Staff Health Insurance Officers to support them.

501 The Global Standing Committee is composed of:

501.1 six members and six alternate members representing the administration, including three members and three alternate members from the regional offices designated by the Director-General in consultation with the regional directors;

501.2 six members and six alternate members representing the participants, as follows:

(a) four members and four alternate members designated by staff committees from Headquarters and regional offices (two from Headquarters and two from the regions);

(b) two members and two alternate members elected by the former staff members, at large, who are participants in the Staff Health Insurance under paragraph 60 of the Staff Health Insurance Rules.

502 The members and alternate members designated by the Director-General shall, to the extent possible, represent a balance of expertise in medicine, finance, human resources and health care finance. A similar profile for the other members would be desirable. An alternate member may act in the respective member's place when the member is unable to attend a meeting. Members and their alternates shall serve for a renewable term of two years, with the exception of members elected by the former staff members, who shall serve for a term of four years. Only members or, in their absence, their alternates can vote. The Global Standing Committee members and alternate members cannot serve concurrently on the Global Oversight Committee or on a Regional Surveillance Committee.

503 The Global Standing Committee is advised by:

503.1 a Medical Adviser, appointed by the Director-General on the recommendation of the Global Oversight Committee;

503.2 a Legal Officer from the Office of the Legal Counsel.

504 The Director-General designates an Insurance Officer to act as Secretary of the Committee.

505 An Interim Global Standing Committee shall be established to transact emergency business

when the Global Standing Committee itself is not in session. The Interim Global Standing Committee is composed of four members (and four alternate members) representing the two groups that form the quorum. The members of the Interim Global Standing Committee shall be appointed by the Staff Health Insurance Global Standing Committee for a two-year period from among the Global Standing Committee members. The Director-General, following consultation with the Staff Association, shall appoint the Chair from the membership of the Committee. As far as is practicable, the Interim Global Standing Committee shall observe the rules of procedure established for the Global Standing Committee. However, the Interim Global Standing Committee shall be empowered to adopt such additional operating guidelines as may be necessary for it to conduct its work. The Secretariat officer and advisers shall not participate in the taking of decisions, or in any voting. All decisions of the Interim Global Standing Committee shall be reported to the Global Standing Committee at its next meeting.

506 The Global Standing Committee shall function in accordance with the rules of procedure described in Appendix G.

Regional Surveillance Committees

510 In each region the regional director establishes a surveillance committee composed of representatives of the administration, staff and retired staff. The committee must have at least three members. The regional budget and finance officer acting as regional insurance officer serves as secretary of the committee. The regional surveillance committee is responsible for:

510.1 keeping under review the working of the Insurance in the region, and reporting thereon not less frequently than once a quarter to the regional director, the regional staff committee and the Global Standing Committee;

510.2 disallowing claims that on the basis of evidence acceptable to the committee are not considered bona fide, or limiting reimbursement if it finds the charges for any service clearly excessive [see paragraph 201];

510.3 proposing to the Global Standing Committee, after consultation with the regional director and the regional staff committee, any modifications in the rules or practices of the Insurance that they may consider advisable in the light of experience.

511 The Regional Surveillance Committees shall function in accordance with the rules of procedure described in Appendix G.

Appeals

530 A Medical Review Committee has been established at Headquarters to receive and examine any complaints from a staff member, a retired staff member, or a surviving spouse or dependant that a claim has not been settled in accordance with these rules in so far as its medical aspects are concerned. Such complaints must first have been examined by the Staff Health Insurance Officer (regional budget and finance officer) and the Global Standing Committee must have taken a decision on the interpretation of these rules. The Medical Review Committee shall report to the Director-General who shall make the final determination. However, a staff member, retired staff member or surviving spouse or

dependent, may refer the decision of the Director-General to the Administrative Tribunal of the International Labour Organization, in accordance with the provisions of the Statute of the Tribunal.

535 The Medical Review Committee is composed of one member and one alternate designated by the Director-General, one member and one alternate named by the Staff Committee at Headquarters, and a Chair and an alternate Chair designated by the Director-General on the recommendation of the other members of the Committee. All members must be medical officers and the member and alternate member designated by the Director-General must have served in regional or field assignments. The term of office of each member is two years. The Director-General designates an insurance officer to serve as secretary.

540 The Medical Review Committee establishes its own procedures and may seek whatever advice it may need from any source. The expenses arising from consultations initiated by the Committee are borne by the Insurance.

545 Complaints to the Medical Review Committee should be made in writing and addressed to the Chair, Medical Review Committee, care of Staff Health Insurance Officer, Headquarters, Geneva, in an envelope marked "Confidential". They must be made within three months of the date of the notification of the decision of the Global Standing Committee to which the claimant has taken exception and be supported by any relevant evidence. The claimant also notifies the Staff Health Insurance Officer (regional budget and finance officer) that he/she has made such a complaint.

550 Complaints relating to decisions of the Global Standing Committee or of a Regional Surveillance Committee, of an administrative nature on the settlement of any claim, may be referred to the Director-General within 60 days of the date of their notification. For such complaints, the Global Standing Committee must have given its opinion on the interpretation of these rules. The Director-General's decision shall be final. However, a staff member, retired staff member or surviving spouse or dependent may refer the decision of the Director-General to the Administrative Tribunal of the International Labour Organization, in accordance with the provisions of the Statute of the Tribunal. Fraud, infringement of Insurance Rules.

Fraud, infringement of Insurance Rules

560 All cases of fraud, confirmed, attempted or suspected, against the funds of the Insurance shall be dealt with in accordance with the procedure for reporting and follow-up of cases of fraud and losses of cash or property laid down in the relevant provision of the e-Manual. If it is established that fraud has in fact been committed or attempted, the case shall be referred to the Global Standing Committee or relevant regional surveillance committee.

562 The Global Standing Committee examines the case in the light of its facts and circumstances and may recommend to the Director-General the full or partial suspension or exclusion of the benefits and entitlements of the participant concerned. Regional surveillance committees examine cases referred to them in accordance with paragraph 560 in the light of the facts and circumstances and may recommend to the Global Standing Committee, through the regional director, the full or partial suspension or exclusion of the benefits and entitlements of the participant concerned. The participant is given the opportunity to communicate his/her comments in writing to the Global Standing Committee before any recommendation is made by the latter to the Director-General on the measures

described in these provisions.

564 The Director-General takes the decision on the suspension or exclusion of participation in the Insurance on the basis of the recommendation of the Global Standing Committee. A participant may refer the decision of the Director-General to the Administrative Tribunal of the International Labour Organization, in accordance with the provisions of the Statute of the Tribunal.

Distraint against claims

566 Benefits payable to participants, or their dependants, in respect of claims against the Insurance, may not be withheld in settlement, wholly or in part, of debts due to the Organization.

Amendments

570 Proposals to amend the Insurance in whole or in part, of whatever origin, are examined by the Global Oversight Committee, which, after consultation with and acceptance by the Global Standing Committee/majority of the regional surveillance committees and of the staff committees at Headquarters and in the regions, submits to the Director-General for his/her concurrence the proposals that it wishes to recommend for adoption. On receipt of the Director-General's agreement, the revisions come into force.

575 Proposals to dissolve the Insurance must first be endorsed by the Global Oversight Committee after consultation with the Global Standing Committee/regional surveillance committees and sent to the Director-General for his/her concurrence, and then submitted to a referendum of the whole staff of the Organization.

580 If it is decided to dissolve the Insurance, the Global Oversight Committee must in the first place make arrangements to safeguard the rights of retired staff members for continued coverage, including the transfer of the reserve fund set aside for this purpose. It will then make proposals to the Director-General and the staff for the liquidation of the remaining assets, special consideration being given to the rights of staff members with the longest periods of participation.

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Appendix A

Rates of contribution

[paragraph 420 of the rules]

A.10 The rates of contributions to the first tier, expressed as a percentage of salary, are:

	Staff member	WHO
For a staff member or temporary staff member covered under paragraph 30 or paragraph 50; a retired staff member; a surviving spouse; a surviving child; a spouse covered under paragraphs 80.1, 90.1 (a) or 90.1 (b) of the rules:	2.13%	4.26%
For a dependent child up to age 21:	0.29%	0.58%
For a child as defined in paragraph 90.4 of the rules:	0.85%	1.70%
For a dependent parent, brother or sister:	4.77%	9.54%

A.15 When there is a regional deficit calling for a second tier to be financed jointly by the Organization and the participants [see paragraph 397], the rates of contribution to the second tier shall be fixed so as to yield an amount equal to the preceding year's regional deficit. These rates shall bear the same relation to each other as do those set out in paragraph A.10 of this appendix.

A.20 For staff members and temporary staff members covered under paragraph 30 or paragraph 50 of the rules, the calculation of the contribution is based on the total of net salary plus either post adjustment or non-resident's allowance [see paragraph 400 of the rules].

A.30 For retired staff members or surviving dependants and eligible family members, the calculation of the contribution is based on the higher amount of (a) the benefit granted under the Regulations of the United Nations Joint Staff Pension Fund based on a minimum of 30 years of service; or (b) an amount equal to one third of the annual net salary payable to the staff member at the date of retirement or death [see paragraphs 410 and 415 of the rules].

A.40 For retired staff members who are already participating in the Insurance and who are employed as temporary staff, the calculation of the contribution is based on the total of the amount resulting from paragraph 30 plus their salary including either post adjustment or non-resident's allowance.

A.50 For the contributions of all other temporary staff, see Appendix C, paragraphs C.210–C.220.

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Appendix B

[Deleted]

Benefits Table

Benefits of the Staff Health Insurance applicable to staff members participating under paragraphs 30 and 50, their recognized dependants, and other insured family members.

Para.	Benefit	Maximum reimbursement / ceiling	Prior approval	Requirement for consideration	Approval required from		Rate of reim.	Supp. Benefit
					SHI Officer	RSC/ GSC		
Surgery and non-surgical treatment - N.B. rule on "place of treatment" applies								
B.10	**Surgery and non-surgical treatment**	Under US$ 50 000.- (no prior approval required)	Recommended	Medical report + estimate cost	x		80%	Yes
B.10.1		Between US$ 50 000.- and US$ 200 000.-	Compulsory	Medical report + estimate cost	x		80%	Yes
B.10.2		Above US$ 200 000.-	Compulsory	Medical report + estimate cost		x	80%	Yes
B.20	**Aesthetic surgery**	No reimbursement except for: - Reconstructive or plastic surgery following injury, neoplasms, infection or other diseases.		Medical report	x		80%	Yes
B.20.1			Breast reduction surgery for medical reasons	A medical report from surgeon other than one performing surgery including history of medically justified symptoms: weight of tissue removed should be equal or superior to 500 grams per breast.(BMI should not be over 25.)		x	80%	Yes
B.20.2			Plastic surgery for children under age 18 with serious congenital malformations	A medical report from surgeon other than one performing surgery including psychiatrist report on psychological impact.		x	80%	Yes
B.20.3			Major medical consequences of plastic surgery	A medical report from surgeon other than one performing the surgery or a specialist outlining medical risks if no surgery is undertaken.		x	80%	Yes
B.123			Maxillofacial surgery	see under dental services				

Para.	Benefit	Maximum reimbursement / ceiling	Prior approval	Requirement for consideration	Approval required from		Rate of reim.	Supp. Benefit
					SHI Officer	RSC/ GSC		
Hospitalization (room and board, general care and specialized hospital services) - N.B. rule on "place of treatment" applies								
B.30.1	In Canada or USA: minimum cost of a semi-private (2 beds) room, **subject to max. regional daily rate.**	365 days per accident or illness.	N/A	Medical report to be submitted every 30 days.	x		80%	Yes
B.30.2	In all other countries: Minimum cost of a private room subject to max. regional daily rate.	365 days per accident or illness.	N/A	Medical report to be submitted every 30 days.	x		80%	Yes
B.30.3	Hospitalization and medical treatment in a public ward in a public hospital	365 days per accident or illness.	N/A	Medical report to be submitted every 30 days.	x		100%	Yes
B.30.4	Hospitalization for day-care surgery/medical treatment (no overnight stay)	Day Packages: In hospitals/clinics where these exist, the SHI officer may limit reimbursement to the cost of the Package.	N/A		x		80%	Yes
B.30.5	Hospitalization for psychiatric care	365 days per 5-year period.	N/A	Medical report to be submitted every 30 days for first 90 days and every 90 days thereafter.	x		80%	No
B.30.6	Hospitalization for geriatric care		N/A	Medical report to be submitted every 30 days.	x		80%	No
B.30.7	Hospitalization at home	Cost cannot be more than a hospital and SHI will limit to cost of hospital if more at home.	N/A	Medical report to be submitted every 30 days.	x		80%	Yes
B.30.8	Hospitalization for reconstructive or plastic surgery following injury, neoplasms, infection or other diseases	365 days per accident or illness.	N/A	Medical report	x		80%	Yes
B.30.9	Hospitalization for breast reduction surgery for medical reasons.		Yes	Medical report		x	80%	Yes
B.30.10	Hospitalization for plastic surgery for children under age 18 with serious congenital malformations		Yes	Medical report		x	80%	Yes
B.30.11	Hospitalization for major medical consequences of plastic surgery		Yes	Medical report		x	80%	Yes

Para.	Benefit	Maximum reimbursement / ceiling	Prior approval	Requirement for consideration	Approval required from		Rate of reim.	Supp. Benefit
					SHI Officer	RSC/ GSC		
B.31	Hospitalizations		Yes – when over 365 days	Medical report		x	80%	Yes except for psychiatric care
B.32	Hospitalization for general medical check-up	No reimbursement						
B.33	Hospitalization for aesthetic surgery	No reimbursement						
B.60	Hospitalization for substance abuse	(see below)						
B.123	Hospitalization for maxillofacial surgery	(see below)						
Specialized hospital services								
B.50.1	Nursing care		N/A				80%	
B.50.2	Operating theatre		N/A				80%	
B.50.3	Delivery room		N/A				80%	
B.50.4	Radiology and laboratory services		N/A				80%	
B.50.5	Prescribed therapies incl. blood transfusions		N/A				80%	
B.50.6	Prescribed medicines		N/A				80%	
B.50.7	Anaesthetics		N/A				80%	
B.50.8	Physiotherapy		N/A				80%	
B.50.9	Accompanying person	No reimbursement						
Substance abuse								
B.60	Detoxification inpatient treatment	US$ 30 000 Lifetime entitlement	Yes	Medical report	x		80%	No
Convalescence following a period of hospitalization								
B.70.1	In USA and Canada: cost of a semi-private (2 beds) room, subject to max. regional daily rate in a recognized medical institutions: convalescent, nursing or geriatric home, cardiovascular rehabilitation.	30 days.	N/A	Prescription.			80%	Yes
B.70.2	In all other countries: Minimum cost of a private room subject to max. regional daily rate.	30 days.	N/A	Prescription			80%	Yes
B.71	Convalescence beyond 30 days	30 days.	Yes	Prescription and medical report	x		80%	Yes

Para.	Benefit	Maximum reimbursement / ceiling	Prior approval	Requirement for consideration	Approval required from		Rate of reim.	Supp. Benefit
					SHI Officer	RSC/ GSC		
Nursing								
B.80	Nursing for an acute condition: e.g. dressing wounds or administering injections.	30 days.	N/A	Prescription.			80%	Yes
B.80.1	Nursing for an acute condition beyond 30 days.	Duration to be approved	Yes	Medical report.	x		80%	Yes
B.81	Long-term nursing care in a specialized institution (or in a hospital where the patient is awaiting placement in a specialized institution).	US$ 100.- per day. N.B.: If nursing care cannot be identified 50% of bill will be considered as nursing care.	Yes	Medical report every 12 months.	x		80%	No
B.82	Long-term domiciliary care for a chronic disease including a geriatric condition.	US$ 100.- per day.	Yes	Medical report every 12 months.	x		80%	No
Other services								
B.83	Hospice care for terminally ill persons	See long-term nursing care in a specialized institution.						
B.84	Home help (for non-nursing care)	No reimbursement						
B.85	Care provided by family member	No reimbursement						
B.86	Spa treatments	No reimbursement.						
B.87	Aesthetic treatments for sole purpose of improving the appearance	No reimbursement						
Out-patient treatment								
B.90	Physician		N/A				80%	Yes
B.91	Midwife		N/A				80%	Yes
B.92	Immunization		N/A	Prescription			80%	Yes
B.93	Laboratory technician		N/A	Prescription			80%	Yes
B.94	Radiographer		N/A	Prescription			80%	Yes
B.95	Audiologist		N/A	Prescription			80%	Yes
B.96	Orthoptist (for children up to age 18)	12 sessions per year	N/A	Prescription			80%	Yes

Para.	Benefit	Maximum reimbursement / ceiling	Prior approval	Requirement for consideration	Approval required from		Rate of reim.	Supp. Benefit
					SHI Officer	RSC/ GSC		
B.97	Dietitian	6 sessions per year only if: BMI >30 or <15 or - Celiac disease - Chronic colitis - Chronic inflammatory bowel disease - Chronic renal disease - Cystic fibrosis - Diabetes - HIV - Neuromuscular disease	N/A	Prescription			80%	Yes
		Other pathologies	Yes	Medical report with ICD-10 code	x		80%	Yes
B.98	Occupational therapist	12 sessions per year	N/A	Prescription			80%	Yes
B.99	Osteopath/Chiropractor	24 sessions per year	N/A	Prescription			80%	Yes
B.101	Physiotherapist	24 sessions per year plus any unused session from 2 previous years.	N/A	Prescription			80%	Yes
B.102	Psychomotor therapist (for children up to age 18)	12 sessions per year	N/A	Prescription			80%	Yes
B.103	Podiatrist	12 sessions per year	N/A	Prescription			80%	No
B.104	Speech therapist for children up to age 18	150 sessions	N/A	Prescription			80%	Yes
B.105	Speech therapist for adults	Number of sessions and period to be approved	Yes For speech defects following an accident or illness.	Medical report	x		80%	Yes

Para.	Benefit	Maximum reimbursement / ceiling	Prior approval	Requirement for consideration	Approval required from		Rate of reim.	Supp. Benefit
					SHI Officer	RSC/ GSC		
B.106	Psychotherapist/Psychoanalysist	24 sessions per year plus any unused sessions from 2 previous years. Distance sessions subject to prior approval from GSC. Communication costs not covered.	N/A	Prescription and licensed practitioner must be recognized by the health authorities of the country in which treatment is provided.	x		80%	No
B.106.1	Psychotherapist for pathologies list in App. F (above credit must be used before)		N/A	Medical report with ICD-10 code every 12 months.	x		80%	Yes
Optical Care - Pro rata temporis for new participants entering the insurance or resuming participation in the course of a year to be applied to maximum amounts below:								
B.110	Corrective lenses and frames, contact lenses, replacement of damaged corrective lenses or frames	US$ 250 optical credit each year, plus any unused optical credit for prior 2 years.	N/A	Certification from an ophthalmological specialist or licensed registered optometrist.			80%	No
B.111	Corrective lenses following eye surgery	US$ 250 for purchase of lenses only in 12 months following eye surgery.	N/A	Medical report			80%	No
B.112	Refractive eye surgery	US$ 2 000 per eye lifetime coverage.	N/A	Medical report to confirm one of following: ■ Myopia with or without astigmatism (ametropia) of more than –1.5 dioptres but not more than –10; ■ Hypermetropia with or without astigmatism (from +1.5 dioptres to +6).			80%	No

Para.	Benefit	Maximum reimbursement / ceiling	Prior approval	Requirement for consideration	Approval required from		Rate of reim.	Supp. Benefit
					SHI Officer	RSC/ GSC		
B.113	Blepharoplasty	US$ 2 000 per eye lifetime coverage.	Yes	Medical report from physician other than the one performing the surgery, with field vision evaluation report and photos of patient's eye area.	x		80%	No
Dental Services - Pro rata temporis for new participants entering the insurance or resuming participation in the course of a year to be applied to maximum amounts below:								
B.120	General dental care, including: Hygienist, orthodontic care, prosthetic care (including cost of services of dentist and technician, materials required, crowns, bridges, dentures, implants or similar devices)	US$ 1 500 per year based on date of treatment, plus any unused dental credit from prior 2 years.	N/A				80%	No
B.121	Prosthetic replacement of one or more teeth due to consequences of severe systemic illness (e.g. cancer, heart disease) or of a non-dental congenital defect or to allow for a non-dental surgical intervention to be performed	US$ 3 500 (without impact on available dental credit).	Yes	Medical report	x		80%	No
B.122	Dental care as a result of an accident	Without impact on available dental credit.	Yes	Medical report	x		80%	Yes
B.123	Maxillofacial surgery	Without impact on available dental credit.	Yes	Medical report	x	x	80%	Yes
Preventive Measures (reimbursed at 100% up to maximum reimbursement below, remaining balance reimbursed at 80%)								
B.150	Vaccines (from the following):	US$ 200 per year	N/A	Prescription			100%	N/A
	Diphtheria		N/A					N/A
	Haemophilus influenzae type b		N/A					N/A
	Hepatitis A		N/A					N/A
	Hepatitis B		N/A					N/A
	Influenza		N/A					N/A
	Japanese encephalitis		N/A					N/A
	Measles		N/A					N/A

Para.	Benefit	Maximum reimbursement / ceiling	Prior approval	Requirement for consideration	Approval required from		Rate of reim.	Supp. Benefit
					SHI Officer	RSC/ GSC		
	Meningococcal conjugate		N/A					N/A
	Mumps		N/A					N/A
	Pertussis (whooping cough)		N/A					N/A
	Pneumococcal conjugate and polysaccharide		N/A					N/A
	Poliomyelitis		N/A					N/A
	Rabies		N/A					N/A
	Rubella		N/A					N/A
	Rotavirus		N/A					N/A
	Tetanus		N/A					N/A
	Yellow fever		N/A					N/A
	Varicella		N/A					N/A
B.151	Human papillomavirus (HPV)	US$ 500.	N/A	Within WHO's recommendations and with prescription			100%	N/A
B.152	Mammography from age 40	US$ 300 every 2 years	N/A				100%	N/A
B.153	Gynaecological check-up (incl. Pap smear test)	US$ 150 every 2 years.	N/A				100%	N/A
B.154	PSA (prostate test) from age 50	US$ 50 per year.	N/A				100%	N/A
B.155	Colonoscopy from age 50	US$ 600 every 5 years.	N/A				100%	N/A
B.156	General medical check-up (outpatient): basic blood and urine tests only + ECG, if required	US$ 500 every 2 years.	N/A				100%	N/A
B.157	HIV test (incl. pre-test/post-test counselling)	US$ 100 per year.	N/A				100%	N/A
B.158	Hepatitis B and C tests (incl. pre-test/post-test counselling)	US$ 100 per year.	N/A				100%	N/A
Reproductive Health								
B.160	Amniocentesis/villocentesis		N/A				80%	Yes
B.161	Preparation for birth delivery classes given by a midwife		N/A				80%	Yes
B.162	Epidural		N/A				80%	Yes

Para.	Benefit	Maximum reimbursement / ceiling	Prior approval	Requirement for consideration	Approval required from		Rate of reim.	Supp. Benefit
					SHI Officer	RSC/ GSC		
B.163	Home delivery with assistance from a midwife or physician		N/A				80%	Yes
B.164	Hospital delivery		N/A				80%	Yes
B.165	Fertility Treatment	US$ 30 000 lifetime entitlement for medical examinations, laboratory tests, scans, medical treatment, hospitalization, artificial insemination, IVF drugs, donor eggs, donor sperm, freezing of embryos.	N/A				80%	No
B.166	Prescribed contraceptives		N/A	Prescription			80%	Yes
B.167	Sterilization		N/A				80%	Yes
B.168	Prenatal exercises	No reimbursement						
B.169	Postnatal exercises	No reimbursement						
B.170	Surrogacy	No reimbursement						
Medicinal products								
B.180	Prescribed medicines reimbursed by SHI		N/A	Prescription			80%	Yes
B.181	Medicines prescribed by staff members/former staff members who are physicians	for themselves and insured family members only	N/A	Prescription (max. validity 6 month)			80%	Yes
B.182	Dressings (following surgery/accident)		N/A	Prescription			80%	Yes
B.183	Homeopathy		N/A	Prescription			80%	Yes
B.184	Medication for erectile dysfunction following: - Prostatectomy - Pelvic surgery		N/A	Prescription			80%	Yes
B.185	Tobacco substitutes		N/A	Prescription			80%	Yes
Non-reimbursable medicinal products (non-exhaustive)								
B.200	Incontinence pads	No reimbursement						
B.201	Mineral waters	No reimbursement						
B.202	Over-the-counter medicinal products	No reimbursement						

Para.	Benefit	Maximum reimbursement / ceiling	Prior approval	Requirement for consideration	Approval required from		Rate of reim.	Supp. Benefit
					SHI Officer	RSC/ GSC		
B.203	Phytotherapy, Herbal medicine	No reimbursement						
B.204	Special shampoos, hair tonics or soaps	No reimbursement						
B.205	Sun screen	No reimbursement						
B.206	Toiletries	No reimbursement						
B.207	E-cigarettes	No reimbursement						
B.208	Web-purchased medicaments	No reimbursement						
Appliances and accessories - maximum amount per purchase (non-exhaustive)								
B.210	Bra (special) after mastectomy	US$ 200 per year	N/A	Prescription			80%	No
B.211	Prosthesis for bra after mastectomy	US$ 400 per year	N/A	Prescription			80%	No
B.212	Hearing aid including maintenance	US$ 2 000 per ear every 5 years.	N/A	Prescription			80%	No
B.212.1	Hearing aid where hearing has deteriorated significantly within 5 years of previous purchase	US$ 2 000 per ear	Yes	Medical report with audiogram	x		80%	No
B.213	Inhaler	US$ 100 every 5 years	N/A	Prescription			80%	No
B.214	Insoles (orthopaedic and made-to-measure)	US$ 500 per year	N/A	Prescription			80%	No
B.215	Stockings (support)	US$ 140 per year	N/A	Prescription			80%	No
B.216	Shoes (orthopaedic and made-to-measure)	US$ 1 800 per year	N/A	Prescription			80%	No
B.217	Wig	US$ 800 every 2 years	Yes	Medical report	x		80%	No
Appliances and accessories - maximum amount for rental or purchase								
B.220	Breastfeeding pump	US$ 250 per newborn child	N/A	Prescription			80%	No
B.221	Collar (orthopaedic)	US$ 50 per year	N/A	Prescription			80%	No
B.222	Crutches	US$ 50 per year	N/A	Prescription			80%	No
B.223	Glucometer including maintenance	US$ 100 every 2 years	N/A	Prescription			80%	No
B.224	Walking frame	US$ 50 every 2 years	N/A	Prescription			80%	No
B.225	Apnoea Machine incl. humidifier (device to sleep) including maintenance	US$ 2 300 lifetime coverage	Yes	Medical report incl. results of polysomnography	x		80%	No

Para.	Benefit	Maximum reimbursement / ceiling	Prior approval	Requirement for consideration	Approval required from		Rate of reim.	Supp. Benefit
					SHI Officer	RSC/ GSC		
B.226	Wheelchair (either electric or manual) including maintenance	US$ 3 000 (every 5 years)	Yes	Medical report	x		80%	No
B.226.1	Wheelchair where condition has deteriorated significantly within 5 years of previous purchase	US$ 3 000	Yes	Medical report	x		80%	No
B.227	Pressure relief mattress	US$ 400 (every years)	N/A	Prescription	x		80%	No
B.228	Other reimbursable appliances not covered above	up to US$ 1 000	N/A	Prescription	x		80%	No
B.229	All reimbursable appliances and accessories	over US$ 1 000	Yes	Medical report	x		80%	No
Non reimbursable appliances and accessories (non-exhaustive)								
B.230	Adaptation to house (e.g. shower, stair lift, special lavatory, bath seat)	No reimbursement						
B.231	Air purifier or humidifier	No reimbursement						
B.232	Bathing suit after mastectomy	No reimbursement						
B.233	Batteries (for hearing aid, etc.)	No reimbursement						
B.234	Bedding (other than pressure relief mattress)	No reimbursement						
B.235	Blood pressure monitor	No reimbursement						
B.236	Incontinence appliances	No reimbursement						
B.237	Lamp (infrared)	No reimbursement						
B.238	Separate maintenance of purchased equipment	No reimbursement						
B.239	Thermometer	No reimbursement						
Traditional and complementary/alternative medicine interventions								
B.240	Acupuncturist	24 sessions per calendar year	N/A	Treatment and therapist must be recognized by the health authorities of the country in which treatment is provided. A prescription from a physician is required			80%	Yes

Para.	Benefit	Maximum reimbursement / ceiling	Prior approval	Requirement for consideration	Approval required from		Rate of reim.	Supp. Benefit
					SHI Officer	RSC/ GSC		
B.241	Other traditional and complementary/alternative medicine interventions (e.g. Ayurveda) - outpatient treatment only	12 sessions per calendar year.	N/A	Treatment and therapist must be recognized by the health authorities of the country in which treatment is provided. A prescription from a physician is required.			80%	Yes
Transportation								
B.250	Emergency:							
B.250.1	- Ambulance to the nearest hospital where the patient can be treated.		N/A				80%	Yes
B.250.2	- Ambulance or any other means to the nearest rail, sea or air connection (in a remote area)		N/A	Medical report	x		80%	Yes
B.250.3	- Helicopter ambulance to the nearest hospital where patient can be treated.		N/A	Medical report	x		80%	Yes
B.251	Non-emergency:							
B.251.1	- Ambulance between hospitals		Yes	Medical report	x		80%	Yes
B.251.2	- Other transport (in critical cases) to the nearest location where the patient can be treated		Yes	Medical report	x		80%	Yes
B.252	Search and rescue	No reimbursement						
B.253	Medical evacuation/repatriation	No reimbursement						
B.254	Transport to a location where cost of treatment is cheaper	No reimbursement						
Death								
B.255	Repatriation	No reimbursement						
B.256	Mortuary/funeral expenses	No reimbursement						

Appendix C

Insurance of staff members on temporary appointments of 60 days or less and paid on a daily basis

Participation

C.10 Staff members on temporary appointments of 60 days or less and paid on a daily basis, ("temporary staff under paragraph 55 of the rules") participate in the Staff Health Insurance to the extent set out in this appendix, Appendix C1, and paragraphs 10–20, 340–380 and 490–580 of the Staff Health Insurance Rules.

C.20 The spouses and children of temporary staff are not covered by these provisions.

Period of protection

C.30 The Insurance takes effect from the date of appointment or from the date on which authorized travel begins, and continues until the date on which employment ceases or authorized travel ends.

C.35 Temporary staff under paragraph 55 of the rules may elect, before the date of termination of their contract, to continue their participation for a further period not exceeding 30 days beyond the date of termination of their contract, provided that they pay both their own and the Organization's contributions.

C.40 However, conditions requiring medical attention and/or treatment that have manifested themselves during the period of contract remain covered 30 days beyond the final date mentioned in paragraphs C.30 and C.35 of this appendix.

C.50 The benefits of the Insurance are not applicable to accidents that took place before the date on which protection commenced or during a break in protection.

Benefits: general provisions

C.60 Subject to an overall limit of US$ 30 000 per case of accident or illness, reimbursement of the expenses of medical treatment is made as detailed in Appendix C1.

C.70 The Insurance does not reimburse that part of any costs incurred that has been or will be reimbursed by:

C.70.1 another insurance, social security or similar scheme;

C.70.2 WHO in accordance with the provisions of the rules governing compensation in eManual III.20, Annex 7E;

C.70.3 a third party liable to pay damages under the national legislation of the country in which the event occurred.

Claims procedure

C.170 Claims for reimbursement should be made in accordance with paragraphs 10–20, 340–380 and 490–580 of the Staff Health Insurance Rules.

Contributions

C.210 The rate of contribution for temporary staff expressed as a percentage of salary is as follows:

Temporary staff member	Organization
0.72%	1.44%

C.220 The calculation of the contribution for Staff members on temporary appointments of 60 days or less and paid on a daily basis is based on the total of net salary plus either post adjustment or non-resident's allowance.

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Appendix C1

Overall limitation of benefits to US$ 30 000 per case of accident or illness. Supplementary benefit (catastrophic expenses) is not applicable.

Para.	Benefit	Maximum reimbursement / ceiling	Prior approval	Requirement for consideration	Approval required from		Rate of reimb.
					SHI Officer	RSC/ GSC	
Hospitalization (room and board, general care and specialized hospital services) - N.B. rule on "place of treatment" applies							
C.30.1	In Canada or USA: minimum cost of a semi-private (2 beds) room, **subject to max. regional daily rate.**	365 days per accident or illness.	N/A	Medical report to be submitted every 30 days.	x		80%
C.30.2	In all other countries: Minimum cost of a private room subject to max. regional daily rate.	365 days per accident or illness.	N/A	Medical report to be submitted every 30 days.	x		80%
C.30.3	Hospitalization and medical treatment in a public ward in a public hospital	Earlier of end of coverage period or overall US$ 30 000	N/A	Medical report to be submitted every 30 days.	x		100%
C.30.4	Hospitalization for day-care surgery/medical treatment (no overnight stay)	Day Packages: In places where these exist, SHI reserves the right to limit reimbursement to the cost of the Package.	N/A		x		80%
C.30.5	Hospitalization for psychiatric care	No reimbursement					
C.30.6	Hospitalization for geriatric care	Earlier of end of coverage period or overall US$ 30 000	N/A	Medical report to be submitted every 30 days.	x		80%
C.30.7	Hospitalization at home	Cost cannot be more than a hospital and SHI will limit to cost of hospital if more at home.	N/A	Medical report to be submitted every 30 days.	x		80%
C.30.8	Hospitalization for reconstructive or plastic surgery following injury, neoplasms, infection or other diseases	Earlier of end of coverage period or overall US$ 30 000	N/A	Medical report	x		80%
C.30.9	Hospitalization for breast reduction surgery for medical reasons.	Earlier of end of coverage period or overall US$ 30 000	Yes	Medical report		x	80%
C.30.11	Hospitalization for major medical consequences of plastic surgery	Earlier of end of coverage period or overall US$ 30 000	Yes	Medical report		x	80%

Para.	Benefit	Maximum reimbursement / ceiling	Prior approval	Requirement for consideration	Approval required from		Rate of reimb.
					SHI Officer	RSC/ GSC	
C.31	All Hospitalizations		Yes – Over 365 days	Medical report		x	80%
C.32	Hospitalization for general medical check-up	No reimbursement					
C.33	Hospitalization for aesthetic surgery	No reimbursement					
C.60	Hospitalization for substance abuse	No reimbursement					
C.123	Hospitalization for maxillofacial surgery	No reimbursement					
Specialized hospital services							
C.50.1	Nursing care		N/A				80%
C.50.2	Operating theatre		N/A				80%
C.50.3	Delivery room		N/A				80%
C.50.4	Radiology and laboratory services		N/A				80%
C.50.5	Prescribed therapies incl. blood transfusions		N/A				80%
C.50.6	Prescribed medicines		N/A				80%
C.50.7	Anaesthetics		N/A				80%
C.50.8	Physiotherapy		N/A				80%
C.50.9	Accompanying person	No reimbursement					
Substance abuse							
C.60	Detoxification inpatient treatment	No reimbursement			x		80%
Convalescence following a period of hospitalization							
C.70.1	In USA, Canada: cost of a semi-private (2 beds) room, subject to max. regional daily rate in a recognized medical institutions: convalescent, nursing or geriatric home, cardiovascular rehabilitation.	30 days.	N/A	Prescription.			80%
C.70.2	In all other countries: Minimum cost of a private room subject to max. regional daily rate.	30 days.	N/A	Prescription			80%
C.71	Convalescence beyond 30 days	30 days.	Yes	Prescription and medical report	x		80%

Para.	Benefit	Maximum reimbursement / ceiling	Prior approval	Requirement for consideration	Approval required from		Rate of reimb.
					SHI Officer	RSC/ GSC	
Nursing							
C.80	Nursing for an acute condition: e.g. dressing wounds or administering injections.	30 days.	N/A	Prescription.			80%
C.80.1	Nursing for an acute condition beyond 30 days.	Duration to be approved	Yes	Medical report.	x		80%
C.81	Long-term nursing care in a specialized institution (or in a hospital where the patient is awaiting placement in a specialized institution).	No reimbursement					
C.82	Long-term domiciliary care for a chronic disease including a geriatric condition.	No reimbursement					
Other services							
C.83	Hospice care for terminally ill persons	No reimbursement					
C.84	Home help (for non-nursing care)	No reimbursement					
C.85	Care provided by family member	No reimbursement					
C.86	Spa treatments	No reimbursement.					
C.87	Aesthetic treatments for sole purpose of improving the appearance	No reimbursement					
Out-patient treatment							
C.90	Physician		N/A				80%
C.91	Midwife		N/A				80%
C.92	Immunization		N/A	Prescription			80%
C.93	Laboratory technician		N/A	Prescription			80%
C.94	Radiographer		N/A	Prescription			80%
C.95	Audiologist		N/A	Prescription			80%
C.97	Dietitian	No reimbursement					
C.98	Occupational therapist	No reimbursement					
C.99	Osteopath / Chiropractor	24 sessions per year	N/A	Prescription			80%
C.101	Physiotherapist	24 sessions per year plus any unused sessions from 2 previous years.	N/A	Prescription			80%
C.103	Podiatrist	12 sessions per year	N/A	Prescription			80%

Para.	Benefit	Maximum reimbursement / ceiling	Prior approval	Requirement for consideration	Approval required from		Rate of reimb.
					SHI Officer	RSC/ GSC	
C.105	Speech therapist for adults	No reimbursement					
C.106	Psychotherapist/Psychoanalysist	No reimbursement					
Optical Care							
C.110	Corrective lenses and frames, contact lenses, replacement of damaged corrective lenses or frames	No reimbursement	N/A				
C.111	Corrective lenses following eye surgery	No reimbursement	N/A				
C.112	Refractive eye surgery	No reimbursement	N/A				
C.113	Blepharoplasty	No reimbursement					
Dental Services							
C.120	General dental care, including: Hygienist, orthodontic care, prosthetic care (including cost of services of dentist and technician, materials required, crowns, bridges, dentures, implants or similar devices)	No reimbursement					
C.121	Prosthetic replacement of one or more teeth due to consequences of severe systemic illness (e.g. cancer, heart disease) or of a non-dental congenital defect or to allow for a non-dental surgical intervention to be performed	No reimbursement					
C.122	Dental care as a result of an accident		Yes	Medical report	x		80%
C.123	Maxillofacial surgery	No reimbursement					
Preventive Measures							
C.150	No reimbursement						
Reproductive Health							
C.160	Amniocentesis/villocentesis		N/A				80%
C.161	Preparation for birth delivery classes given by a midwife	Up to end of 20th week of pregnancy	N/A				

Para.	Benefit	Maximum reimbursement / ceiling	Prior approval	Requirement for consideration	Approval required from		Rate of reimb.
					SHI Officer	RSC/ GSC	
C.165	Fertility Treatment	No reimbursement					
C.166	Prescribed contraceptives	No reimbursement					
C.167	Sterilization		N/A				80%
C.168	Prenatal exercises	No reimbursement					
C.169	Postnatal exercises	No reimbursement					
C.170	Surrogacy	No reimbursement					
Medicinal products							
C.180	Prescribed medicines reimbursed by SHI		N/A	Prescription			80%
C.181	Medicines prescribed by staff members/former staff members who are physicians	for themselves only	N/A	Prescription (max. validity 6 month)			80%
C.182	Dressings (following surgery/accident)		N/A	Prescription			80%
C.183	Homeopathy		N/A	Prescription			80%
C.184	Medication for erectile dysfunction following: - Prostatectomy - Pelvic surgery		N/A	Prescription			80%
C.185	Tobacco substitutes		N/A	Prescription			80%
Non-reimbursable medicinal products (non-exhaustive)							
C.200	Incontinence pads	No reimbursement					
C.201	Mineral waters	No reimbursement					
C.202	Over-the-counter medicinal products	No reimbursement					
C.203	Phytotherapy, Herbal medicine	No reimbursement					
C.204	Special shampoos, hair tonics or soaps	No reimbursement					
C.205	Sun screen	No reimbursement					
C.206	Toiletries	No reimbursement					
C.207	E-cigarettes	No reimbursement					
C.208	Web-purchased medicaments	No reimbursement					

Para.	Benefit	Maximum reimbursement / ceiling	Prior approval	Requirement for consideration	Approval required from		Rate of reimb.
					SHI Officer	RSC/ GSC	
Appliances and accessories							
C.210-239	No reimbursement						
Traditional and complementary/alternative medicine interventions							
C.240	Acupuncturist	24 sessions per calendar year	N/A	Treatment and therapist must be recognized by the health authorities of the country in which treatment is provided. A prescription from a physician is required			80%
C.241	Other traditional and complementary/alternative medicine interventions (e.g. Ayurveda) - outpatient treatment only	12 sessions per calendar year	N/A	Treatment and therapist must be recognized by the health authorities of the country in which treatment is provided. A prescription from a physician is required			80%
Transportation							
C.250	Emergency:						
C.250.1	- Ambulance to the nearest hospital where the patient can be treated.		N/A				80%
C.250.2	- Ambulance or any other means to the nearest rail, sea or air connection (in a remote area)		N/A	Medical report	x		80%
C.250.3	- Helicopter ambulance to the nearest hospital where patient can be treated.		N/A	Medical report	x		80%
C.251	Non-emergency:						
C.251.1	- Ambulance between hospitals		Yes	Medical report	x		80%
C.251.2	- Other transport (in critical cases) to the nearest location where the patient can be treated		Yes	Medical report	x		80%
C.252	Search and rescue	No reimbursement					
C.253	Medical evacuation/repatriation	No reimbursement					
C.254	Transport to a location where cost of treatment is cheaper	No reimbursement					
Death							
C.255	Repatriation	No reimbursement					
C.256	Mortuary/funeral expenses	No reimbursement					

Appendix D

Insurance cover for children not covered under paragraph 80.2 from 18 to 25 years of age

Participation

D.10 A child as defined in paragraph 90.4 of the Staff Health Insurance Rules whose parent is:

D.10.1 a staff member on a fixed-term or continuing appointment or a temporary staff member under paragraph 50 of the rules;

D.10.2 a retired staff member in receipt of a pension from the United Nations Joint Staff Pension Fund who leaves the Organization on or after his/her 55th birthday (or 58th birthday for staff members who joined the United Nations Joint Staff Pension Fund as from 1 January 2014) and at the time of separation has been a participant in the Staff Health Insurance for at least ten years, five years of which must be continuous;

D.10.3 a former staff member receiving a disability benefit from the United Nations Joint Staff Pension Fund;

D.10.4 a surviving spouse of a staff member or of a retired staff member, after the death of the serving or retired staff member, provided that such spouse was a participant in the Health Insurance at the date of death of the serving or retired staff member.

D.20 The spouse and children of the insured person defined in paragraph 10 of this appendix are not covered by these provisions.

Conditions of protection

D.30 Staff members, retired staff members or surviving spouses, who wish to insure a child under the provisions of this appendix, must certify that they provide the main and continuing support for the child and that the child is not gainfully employed.

D.50 The fulfilment of these conditions must be verified and found acceptable by the Organization on the basis of written evidence submitted by the participant.

Period of protection

D.60 Health Insurance coverage begins on the first day after the date on which the request for including a child under this appendix is received.

D.70 Health Insurance coverage ceases at the earliest of the following dates:

D.70.1 the date on which the staff member, retired staff member or surviving spouse ceases to be a participant in the Insurance;

D.70.2 at the end of the month in which the child ceases to fulfil the conditions for eligibility under the provisions of paragraph 30 of this appendix;

D.70.3 at the end of the month in which the child reaches 25 years of age.

Benefits

D.80 The benefits laid down in the Benefits Table of the Staff Health Insurance Rules are applicable subject to the following conditions:

D.80.1 The benefits of the Health Insurance are not applicable to any chronic illness or condition in a child that was known at the time of entering the Insurance, except from the beginning of the fourth year of coverage. In the case of a child of a staff member who has been transferred or seconded from the United Nations or specialized agency where insurance coverage was provided, the period of service with such organization shall be credited against the three-year period referred to in this paragraph.

D.80.2 Any illness or condition of the type referred to in paragraph 80.1 above must be declared and the declaration reviewed by the Staff Health Insurance Officer at Headquarters after consultation with the Medical Adviser, who decides in each case whether or not the provisions of paragraph 80.1 apply.

D.90 The benefits of the Health Insurance do not extend to any expenses incurred after the date on which the insurance coverage ceases. However, if a child is under treatment when he/she reaches the limit of insurance coverage, reimbursement is allowed of expenses for such treatment that are incurred within 90 days of the date on which the insurance coverage ceases.

Claims procedure

D.100 Paragraphs 201 to 380 of the Staff Health Insurance Rules apply, provided that all reimbursement claims are submitted by the staff member or retired staff member or surviving spouse.

Contributions

D.110 See Appendix A, paragraph A.10.

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Appendix E

[Deleted]

Appendix F

List of pathologies as per International Classification of Diseases, ICD-10 (considered in Benefits table, under para B.106.1)

F00–F09 Organic, including symptomatic, mental disorders

F00 Dementia in Alzheimer's disease
F01 Vascular dementia
F02 Dementia in other diseases classified elsewhere
F03 Unspecified dementia
F04 Organic amnesic syndrome, not induced by alcohol and other psychoactive substances
F05 Delirium, not induced by alcohol and other psychoactive substances
F06 Other mental disorders due to brain damage and dysfunction and to physical disease
F07 Personality and behavioural disorders due to brain disease, damage and dysfunction
F09 Unspecified organic or symptomatic mental disorder

F20–F29 Schizophrenia, schizotypal and delusional disorders

F20 Schizophrenia
F21 Schizotypal disorder
F22 Persistent delusional disorders
F23 Acute and transient psychotic disorders
F24 Induced delusional disorder
F25 Schizoaffective disorders
F28 Other nonorganic psychotic disorders
F29 Unspecified nonorganic psychosis
F31 Bipolar affective disorder
F32.2 Severe depressive episode without psychotic symptoms
F32.3 Severe depressive episode with psychotic symptoms
F33.2 Recurrent depressive disorder, current episode severe without psychotic symptoms
F33.3 Recurrent depressive disorder, current episode severe with psychotic symptoms
F42 Obsessive-compulsive disorder
F44 Dissociative [conversion] disorders
F60 Specific personality disorders

F70–F79 Mental retardation

F70 Mild mental retardation

F71 Moderate mental retardation

F72 Severe mental retardation

F73 Profound mental retardation

F78 Other mental retardation

F79 Unspecified mental retardation

F80–F89 Disorders of psychological development

F80 Specific developmental disorders of speech and language

F81 Specific developmental disorders of scholastic skills

F82 Specific developmental disorder of motor function

F83 Mixed specific developmental disorders

F84 Pervasive developmental disorders

F88 Other disorders of psychological development

F89 Unspecified disorder of psychological development

F90–F98 Behavioural and emotional disorders with onset usually occurring in childhood and adolescence

F90 Hyperkinetic disorders

F91 Conduct disorders

F92 Mixed disorders of conduct and emotions

F93 Emotional disorders with onset specific to childhood

F94 Disorders of social functioning with onset specific to childhood and adolescence

F95 Tic disorders

F98 Other behavioural and emotional disorders with onset usually occurring in childhood and adolescence

Appendix G

Rules of procedure: Staff Health Insurance governance

Global Oversight Committee

Chair and alternate Chair

10 The Assistant Director-General, General Management, shall be the Chair of the Global Oversight Committee. The Comptroller shall be his/her alternate.

Conduct of business

15 The presence (in person or through video conference) of four voting members (or alternate members replacing members) constitutes the quorum of the Committee.

16 The Secretariat will provide the members with a proposed agenda together with relevant background information in advance of each meeting.

17 The Committee will adopt its recommendations by consensus wherever possible. In the event that consensus cannot be achieved, the minority views will be recorded in the report. The Secretariat officers, advisers and the Comptroller (when present at meetings but not serving as Chair) will not participate in the taking of decisions, or in any voting.

18 In the event that any decision is contrary to a recommendation made by an adviser to the Committee, the dissenting recommendation will be documented and reported in the minutes of the meeting.

Meetings of the Global Oversight Committee

20 The Global Oversight Committee will meet at least twice annually in person or by telephone/video conference. One of these two meetings shall normally be timed to occur on or around 31 March in order to review the draft Staff Health Insurance annual report for the previous year. Meetings of the Committee shall be convened by the Secretariat.

21 The meetings of the Committee shall be held in private. The records and all correspondence of the Committee shall be private and kept in the care of the Secretary of the Committee.

Secretariat

25 Minutes of each meeting of the Committee shall be prepared by the Secretariat in English. An initial draft shall be distributed as soon as possible to all members and advisers of the Committee, who shall notify the Secretariat of any comments, additions or amendments within two weeks of receipt. The Secretariat shall take into account such comments, additions or amendments and prepare a final version of the minutes, which shall be reviewed and signed by the Chair on behalf of the Committee.

26 The final, approved minutes of each Committee meeting, including all recommendations adopted at the meeting, shall be sent to the Director-General by the Secretariat, highlighting any issues of concern and proposed actions if relevant. This summary shall be sent as soon as is practicable and normally within one month of the

Committee meeting date.

General

29 These rules of procedure may only be amended by a decision of the Director-General. However, subject to the provisions of these rules, the Committee shall adopt such operating guidelines as may be necessary for it to conduct its work.

Global Standing Committee

Chair and alternate Chair and Committee members

30 The Director-General, following consultation with the Staff Association, shall appoint a Chair and alternate Chair from among the membership of the Global Standing Committee.

31 The Chair and alternate Chair shall be from different groups, whenever possible.

32 The term of office for the Chair and alternate Chair shall normally be for a two-year period.

Conduct of business

35 The presence (in person or through telephone/video conference) of six members, three from each group, and either the Chair or alternate Chair, constitutes the quorum of the Committee.

36 The Secretariat will provide the members with a proposed agenda together with relevant background information in advance of each meeting.

37 The Committee will adopt its recommendations by consensus wherever possible. In the event that consensus cannot be achieved, a vote will be taken as follows:

37.1 the decision on the recommendation will be taken by a simple majority of members present at the meeting;

37.2 only a member or an alternate replacing a member can vote;

37.3 the Chair shall cast a vote only in the event of a tie.

38 The Secretariat officers and advisers will not participate in the taking of decisions, or in any voting.

39 In the event that consensus cannot be reached, any minority views shall be recorded in the minutes of the meeting. In addition, in the case of any decision taken that is contrary to a recommendation made by an adviser to the Committee, the dissenting recommendation will be documented and reported in the minutes of the meeting.

Meetings of the Global Standing Committee

40 The Global Standing Committee shall meet at least four times per year, in person or through telephone/video conference. Meetings shall be convened by the Secretariat.

41 The meetings of the Committee shall be held in private. The records and all correspondence of the Committee shall be private and kept in the care of the Secretary of the Committee.

Secretariat

45 Minutes of each meeting of the Committee shall be prepared by the Secretariat in English. An initial draft shall be distributed as soon as possible to all members and advisers of the Committee, who shall notify the Secretariat of any comments, additions or amendments within two weeks of receipt. The Secretariat shall take into account such comments, additions or amendments and prepare a final version of the minutes, which shall be reviewed and signed by the Chair on behalf of the Committee.

46 The final, approved minutes of each Committee meeting, including all recommendations adopted at the meeting, shall be sent to the Secretariat of the Global Oversight Committee, highlighting the decisions taken and advice provided. This summary shall be sent as soon as is practicable and normally within one month of the Committee meeting date.

Regional Surveillance Committees

Chair and alternate Chair and committee members

50 The regional director, following consultation with the Staff Association, shall appoint a Chair and alternate Chair from among the membership of the regional surveillance committee.

51 The Chair and alternate Chair shall be from different groups, whenever possible.

52 The term of office for the Chair and alternate Chair shall normally be for a two-year period.

Meetings of the regional surveillance committee

55 The regional surveillance committee shall meet at least four times per year, in person or though telephone/video conference. Meetings shall be convened by the Secretariat.

56 The meetings of the committee shall be held in private. The records and all correspondence of the committee shall be private and kept in the care of the Secretary of the committee.

Secretariat

60 Minutes of each meeting of the committee shall be prepared by the Secretariat in English. An initial draft shall be distributed as soon as possible to all members and advisers of the committee, who shall notify the Secretariat of any comments, additions or amendments within two weeks of receipt. The Secretariat shall take into account such comments, additions or amendments and prepare a final version of the minutes, which shall be reviewed and signed by the Chair on behalf of the committee.

61 The final, approved minutes of each committee meeting, including all recommendations adopted at the meeting, shall be sent to the Secretariat of the Global Standing Committee, highlighting the decisions taken and advice provided. This summary shall be sent as soon as is practicable and normally within one month of the committee meeting date.