



European Organization for Nuclear Research
Organisation européenne pour la recherche nucléaire

Rules of the CERN Health Insurance Scheme (CHIS)

Updated
1 May 2023

Preamble

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

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

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

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

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

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

Considering the provisions of Chapter IV of the CERN Staff Rules and Regulations entitled “Social insurance cover” and the provisions for its implementation;

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

Considering the Council decision of 16 December 2010 to make certain modifications to the contributions payable to the CERN Health Insurance Scheme and to authorise the Director-General to take timely measures to contain the increase of the Scheme’s expenses, such as incentives to use healthcare providers and treatments that provide the best value for money;

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

Hereby adopts the updated “Rules of the CERN Health Insurance Scheme (CHIS)”, to enter into force on 1 May 2023.

Table of Contents

CHAPTER I - THE CERN HEALTH INSURANCE SCHEME.....	5
SECTION 1 - GENERAL FRAMEWORK.....	5
SECTION 2 - CATEGORIES OF BENEFITS OF THE SCHEME	6
SECTION 3 - GENERAL PRINCIPLES OF THE SCHEME	6
CHAPTER II - DEFINITIONS	7
SECTION 1 - MEMBERS	7
SECTION 2 - HEALTH CONDITIONS.....	8
SECTION 3 - HEALTHCARE PROVIDERS.....	8
SECTION 4 – CONTRIBUTIONS	9
SECTION 5 – REIMBURSEMENTS.....	9
SECTION 6 - GOVERNANCE AND ADMINISTRATION.....	9
CHAPTER III - INSURANCE OF MAIN MEMBERS.....	11
SECTION 1 - COMPULSORY MAIN MEMBERS.....	11
SECTION 2 - POST-COMPULSORY MAIN MEMBERS.....	11
SECTION 3 - VOLUNTARY MAIN MEMBERS.....	13
CHAPTER IV - INSURANCE OF SUBSIDIARY MEMBERS.....	14
SECTION 1 - COVER FOR SUBSIDIARY MEMBERS.....	14
SECTION 2 - OBLIGATION TO FURNISH INFORMATION	15
CHAPTER V - GENERAL PROVISIONS.....	18
SECTION 1 - CONTRIBUTIONS	18
SECTION 2 - BENEFITS	18
SECTION 3 - RESPONSIBILITY AND REPRESENTATION	19
SECTION 4 - SPECIFIC SITUATIONS.....	19
SECTION 5 - SUSPENSION AND EXCLUSION FROM THE SCHEME	20
CHAPTER VI - REIMBURSEMENT OF MEDICAL EXPENSES.....	21
SECTION 1 - REQUESTS FOR REIMBURSEMENT (CLAIMS)	21
SECTION 2 - PROCEDURES FOR THE PAYMENT OF BENEFITS	22
SECTION 3 - PRIOR APPROVALS AND OPINIONS	23
SECTION 4 - CURES AND CONVALESCENCE STAYS	23
SECTION 5 - HOSPITAL GUARANTEE	24
SECTION 6 - EXCEPTIONAL PROCEDURES	24
CHAPTER VII - NORMAL HEALTH INSURANCE	26
SECTION 1 - GENERAL DESCRIPTION	26
SECTION 2 - CONTRIBUTIONS	26
SECTION 3 - BENEFITS	27

CHAPTER VIII - REDUCED HEALTH INSURANCE	29
SECTION 1 - GENERAL DESCRIPTION	29
SECTION 2 - CONTRIBUTIONS	29
SECTION 3 - BENEFITS	29
CHAPTER IX INSURANCE AGAINST THE CONSEQUENCES OF OCCUPATIONAL ILLNESS AND ACCIDENTS	30
SECTION 1 - GENERAL DESCRIPTION	30
SECTION 2 - CONTRIBUTIONS	30
SECTION 3 - BENEFITS	30
CHAPTER X - LONG-TERM CARE BENEFITS	31
SECTION 1 - GENERAL DESCRIPTION	31
SECTION 2 - PROCEDURE FOR THE AWARD OF THE BENEFIT	31
SECTION 3 - CONTRIBUTIONS	32
SECTION 4 - BENEFITS	32
CHAPTER XI - ALLOWANCE FOR THE REDUCED EARNING CAPACITY OF A FAMILY MEMBER.....	33
SECTION 1 - ELIGIBILITY	33
SECTION 2 - PROCEDURE FOR APPLYING FOR THE ALLOWANCE	33
SECTION 3 - CONTRIBUTIONS	34
SECTION 4 - BENEFITS	34
SECTION 5 - MODIFICATIONS TO OR TERMINATION OF BENEFITS	34
CHAPTER XII - REFERENCE SALARIES	35
CHAPTER XIII - OPERATION OF THE SCHEME	36
SECTION 1 - GOVERNANCE	36
SECTION 2 - RESERVE FUND	37
SECTION 3 - AUDITING	37
CHAPTER XIV - SETTLEMENT OF DISPUTES	38
SECTION 1 - CHALLENGING A DECISION	38
SECTION 2 - REQUESTING A REVIEW	38
SECTION 3 – APPEAL.....	39
ANNEX I - LIST OF BENEFITS	43
ANNEX II - REIMBURSEMENT RATE	48
ANNEX III - CONTRIBUTION RATES	49
ANNEX IV - LONG-TERM CARE BENEFITS	50

Chapter I - The CERN Health Insurance Scheme

Section 1 - General framework

I 1.01 OBJECTIVE OF THE SCHEME

¹ The objective of the CERN Health Insurance Scheme (hereinafter the “Scheme”), in accordance with Article S IV 2.01, item a, of the CERN Staff Rules and Regulations, is to safeguard its Members against the financial consequences of illness, accidents and maternity by providing for the reimbursement of the expenses arising from medical treatment.

² The Scheme also safeguards certain Members against the financial consequences of dependence and, in accordance with Article S IV 2.02 of the Staff Rules and Regulations, of disability.

I 1.02 MANAGEMENT OF THE SCHEME

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

I 1.03 RULES

¹ The Rules of the CERN Health Insurance Scheme (hereinafter the “CHIS Rules”) specify the social insurance measures provided by the Scheme and the associated terms and conditions.

² They are adopted by the Director-General following discussion in the Standing *Concertation* Committee (SCC), on the basis of:

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

I 1.04 INTERPRETATION OF THE RULES

¹ The provisions of the Rules are interpreted by the Director-General in accordance with their terms and purpose.

² The Rules are interpreted with reference to the CERN Staff Rules and Regulations and the provisions for their implementation.

³ Moreover, in the event of difficulty in interpreting or applying the Rules, in particular where they are silent on an issue, reference may be made subsidiarily and by analogy to Swiss and/or French legislation governing social security and health insurance matters.

⁴ Both the English and French texts of the Rules are authentic.

I 1.05 DECISIONS TAKEN IN APPLICATION OF THE RULES

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

I 1.06 CHIS DIRECTIVES

The provisions governing the application of the CHIS Rules may be laid down in Directives (hereinafter “CHIS Directives”), which are approved and amended by the Director-General following discussion at the SCC; the SCC discussions are prepared by the CHIS Board.

I 1.07 GUARANTEE OF BENEFITS

CERN guarantees the benefits acquired under the CHIS Rules by the Scheme’s Members until the cessation of the rights of the last Member.

In the event of the Organization’s dissolution, the CERN Council will take the measures needed to guarantee the rights acquired on the date of dissolution.

Section 2 - Categories of benefits of the Scheme

I 2.01

CATEGORIES OF BENEFITS

The Scheme includes the following categories of benefits:

- a. insurance against the financial consequences of illness, accidents and maternity (hereinafter “health insurance”), based on two types of cover:
 1. normal health insurance (Chapter VII);
 2. reduced health insurance (Chapter VIII);
- b. insurance against the financial consequences of occupational accidents and illness (hereinafter “occupational insurance”) (Chapter IX);
- c. insurance against the financial consequences of dependence (hereinafter “long-term care benefits”) (Chapter X);
- d. insurance against the reduced earning capacity of a family member (hereinafter “reduced earning capacity allowance”) (Chapter XI).

Section 3 - General principles of the Scheme

I 3.01

MUTUALITY

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

I 3.02

FAMILY COVER

¹ Normal health insurance, long-term care benefits and the reduced earning capacity allowance may apply to all family members of the Main Members concerned, depending on their status.

² The contribution to the Scheme is not based on the composition of the family. However, a supplementary contribution may be payable for the spouse of a Compulsory Main Member or Post-Compulsory Main Member (Article IV 1.05).

I 3.03

PRIMARY HEALTH INSURANCE

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

I 3.04

GLOBAL COVER

Members are covered for the cost of medical treatment carried out anywhere in the world.

I 3.05

FREE CHOICE OF HEALTHCARE PROVIDER

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

I 3.06

ADMISSIBILITY OF TREATMENT

In order to be covered by the Scheme, treatments must be:

- a. appropriate;
- b. recognised by the competent authorities of the State in which they are dispensed; and
- c. dispensed by providers and/or in establishments that are recognised by the competent authorities of the State in which they operate.

I 3.07

PERSONAL DATA PROCESSING

In the context of the CHIS, personal data is processed in accordance with the provisions of Operational Circular No. 11 “*The processing of personal data at CERN*”, and sensitive personal data is processed only insofar as is strictly necessary for CERN to carry out its legal obligations. The Third-Party Administrator, as an external entity, also complies with the relevant provisions of this Circular when processing personal data, including sensitive personal data, for CERN or on CERN’s behalf. In addition, professional medical secrecy is preserved.

Chapter II - Definitions

Section 1 - Members

II 1.01

MAIN MEMBER

The following are Main Members of the Scheme:

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

II 1.02

SUBSIDIARY MEMBER

¹ The following are Subsidiary Members of the Scheme:

- a. any family member of a Compulsory Main Member;
- b. any family member of a Post-Compulsory Main Member, except:
 - i) spouses who married the Main Member on or after 1 January 2021 and for whom a surviving spouse's pension has not been acquired;
 - ii) children born to a Main Member on or after 1 January 2021 and more than one year after the retirement of the Main Member, and whose other parent is not a Member of the Scheme;
 - iii) children adopted or officially recognised by a Main Member on or after 1 January 2021 and after the retirement of the Main Member, and whose other parent is not a Member of the Scheme.
- c. any family member of a Voluntary Main Member with normal health insurance.

² The membership of Subsidiary Members who meet the above criteria is compulsory and automatic.

³ However, a family member of a Main Member is him- or herself a Main Member if he or she

- a. belongs to a category of the CERN personnel for which membership is compulsory under Article III 1.01; or
- b. can apply to be a Post-Compulsory Member under Article III 2.01.

II 1.03

MEMBER

All Main and Subsidiary Members are considered Members of the Scheme.

II 1.04

GENDER

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

II 1.05

SPOUSE

In the framework of these Rules, the term "marriage" includes registered civil partnerships¹; the term "spouse" includes registered partners, and the term "divorce" includes the dissolution of a registered civil partnership.

II 1.06

FAMILY

The family of a Main Member is defined in accordance with CERN's Staff Rules and Regulations.

II 1.07

CERN PENSIONER

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

¹ Pursuant to the CERN Council's decision of 17 December 2015, according to which registered civil partnerships are recognised as equivalent to marriage.

II 1.08 CERN RETIREMENT AGE	In these Rules, all references to “CERN retirement age” are to be understood as the highest age limit for a staff member, as defined in CERN’s Staff Rules and Regulations.
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Section 2 - Health conditions

II 2.01 ILLNESS, ACCIDENT, CERTIFICATION, CONSOLIDATION, RECOVERY AND RELAPSE	These terms are defined in Administrative Circular No. 14 “ <i>Protection of members of the personnel against the financial consequences of illness, accident and incapacity for work</i> ”.
II 2.02 MATERNITY	The physical condition of a woman from the conception to the birth of a child and all medically related occurrences resulting therefrom.
II 2.03 DEPENDENCE	Permanent or long-term inability to perform the ordinary functions of everyday life unaided, as detailed in Chapter X.

Section 3 - Healthcare providers

II 3.01 RECOGNISED HEALTHCARE PROVIDERS	In order to be recognised by the Scheme, the healthcare providers used by the Members must be recognised, qualified and licensed to practice medicine and/or to provide the healthcare or medical treatment concerned by the competent national authorities of the country where they operate.
II 3.02 MEDICAL TREATMENT	All examinations and treatments carried out with a view to restoring or preserving health and/or physical integrity. Vaccination is also considered to be a medical treatment. Medical treatment must be recognised as such by the competent health authorities of the State in which it is dispensed.
II 3.03 HOSPITAL	Any establishment providing medical, surgical or functional rehabilitation treatment and recognised as a hospital by the competent health authorities of the State concerned.
II 3.04 PUBLIC HOSPITAL	Any hospital, or part thereof, recognised as public by the competent health authorities of the State concerned.
II 3.05 PRIVATE HOSPITAL	Any hospital, or part thereof, that does not correspond to the definition in Article II 3.04.
II 3.06 APPROVED HOSPITAL	Any public hospital as defined in Article II 3.04, or any private hospital as defined in Article II 3.05 provided that it is established: <ul style="list-style-type: none">a. in Switzerland and has concluded a tariff agreement with the Scheme;b. outside Switzerland and has concluded a tariff agreement with the relevant national social security scheme and applies to the Scheme’s members similar tariffs to those stipulated in the aforementioned agreement for medical treatment and accommodation.
II 3.07 UNAPPROVED HOSPITAL	Any hospital that does not correspond to the definition in Article II 3.06.
II 3.08 SPECIALISED INSTITUTION	Any establishment other than a hospital providing patients with care, medical assistance and rehabilitation measures for long periods (medico-social establishments (MSE) or any similar type of facility).

II 3.09 MEDICAL AUXILIARY	Any person qualified and licensed, by the competent national authority of the State in which the treatment is provided, to provide services on the basis of a medical prescription and assist the medical profession in administering treatment and care following maternity, illness or accidents.
II 3.10 AUXILIARY APPLIANCES	Any device or item of equipment that needs to be purchased or rented by Members in order to improve their state of health, for example prostheses other than dental prostheses, dialysis machines, equipment to enhance personal autonomy (wheelchairs, hospital beds, etc.).
II 3.11 ALTERNATIVE THERAPIES	The alternative therapies recognised by the Scheme are acupuncture, Chinese medicine, chiropractic medicine, osteopathy and etiopathy, provided that they are dispensed by healthcare providers recognised for these specific treatments in accordance with Article II 3.01.
II 3.12 HOME NURSE	Any person qualified to assist dependent persons in performing the ordinary functions of everyday life.
II 3.13 CURE	¹ Stay, prescribed by a physician, in a residential medical establishment, a thermal centre or a similar establishment, which is part of a course of treatment of an existing pathology. ² High-altitude, rejuvenation, rest and change-of-air therapy and any other such therapy is not considered as a “cure” within the meaning of these Rules.

Section 4 – Contributions

II 4.01 CONTRIBUTION RATE	Members’ contributions are calculated based on the multiplication of the Reference Salary by a contribution rate. The contribution rates are defined in Annex III.
II 4.02 REFERENCE SALARY	The Reference Salary used to calculate the contribution of each Member depends on the type of membership. The Reference Salaries to be used are set out in Chapter VII Section 2 and the Reference Salaries themselves are set out in Chapter XII.

Section 5 – Reimbursements

II 5.01 GENERAL REIMBURSEMENT RULE	Rule defining the reimbursement rates according to the costs borne by the insured member (referred to hereinafter by the French acronym FCA) cumulated by the Member over a calendar year, as detailed in Article A II 1.01.
II 5.02 COSTS BORNE BY THE INSURED MEMBER (FCA)	The part of the expenses not reimbursed by the Scheme, up to the applicable ceiling if relevant, for the benefits covered by the General Reimbursement Rule.

Section 6 - Governance and administration

II 6.01 STRATEGIC ADVISOR TO THE DIRECTOR- GENERAL	The CERN staff member appointed by the Director-General of the Organization to advise him or her on health insurance matters.
II 6.02 CHIS BOARD	The CHIS Board is the joint committee in which discussion on health insurance matters takes place. Its role and composition are defined in Article XIII 1.03.
II 6.03 CHIS MANAGER	The CERN staff member appointed by the Director-General to manage the operation of the CERN Health Insurance Scheme.

II 6.04
THIRD-PARTY
ADMINISTRATOR

The Director-General appoints a Third-Party Administrator for the day-to-day administration of the Scheme.

Chapter III - Insurance of Main Members

Section 1 - Compulsory Main Members

III 1.01

COMPULSORY MEMBERSHIP

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

- a. staff members, graduates and fellows² (hereinafter collectively referred to as “employed members of the personnel”);
- b. students, except in certain cases as laid down in Administrative Circular No. 11 “*Categories of members of the personnel*”.

III 1.02

CATEGORIES OF BENEFITS

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

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

III 1.03

DURATION OF COMPULSORY MEMBERSHIP

¹ Membership as a Compulsory Main Member extends from the first to the last day of the contract of employment or association with the Organization.

² Compulsory membership is interrupted during any period of unpaid special leave or unpaid authorised absence of one month or more, except in the case of parental leave.

Section 2 - Post-Compulsory Main Members

III 2.01

CONTINUATION OF COVER FOR AN INDEFINITE PERIOD

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

- a. CERN pensioners who have remained Members of the Scheme without interruption since the end of their compulsory membership;
- b. beneficiaries of a deferred pension from the CERN Pension Fund who have remained Members of the Scheme without interruption since the end of their compulsory membership.

III 2.02

CONTINUATION OF COVER FOR A FIXED PERIOD

¹ The following persons may apply to remain Main Members of the Scheme as Post-Compulsory Members, or may apply to become such after having been Subsidiary Members, in both cases for a defined period::

- a. former staff members in receipt of unemployment benefits from the Organization, throughout the period during which they receive these benefits;
- b. Compulsory Members, during any period of unpaid special leave or unpaid authorised absence of one month or more, for the whole duration of such leave;
- c. former Compulsory Members who have been Members of the Scheme for one year or more and who are not entitled to membership under the terms of Article III 2.01, for a maximum period of 12 months;
- d. former Compulsory Members who have been Members of the Scheme for more than 13 weeks but less than one year, for a maximum period of one month;
- e. the children of a Compulsory or Post-Compulsory Main Member who are no longer dependent, within the meaning of the CERN Staff Rules and Regulations and are aged under 26 years, for the period up to and including the date of their 26th birthday or until the end of the continued membership of the parent, whichever is earlier (they become a Main Member and pay their own contribution;

² Fellows appointed under the former fellowship programme shall be distinguished from the research fellows appointed under the new Graduate programmes

however, they alone are covered, i.e. members of their family cannot be Subsidiary Members);

- f. in the event of the divorce of a Compulsory or Post-Compulsory Member who has been a Member for one year or more, the former spouse and his or her dependent children (who were considered as family members on the final date of the divorce), for a maximum period of 12 months;
- g. in the event of the death of a Compulsory or Post-Compulsory Member, the members of his or her family on the date of death, if they do not become CERN pensioners, for a maximum period of 12 months.

² It is the responsibility of the person applying for Post-Compulsory membership to verify that such membership is compatible with his or her legal obligations in the country of residence or work.

III 2.02 bis CONTINUATION IN THE EVENT OF THE DEATH OF THE MAIN MEMBER

Upon the death of a Compulsory or Post-Compulsory Main Member his or her spouse and children may apply to become Main Members of the Scheme as Post-Compulsory Members for an indefinite period, provided that they become CERN Pensioner.

III 2.02 ter NON-INTERRUPTION OF COVER

Post-Compulsory cover starts on the day immediately following the last day of the corresponding Compulsory cover; there is no interruption of cover nor of the payment of contribution.

III 2.03 PENSIONERS WHO ARE THE SPOUSES OF MAIN MEMBERS

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

III 2.04 APPLICATION FOR POST-COMPULSORY MEMBERSHIP

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

III 2.05 DURATION OF POST-COMPULSORY MEMBERSHIP

Post-Compulsory membership terminates, where applicable:

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

III 2.06 CANCELLATION OF POST-COMPULSORY MEMBERSHIP

¹ Post-Compulsory Members may cancel their membership by giving 30 calendar days' notice. This cancellation is irrevocable and takes effect at the end of a calendar month.

² However, Post-Compulsory Members may cancel their membership without notice if they are required to become compulsory members of another health insurance scheme pursuant to a legal provision of the State in which they reside or work. In such cases, cancellation is effective from the day on which the cover of the other health insurance scheme enters into force.

III 2.07 CATEGORIES OF BENEFITS

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

- a. normal health insurance;
- b. long-term care benefits;
- c. allowance for the reduced earning capacity of a family member, in accordance with the conditions defined in Chapter XI.

Section 3 - Voluntary Main Members

III 3.01 VOLUNTARY MEMBERSHIP

Members who were Voluntary Members on 1 September 2017 may remain so, including in cases where their contract is renewed, provided that they meet the conditions defined in Article III 3.02.

III 3.02 CONDITIONS AND DURATION OF VOLUNTARY MEMBERSHIP

¹ To continue to be Voluntary Main Members, the persons concerned must continuously

- a. hold a valid contract of association with CERN; and
- b. be in possession of a '*Carte de légitimation*' issued by the Swiss authorities.

² Their membership of the Scheme terminates automatically and definitively on the day on which the conditions in the previous paragraph are no longer met, or when their membership is cancelled pursuant to a provision of these Rules.

III 3.03 CHANGE OF TYPE OF COVER

¹ An application to change the type of cover can be accepted only if it is justified by:

- a. the age of the Main Member, as specified in Article III 3.05; or
- b. a change in the family status of the Voluntary Member, in particular marriage, divorce, or the birth or adoption of a child.

² Applications to change the type of cover must be submitted within the 30 calendar days following the event giving entitlement to the change.

III 3.04 CANCELLATION OF THE INSURANCE

¹ Voluntary Members may cancel their membership subject to 30 calendar days' notice. The cancellation takes effect at the end of a calendar month.

² Notice is not required if the Voluntary Member is required to become a compulsory member of another health insurance scheme pursuant to a legal provision of the State in which he or she resides or works. In such cases, cancellation is effective from the day on which the cover of the other health insurance scheme enters into force.

³ All cancellations are irrevocable.

III 3.05 CATEGORIES OF BENEFITS

Voluntary Members are entitled only to the health insurance benefit and may choose between

- a. normal health insurance, provided that they are younger than the CERN retirement age, and
- b. reduced health insurance, for which there is no age limit.

Chapter IV - Insurance of Subsidiary Members

Section 1 - Cover for Subsidiary Members

IV 1.01 SUBSIDIARY MEMBERS

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

IV 1.01 bis DURATION OF SUBSIDIARY MEMBERSHIP

¹ Unless the provisions of Article IV 2.01 bis apply, Subsidiary Members are insured as such until

- a. the day on which the Main Member's membership terminates; or
- b. the last day of the month following the month during which the Organization decides to no longer recognise them as family members.

² Subsidiary Members who opt to remain members of the Scheme in accordance with Articles III 2.01 or III 2.02 become Main Members.

IV 1.02 PRIMARY OR SUPPLEMENTARY INSURANCE

¹ As a general rule, the Scheme serves as primary insurance for Subsidiary Members.

² However, when a Main Member has declared that his or her spouse is covered by another adequate health insurance scheme, the Scheme serves as supplementary insurance. In this case, the spouse must submit his or her bills for reimbursement to the other health insurance scheme in the first instance.

³ If one or more children who are Subsidiary Members are covered by the spouse's health insurance, the Scheme may also serve as their supplementary insurance.

IV 1.03 ADEQUATE HEALTH INSURANCE

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

- a. any health insurance provided by the national system of a Member State of the Organization, provided that it is valid in the spouse's State of residence for the whole duration of his or her residence;
- b. any private or public, individual or collective health insurance that provides benefits and reimbursement levels in the spouse's State of residence that are at least broadly equivalent to those guaranteed under the Swiss federal law on health insurance (LAMal).

IV 1.04 SUPPLEMENTARY REIMBURSEMENT

¹ Any difference between the amount reimbursed by the primary health insurance and the actual expenses incurred may be submitted to the Scheme for reimbursement, in accordance with the provisions of these Rules.

² However, if the reimbursement under the spouse's other health insurance is subject to an annual deductible, this is not reimbursed by the Scheme.

IV 1.05 SUPPLEMENTARY CONTRIBUTION

¹ As a general rule, no supplementary contribution is required for Subsidiary Members.

² However, where a Compulsory or Post-Compulsory Main Member who

- a. is or has been an employed member of the personnel or
- b. is a CERN pensioner

has a spouse who is in receipt of income or a retirement pension, as defined in Articles IV 2.04 and IV 2.05, but is not a member of an adequate health insurance scheme, a supplementary contribution must be paid so that the spouse can use the Scheme as his or her primary insurance.

³ To this end, the Main Member concerned is required to provide information about the spouse, in accordance with Section 2 of this chapter.

⁴ No supplementary contribution is required for dependent children who are Subsidiary Members.

Section 2 - Obligation to furnish information

IV 2.01 DECLARATION OF FAMILY STATUS

¹ By extension of the provisions of Article R V 1.38 of the Staff Rules and Regulations, all Main Members must declare³ the following within 30 calendar days:

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

² Subsidiary Members are determined as a function of these declarations and by analogy with the practices deriving from the relevant provisions of the Staff Rules and Regulations.

IV 2.01 bis FAILURE TO DECLARE A CHANGE IN FAMILY STATUS

¹ In the event of a failure to declare a change in family status (Article IV 2.01, paragraph 1, item a) within the specified time limit, where such a declaration would result in the end of Subsidiary Membership status, the person concerned will retroactively be made a Post-Compulsory Member with effect from the date on which the Subsidiary Membership ended.

² In such cases, the Main Member must pay the corresponding contributions in arrears, unless the failure to comply with the specified time limit is due to circumstances beyond the control of the Main Member, as determined by the CHIS Manager on the basis of documentary evidence.

IV 2.02 SPOUSE HEALTH INSURANCE & PROFESSIONAL INCOME DECLARATION (SHIPID)

¹ Each Compulsory or Post-Compulsory Main Member who is a current or a former employed member of the personnel, or who is a CERN pensioner, is required to declare in writing² the situation of his or her spouse who is a Subsidiary Member with respect to:

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

² This declaration must be made within the 30 calendar days following:

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

³ The effective date of a declaration of a change is the day on which the change occurs, even if the notification is late.

³ This declaration must be made to the Human Resources department by Compulsory Members, to the CERN Pension Fund by beneficiaries of the Pension Fund, to the Third-Party Administrator by Voluntary Members and to the CHIS Manager by all other persons.

IV 2.03 DECLARATION OF A MAIN MEMBER'S INCOME

¹ As a general rule, a Main Member is not required to make a specific declaration of his or her own income, unless he or she is a CERN pensioner and the spouse of another Main Member.

² In this latter case, in order to determine his or her Reference Salary V as per Article XII 1.05, if

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

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

³ This declaration must be made within the 30 calendar days following:

- a. the date on which he or she becomes a CERN pensioner;
- b. the date of a change (or of the notification of a change) in professional or pension income resulting in a change of the income bracket as defined in Article XII 1.06;
- c. each request by the Scheme (including in the context of annual renewal).

IV 2.04 PROFESSIONAL INCOME

¹ Any form of remuneration, salary, fee or payment deriving from a professional activity, including subsistence allowances (whether paid by the home institution, or through a Third Party Account, or by CERN), any amount paid by the employer towards health insurance premium costs and replacement salaries received during periods of leave.

² The following are not considered as professional income:

- a. unemployment benefits;
- b. disability pensions;
- c. dependent child allowances;
- d. maternity benefits if they are not a replacement salary;
- e. adoption benefits; and
- f. reimbursement by the employer of professional expenses incurred.

IV 2.05 RETIREMENT PENSION

¹ Any payment from an old-age insurance scheme, including the CERN Pension Fund, is considered to be a retirement pension.

² The following are not considered as retirement pensions:

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

IV 2.06 AMOUNT TO BE DECLARED

¹ The amount to be declared is the monthly gross total professional income and retirement pension paid to the Member in question.

² Where the income concerned is not known by the deadline stipulated in Article IV 2.03, for example in the case of non-salaried activities, the Main Member must declare an estimated income. The actual gross income must be declared within 30 calendar days of its becoming known.

³ Where only a multi-month (for example annual) income of the spouse is known, the monthly income to be declared is the average monthly income for the period concerned, for example 1/12 of the annual income.

IV 2.07 SUPPORTING DOCUMENTATION

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

IV 2.08**LATE, INACCURATE
OR INCOMPLETE
SHIPID**¹ Where a Main Member

- a. is late in meeting the obligations laid down in Article IV 2.02, paragraph 2, item a or b, or Article IV 2.03, paragraph 3, item a or b; or
- b. has made an inaccurate declaration,

any unpaid supplementary contributions due will be collected retroactively, up to a limit of five years. Only undue supplementary contributions paid in respect of the month during which the Main Member informed the Scheme and the preceding two months will be reimbursed to him or her (no other undue supplementary contributions paid will be reimbursed).

² Any failure to make a declaration in accordance with Articles IV 2.02, paragraph 2, item c, or IV 2.03, paragraph 3, item c, or to provide supporting documentation in accordance with Article IV 2.07 will result in a deduction, from the salary, allowance or pension received from CERN, of a flat-rate supplementary contribution based on the highest value of Reference Salary VI (Article XII 1.06). This deduction will apply from the month following the expiry of the relevant time limit and will continue to be applied until the required declaration or documentation has been provided. Such contributions are not reimbursable, except in exceptional circumstances as determined by the CHIS Manager on the basis of documentary evidence.

Chapter V - General provisions

Section 1 - Contributions

V 1.01 CONTRIBUTIONS

¹ Main Members pay a monthly contribution corresponding to the categories of benefits applicable to them.

² Unless otherwise specified in these Rules, the Organization also pays a contribution in accordance with the procedures defined in Annex III.

V 1.02 PRO RATA CONTRIBUTIONS

¹ The amount of the main contribution is calculated *pro rata temporis* based on the actual number of days of membership of the Scheme.

² The amount of the supplementary contribution due in respect of a spouse

- a. is zero in the month in which he or she starts to meet the criteria set-out in Article IV 1.5, paragraph 2, if this occurs after the first day of the month;
- b. is full in the month in which he or she ceases to meet the criteria set-out in Article IV 1.5, paragraph 2, in the course of a month if this occurs after the first day of the month.

³ Notwithstanding the above, in the event of the death of a Post-compulsory Main member, the main and supplementary contributions are due in full for the month in which the death occurred and no other contribution for that month is due.

Section 2 - Benefits

V 2.01 CEILING OF PRO RATA BENEFITS

Any annual ceilings applicable are reduced *pro rata temporis* based on the duration of membership of the Scheme, except in the event of death.

V 2.02 NON-CONCURRENCE OF BENEFITS

¹ The amount of any benefit received as a result of compulsory membership of a national, public or equivalent social-security scheme (health insurance and/or compulsory supplementary mutual insurance) will be deducted from the benefits provided by the Scheme. Members are required to inform the Third-Party Administrator if they are in receipt of such benefits. This provision does not apply to benefits resulting from membership of a scheme to which the Member has opted to contribute, such as voluntary supplementary insurance.

² If the reimbursement under another primary insurance scheme is subject to an annual deductible, the deductible is not reimbursed by the Scheme.

³ Where medical expenses have been partly paid or reimbursed, for example by another insurance scheme, the Member may submit a reimbursement claim to the Scheme only for the amount remaining at his or her expense.

V 2.03 EXCLUDED BENEFITS

¹ No reimbursement will be made in the event of fraud or abuse, as defined in Articles V 4.05 and V 4.06.

² The following are also excluded:

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

**V 2.04
REIMBURSEMENT AT
THE END OF COVER**

¹ All medical costs incurred up to the last day of insurance cover for non-occupational accidents and illnesses may be submitted for reimbursement in accordance with the provisions and deadlines specified in these Rules.

² Where a hospital stay extends beyond the last day of insurance cover, the Member concerned may remain a Voluntary Member of the Scheme (Article III 2.02) until such time as he or she is able to join another primary health insurance scheme or to leave the hospital, whichever comes first.

**V 2.05
SUBROGATION**

Up to the amount of the reimbursement made by the Scheme, the Third-Party Administrator will, on behalf of the Scheme, be subrogated to the rights which a victim of an accident or illness may have against any third parties who are liable. The Member may forfeit his right to reimbursement in accordance with Article V 5.01 if he or she does not confirm in writing such subrogation when so requested by the Third-Party Administrator.

**V 2.06
REIMBURSEMENT IN
THE EVENT OF THE
DEATH OF A
MEMBER**

In the event of the death of a Member, all reimbursements will be paid to his or her estate.

Section 3 - Responsibility and representation

**V 3.01
RESPONSIBILITY OF
THE MAIN MEMBER**

The Main Member bears responsibility for all declarations and reimbursement claims made by the Subsidiary Members of his or her family, except where explicitly provided otherwise in these Rules or in duly substantiated exceptional circumstances.

**V 3.02
REPRESENTATION OF
A MEMBER**

¹ A Member may arrange to be represented by a third party, if necessary, in all actions relating to the Scheme.

² The Third-Party Administrator may require the third party to provide evidence of his or her power of representation in the form of a written authorisation or a court decision.

Section 4 - Specific situations

**V 4.01
RECOVERY OF
UNDUE PAYMENTS**

¹ Any amount paid by the Scheme and to which the Member is not entitled must be repaid. The Scheme is entitled to claim the repayment of sums unduly received by the Member up to five years after the payment is made, unless the payment resulted from a fraudulent declaration, in which case no deadline applies. The undue payment will be recovered in accordance with the Organization's usual procedures.

² In the event of the death of the Member, the daily long-term care allowances already received for the month in which the death occurs do not have to be repaid.

**V 4.02
RECOVERY OF
DEBTS**

¹ In the event of non-payment by the Main Member of any contribution to the Scheme, contribution to medical costs incurred, repayment of sums unduly received or any other payment due to the Scheme, and after formal notice from the Third-Party Administrator proves unsuccessful, an amount will be withheld from the salary, indemnity, allowance or pension paid by the Organization. The amounts concerned may also be recovered by deduction from reimbursements or by recourse to the competent national jurisdiction.

² In cases involving Voluntary Members where it has not been possible to recover debts in accordance with the paragraph above, the case will be reported to the Voluntary Member's home institute, which will be responsible for paying the amounts due.

**V 4.03
REFUND OF OVER-
PAYMENT OF
CONTRIBUTIONS**

¹ In the event of over-payment of contributions to the Scheme, a refund will be made as soon as possible after the facts have been established.

² Over-payments will be refunded for a maximum period of:

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

³ Where the over-payment is made as a result of a fraudulent declaration, it will not be refunded.

**V 4.04
EXCESSIVE RATES**

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

**V 4.05
ABUSE**

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

**V 4.06
FRAUD**

¹ CERN's Staff Rules and Regulations define fraud as "any intentional act or omission designed to deceive others and to achieve a gain for the perpetrator or a third party, resulting in the Organization suffering a loss of funds, property or reputation".

² The provisions of Operational Circular No. 10 "*Principles and procedures governing investigation of fraud*" apply by extension to all Members of the Scheme.

Section 5 - Suspension and exclusion from the Scheme

**V 5.01
SUSPENSION OR
REFUSAL OF
BENEFITS**

¹ The Third-Party Administrator may suspend, with the consent of the CHIS Manager, all or part of the benefits:

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

² The Third-Party Administrator, with the prior consent of the CHIS Manager, may refuse to reimburse the suspended benefits.

**V 5.02
GROUNDS FOR
REFUSAL, REDUCTION
OR WITHDRAWAL OF
BENEFITS**

¹ The allowance for reduced earning capacity and the long-term care allowance may be refused, reduced or withdrawn, temporarily or permanently, if the person concerned has caused or worsened his or her own health condition, intentionally or by serious negligence, or by committing a criminal offence.

² The treatment of the after-effects of a treatment not eligible for reimbursement by the Scheme is also not eligible for reimbursement.

**V 5.03
DISCIPLINARY OR
ADMINISTRATIVE
SANCTIONS**

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

**V 5.04
EXCLUSION FROM
THE SCHEME**

¹ After holding a hearing with the Member concerned, the Organization may exclude a Post-Compulsory or Voluntary Member for one of the following reasons:

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

² The decision to exclude a Member from the Scheme is taken by the CHIS Manager, after consulting the Strategic Advisor.

Chapter VI - Reimbursement of medical expenses

Section 1 - Requests for reimbursement (Claims)

VI 1.01 TIME LIMIT FOR CLAIM SUBMISSIONS

¹ Claims for the reimbursement of expenses arising from medical treatment and all supporting documentation must be submitted within the twelve months following the date of the bill.

² In the event of the death of the Main Member, the above time limit shall be extended by 180 calendar days.

VI 1.01bis CONFORMITY OF CLAIMS

By signing a claim form or by submitting one electronically, the Member confirms that:

- a. the bills for which reimbursement is claimed have been paid in full and that any discounts and/or any payments received or expected to be received from other sources have been declared;
- b. the bills submitted have been verified by him or her and correspond to treatment received by the Member concerned from the indicated health care provider(s);
- c. in the case of electronic claim forms, all the supporting documents provided are true copies of the originals.

VI 1.02 SUPPORTING DOCUMENTATION

¹ Claims for primary reimbursement of medical expenses must be accompanied by the corresponding prescriptions, bills and proofs of payment.

² Claims for supplementary reimbursement by the Scheme must be accompanied by the reimbursement statement received from the primary health insurance scheme, indicating the initial total amount of the medical expenses and the sums already reimbursed by that insurance scheme.

³ The originals of the above supporting documentation shall:

- a. in the case of non-electronic claim forms, be provided with the claim form;
- b. in the case of electronic claims, be kept by the Member submitting the claim for a period of at least two years from the date of submission of the claim, and shall be provided to the Third-Party Administrator upon request.

VI 1.03 INFORMATION REQUIRED ON BILLS

Bills submitted for reimbursement shall clearly indicate all the following information:

- a. the first and last name of the patient,
- b. the name, qualification and address of the medical practitioner or medical service provider,
- c. details (as is customary in the State where the treatment was provided) of the treatment provided,
- d. the date or period of the treatment,
- e. the amount payable and the currency of payment.

VI 1.04 MEDICAL PRESCRIPTION

¹ The purchase of medicines or medical equipment is reimbursed if they are supplied on the basis of a medical prescription.

² Acts performed by medical auxiliaries must be performed in accordance with a medical prescription. However, acts performed by osteopaths, etiopathy therapists, and chiropractors may be reimbursed without a medical prescription, up to a maximum of five sessions per calendar year.

VI 1.05 THIRD-PARTY PAYMENT

¹ In some cases, bills from healthcare providers may be paid directly by the Third-Party Administrator as a third-party payer, particularly in the case of hospitalisation in an approved hospital (Article VI 5.01).

² In cases where the Third-Party Administrator pays the healthcare provider directly, a bill is sent to the Member for his or her share of the expenses. This bill must be paid within 30 calendar days of issue.

**VI 1.06
PAYMENT OF BILLS**

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

**VI 1.07
OCCUPATIONAL
ACCIDENTS AND
ILLNESSES**

¹ Reimbursement in accordance with the provisions concerning occupational accidents and illness can be made only once the illness or accident concerned has been recognised as occupational by the Organization.

² Where reimbursement is claimed for medical expenses resulting from an occupational accident or illness, the reimbursement claim must include a reference to the Organization's decision to classify the accident or illness as such.

³ Where reimbursements have already been made when this decision is taken, the Member should contact the Third-Party Administrator to ensure that his or her rights are taken into account. If necessary, the Third-Party Administrator can help the Member to assemble the documents needed to claim the shortfall.

Section 2 - Procedures for the payment of benefits

**VI 2.01
MEDICAL
INFORMATION**

¹ The Member concerned must provide any information requested by the Third-Party Administrator regarding the illness contracted or the treatment followed.

² The Third-Party Administrator may also communicate directly with healthcare providers. If confidential information is involved, it must be sent in a sealed envelope to the Third-Party Administrator's consulting medical practitioner. The consulting medical practitioner will forward to the service that handles the claims only information relevant to the reimbursement.

**VI 2.02
MEDICAL
EXAMINATION**

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

**VI 2.03
PAYMENT OF
BENEFITS TO MAIN
MEMBERS**

Benefits are usually paid to the Main Member, to the bank account held on record by the Organization, including in the case of benefits relating to a Subsidiary Member.

**VI 2.04
PAYMENT OF
BENEFITS TO
SUBSIDIARY
MEMBERS**

¹ Under certain defined conditions and in accordance with a procedure approved by the Director-General the following may be reimbursed or paid directly to the Subsidiary Member concerned or his or her legal representative:

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

² In such cases, claims for benefits must be made by the Subsidiary Member concerned and he or she is responsible for their accuracy.

³ These claims and the corresponding medical information will be treated confidentially, including with respect to the Main Member.

**VI 2.05
CURRENCIES USED**

¹ All payments in respect of contributions, reimbursements and allowances are made in Swiss francs. Any bank or exchange fees are borne by the Member.

² If the costs to be reimbursed are not expressed in Swiss francs, the rate of exchange to Swiss francs is the official rate in force at CERN on the date on which the reimbursement claim is submitted.

³ Where a guarantee for the direct payment of bills is granted in accordance with Article VI 5.01, bills submitted directly to the Third-Party Administrator by the hospital concerned are paid in the currency of the State in which the treatment was dispensed.

Section 3 - Prior approvals and opinions

VI 3.01

PRIOR APPROVAL

Prior approval by the Third-Party Administrator is required for:

- a. transport (except in the case of emergency transport);
- b. refractive surgery;
- c. thermal spa therapy, convalescence stays, rehabilitation stays, stays in a respite care home or in a unit for those waiting for space to become available in a suitable establishment;
- d. home nurses;
- e. hire or purchase of auxiliary appliances;
- f. cost of accommodation in a hospital for a family member, other than one of the two parents, whose presence is required by the hospitalisation of a child of less than ten years of age.

VI 3.02

TIME LIMIT FOR THE SUBMISSION OF REQUESTS FOR PRIOR APPROVAL

¹ Requests for prior approval and supporting documentation must be submitted in writing to the Third-Party Administrator at least 14 calendar days before the medical expenses concerned are incurred, except in exceptional circumstances. This deadline is increased to 30 calendar days for expenses for thermal spa therapy.

² In the absence of a response from the Third-Party Administrator within 14 or 30 calendar days, as applicable, the request is deemed to have been accepted.

VI 3.03

SUPPORTING DOCUMENTATION

¹ Each request for prior approval must be supported by a medical prescription indicating the treatment, its purpose, its duration and the expected result.

² An estimate must be attached to any request for prior approval of the hire or purchase of auxiliary appliances.

VI 3.04

PRIOR APPROVAL NOT OBTAINED

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

VI 3.05

PRIOR OPINION ON DENTAL TREATMENT

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

Section 4 - Cures and convalescence stays

VI 4.01

PRIOR APPROVAL

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

VI 4.02

CONVALESCENCE STAYS

¹ Convalescence stays are accepted if they follow medical surgery involving hospitalisation, or after a stay in hospital of a least ten calendar days, provided that the convalescence stay commences within the 30 calendar days following the end of the hospital stay.

² Wherever possible, requests for prior approval must be submitted seven calendar days before the start of the convalescence stay.

**VI 4.03
CURES**

¹ The prescription for a course of *cure* must be accompanied by a medical case history setting out the results obtained by the medical treatment preceding the therapy, the programme of medical treatment during the therapy and the expected result with respect to the recovery or consolidation of the state of health of the person concerned.

² In the event of a course of therapy being repeated and commencing less than 12 months after the previous course began, the medical practitioner must submit a detailed supporting document to justify the effectiveness of the therapy.

³ In the event of a third or further course of therapy for the same condition, the medical practitioner must attach a detailed evaluation of the previous courses of therapy to the prescription for the therapy.

⁴ Therapy must be provided by establishments recognised by the competent authorities of the State in which they are located.

**VI 4.04
REFUSAL OF CURE**

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

Section 5 - Hospital guarantee

**VI 5.01
THIRD-PARTY
PAYMENT
GUARANTEE**

¹ Where hospitalisation is in an approved hospital pursuant to Article II 3.06, the Third-Party Administrator will, at the request of the hospital or the patient, issue a third-party payment guarantee at least three working days before the start of the hospitalisation, except in emergencies.

² An initial guarantee is issued for a hospital stay of 14 calendar days. Any request for extension of the guarantee must be submitted by the hospital to the Third-Party Administrator for approval.

³ The Member must provide the hospital with all the information needed for it to submit the request to the Third-Party Administrator.

⁴ Where the Third-Party Administrator grants a third-party payment guarantee, the Member must not make payments directly to the hospital. However, even in cases where the Third-Party Administrator grants a third-party payment guarantee, certain non-medical expenses (e.g. for increased comfort) may be billed directly to the Member by the hospital. These expenses must be paid directly by the Member as they are not eligible for reimbursement by the Scheme.

**VI 5.02
GUARANTEE AS
THIRD-PARTY
GUARANTOR**

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

Section 6 - Exceptional procedures

**VI 6.01
ADVANCE
REIMBURSEMENT**

¹ Under special circumstances and upon prior written request by the Member, the Third-Party Administrator may grant the reimbursement of a bill for high medical costs before the Member has paid the bill.

² The Member must subsequently submit proof of payment of the bill. Failure to settle a bill for which advance reimbursement has been granted constitutes an infringement of the Rules and may lead to the application of Articles V 5.01, V 5.03 and V 5.04.

**VI 6.02
EX GRATIA
PAYMENTS**

¹ In exceptional circumstances, a Member may request that a benefit exceeding a reimbursement ceiling or a benefit not listed in these Rules be granted. A request for an ex gratia payment must be submitted in writing to the Third-Party Administrator, and a decision will be made by the CHIS Manager, in agreement with the Strategic Advisor.

² Notwithstanding the provisions of Article XIV 1.01, decisions with regard to ex gratia payments are not subject to review in principle. Only in exceptional circumstances will they be subject to a reassessment or appeal and only for reasons such as a failure to take account of essential facts, a material error not involving a value judgement, a failure to rule on a conclusion, or the discovery of essential facts that the Member was not able to declare at the time of submitting the request.

Chapter VII - Normal health insurance

Section 1 - General description

VII 1.01 GENERAL DESCRIPTION

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

VII 1.02 ELIGIBLE PERSONS

¹ Compulsory and Post-Compulsory Main Members and the Subsidiary Members who are their dependents benefit from this cover.

² Voluntary Main Members, provided that they have opted for normal health insurance cover before the date specified in Article III 3.01, and the Subsidiary Members who are their dependents, also benefit from this cover.

Section 2 - Contributions

VII 2.01 MEMBER CONTRIBUTIONS

¹ Each Main Member pays a main contribution calculated in accordance with Article VII 2.05, except in cases where both spouses are Main Members (see Article VII 2.02).

² A Main Member may also be required to pay a supplementary contribution for his or her spouse as a Subsidiary Member, calculated in accordance with Article VII 2.07.

³ Both the main and supplementary contributions are calculated by multiplying the Member's Reference Salary (Chapter XII) by a contribution rate. The same rate is used for the spouse's supplementary contribution as for the main contribution of the Main Member.

VII 2.02 CONTRIBUTIONS OF SPOUSES WHO ARE BOTH MAIN MEMBERS

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

VII 2.03 CONTRIBUTION BY THE ORGANIZATION

¹ The Organization pays a contribution for Compulsory Main Members and CERN pensioners, except in the case of beneficiaries of a surviving spouse's pension acquired on or after 1 January 2021, for whom it does not pay a contribution.

² Where the Organization pays a contribution, it is based on the same Reference Salary as that on which the Member's contribution is based.

VII 2.04 CONTRIBUTION RATES

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

VII 2.05 REFERENCE SALARY FOR THE MAIN CONTRIBUTION

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

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

**VII 2.06
AMOUNT OF THE
CONTRIBUTION FOR
CONTINUATION OF
INSURANCE**

¹ The main contribution required for the continuation of normal health insurance, as set out in Articles III 2.01 and III 2.02, is based on the following reference salaries:

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

² The contribution rate used is the total rate defined in Article A III 1.01. The total amount of the contribution is paid by the Member.

**VII 2.07
REFERENCE SALARY
FOR THE
SUPPLEMENTARY
CONTRIBUTION**

The supplementary contribution for the spouse of a Main Member is based on the following Reference Salaries:

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

**VII 2.08
PAYMENT OF THE
MAIN CONTRIBUTION**

¹ The main contribution payable by a Compulsory Main Member or by a CERN pensioner is deducted each month from the remuneration or payment received from the Organization or from the pension received from the CERN Pension Fund.

² In all other cases, the Member pays the main contribution to the Scheme's bank account each month in advance.

**VII 2.09
PAYMENT OF THE
SUPPLEMENTARY
CONTRIBUTION**

¹ The supplementary contribution payable by a Compulsory Main Member or by a CERN pensioner in accordance with Article VII 2.07 is deducted each month from the remuneration or payment received from the Organization or from the pension received from the CERN Pension Fund.

² The supplementary contribution payable for a Subsidiary Member who is a dependent of a Compulsory or Post-Compulsory Member, in accordance with Article VII 2.07, paragraph 3, is deducted each month from the remuneration or payment received by the Main Member from the Organization or from the pension received from the CERN Pension Fund.

³ It is payable directly by the Main Member in all other cases.

Section 3 - Benefits

**VII 3.01
GENERAL BENEFITS**

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

**VII 3.02
BENEFITS FOR
HOSPITALISATION**

¹ The cost of medical treatment and accommodation in a hospital is reimbursed in accordance with the general reimbursement rule, except:

- a. in the case of hospitalisation in a public hospital other than in a private or semi-private room, in which case the cost is 100% reimbursed;
- b. in the case of hospitalisation in an unapproved hospital, in which case the cost is 80% reimbursed.

² Doctors' fees and the costs of laboratory analyses and medical imaging during hospitalisation are reimbursed according to the conditions in force for the hospital concerned.

³ In all cases, the supplement for board and accommodation in a one-bed room invoiced by the hospital is borne exclusively by the Member.

VII 3.03 PREVENTION	<p>¹ Certain preventive examinations and treatments are 100% reimbursed, as defined in Article A II 1.03.</p> <p>² Other preventive examinations and treatments (e.g. vaccinations) are reimbursed in accordance with the general reimbursement rule.</p>
VII 3.04 REIMBURSEMENT RATES	<p>The reimbursement rates under the general reimbursement rule are specified in Article A II 1.01 as a function of the accumulated FCA for the calendar year in which the expenses were incurred.</p>
VII 3.05 CEILINGS	<p>¹ Certain benefits are subject to a maximum ceiling, which generally applies per calendar year and in certain cases can be cumulated over several years. Details of these ceilings are given in Annex I.</p> <p>² Under Article VI 6.02, these ceilings may be exceeded with the prior approval of the Third-Party Administrator, in particular in the case of children or the elderly whose state of health requires prolonged medical treatment.</p>
VII 3.06 DETERMINATION OF CEILINGS	<p>The maximum amounts reimbursable per benefit category (ceilings) are set annually by CERN, for application as of 1 January of the following year.</p>
VII 3.07 REIMBURSEMENT BONUS	<p>¹ The reimbursement rate may be increased for certain benefits covered by the general reimbursement rule, provided that the total reimbursement rate does not exceed 100%.</p> <p>² The amount of this bonus and the applicable conditions are defined by the Director-General and reviewed annually (Article A II 1.02).</p>
VII 3.08 SERIOUS CASE	<p>Expenses under categories B1 to B5 of Annex I that are incurred for a given illness or accident after the point where the expenses cumulated for that illness or accident during membership of the Scheme exceed 80000 CHF are 100% reimbursed. The Member must contact the Third-Party Administrator to ensure that his or her rights to this benefit are taken into account. If necessary, the Third-Party Administrator can help the Member to compile the file required to claim this benefit.</p>
VII 3.09 INDEMNITY IN THE EVENT OF DEATH	<p>In the event of the death of a CERN staff member or a member of his or her family, an indemnity will be paid to the staff member's estate in accordance with the conditions set out in Annex I.</p>

Chapter VIII - Reduced health insurance

Section 1 - General description

VIII 1.01 GENERAL DESCRIPTION

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

VIII 1.02 ELIGIBLE PERSONS

¹ Voluntary Main Members are entitled to this cover provided that they have opted in before the date specified in Article III 3.01 or if they previously had normal health insurance cover and request a change of cover.

² The family members of a Main Member are not covered by reduced health insurance cover and may not opt into it.

Section 2 - Contributions

VIII 2.01 CONTRIBUTION

¹ The contribution for reduced health insurance is 50% of Reference Salary II, multiplied by the total health insurance contribution rate indicated in Article A III 1.01.

² The Organization does not pay a contribution.

VIII 2.02 PAYMENT OF THE CONTRIBUTION

The contribution is paid to the Scheme's bank account by the Member each month in advance.

Section 3 - Benefits

VIII 3.01 BENEFITS

¹ Reduced health insurance cover provides the same benefits as normal health insurance cover (Chapter VII Section 3) except in the case of:

- a. treatment dispensed by medical auxiliaries;
- b. prostheses, orthopaedic appliances and hearing aids;
- c. dental prostheses;
- d. optics (spectacles, contact lenses and refractive surgery);
- e. the cost of accommodation in a respite care home or a unit for those waiting for space to become available in a suitable institution;
- f. infertility treatment.

² All other medical expenses subject to reimbursement, as well as the applicable rates and ceilings, are specified in Annex I of these Rules.

Chapter IX Insurance against the consequences of occupational illness and accidents

Section 1 - General description

IX 1.01 GENERAL DESCRIPTION	Accidents and illnesses recognised as occupational by the Organization in accordance with the provisions of Administrative Circular No. 14 “ <i>Protection of members of the personnel against the financial consequences of illness, accident and incapacity for work</i> ” give entitlement to specific cover for the expenses for medical treatment directly associated with them.
IX 1.02 ELIGIBLE PERSONS	Only Compulsory Main Members are entitled to this cover.
IX 1.03 END OF COVER	<p>This cover ends when the Member ceases to be a Compulsory Main Member. However, benefits arising from:</p> <ul style="list-style-type: none"> a. an occupational accident recognised by CERN as having occurred during the membership period, or b. an occupational illness recognised by CERN as having been contracted during the membership period <p>are payable until recovery from or consolidation of the condition.</p>

Section 2 - Contributions

IX 2.01 CONTRIBUTION	The Organization pays 100% of the contribution for this cover.
IX 2.02 CONTRIBUTION RATE	The contribution rate, as indicated in Article A III 1.01, is a percentage of the applicable Reference Salary.

Section 3 - Benefits

IX 3.01 BENEFITS	<p>¹ Subject to obtaining the applicable prior opinion or approval, medical expenses and treatments directly linked to an occupational illness or accident are 100% reimbursed, without any limit or ceiling.</p> <p>² Medical treatment for the condition concerned will cease to be reimbursed under the occupational scheme in the event of recovery or consolidation. The right to such reimbursement may resume in the event of a relapse.</p> <p>³ No medical treatment resulting from an occupational accident sustained or an occupational illness contracted before the start of the insurance cover provided for in this Chapter is reimbursed by the Scheme as an occupational accident or illness.</p>
IX 3.02 TIME LIMIT	<p>¹ The time limit for submitting a reimbursement claim for medical expenses or treatments resulting from an occupational accident or illness is the same as under Article VI 1.01. This time limit starts on the date on which the accident or illness was recognised as occupational by the Organization or on the date of the bill, whichever is the later.</p> <p>² If reimbursements have already been made before the accident or illness is recognised as occupational, the Member must inform the Third-Party Administrator.</p>

Chapter X - Long-term care benefits

Section 1 - General description

X 1.01 GENERAL DESCRIPTION

¹ Long-term care benefits are granted to eligible Members who are recognised as being in a state of dependence, i.e. unable to perform the ordinary functions of everyday life unaided. These benefits are aimed, among other things, at allowing these Members to live with their disability under decent conditions without necessarily having recourse to stays in a hospital or a specialised institution.

² These benefits are also referred to by the acronym LTC (Long-Term Care).

X 1.02 ELIGIBLE MEMBERS

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

Section 2 - Procedure for the award of the benefit

X 2.01 APPLICATION FOR THE BENEFIT

¹ Any eligible Member who considers him- or herself to be unable to perform the ordinary functions of everyday life unaided may apply to receive long-term care benefits.

² The application must be submitted to the Third-Party Administrator in writing. It must specify whether the Member concerned lives at home or in a specialised institution, as well as the full name and address of his or her medical practitioner.

X 2.02 RECOGNITION OF A STATE OF DEPENDENCE

¹ The recognition of a state of dependence is based upon an assessment by a medico-social panel comprising a representative of CERN's Social Affairs Service, the Third-Party Administrator's consulting medical practitioner specialising in geriatrics and long-term care, appointed in agreement with CERN, and a representative of the Third-Party Administrator.

² The panel's assessment of the Member's state of dependence is based upon two questionnaires: a medical questionnaire completed by the Member's medical practitioner and a medico-social questionnaire completed by the Member concerned and/or his or her family members, friends or others close to him or her. If necessary, the panel may request any additional information it deems necessary.

³ The medico-social panel distinguishes between three levels of dependence (low, moderate or high) according to the Member's degree of ability to perform the following functions unaided:

- a. getting up, sitting down and getting into bed;
- b. moving around;
- c. washing and grooming;
- d. getting dressed and undressed;
- e. eating and drinking;
- f. going to the toilet;
- g. coherence and ability to communicate;
- h. orientation in space and time.

⁴ The panel also determines the date on which the state of dependence began.

⁵ The decision to recognise a state of dependence is taken by the Third-Party Administrator on the advice of the medico-social panel and is communicated in writing to the Member.

X 2.03 EFFECTIVE DATE

¹ Long-term care benefits are granted from the date on which the application was submitted, provided that it is medically recognised that the Member concerned was in a state of dependence on that date.

² Where the date of onset of the state of dependence (as determined by the panel) is later than that of the application, the long-term care benefits are paid only from the date of onset onwards.

**X 2.04
REASSESSMENT OF
THE STATE OF
DEPENDENCE**

¹ The medico-social panel may, at any time, conduct a reassessment of the Member's state of dependence.

² The Member concerned is required to inform the Third-Party Administrator of any lasting change (deterioration or improvement) that may affect his or her state of dependence. Such a notification also triggers a reassessment of the state of dependence of the Member concerned.

³ The reassessment is conducted in the same way and on the same basis as the assessment described in Article X 2.02. The decision as to whether or not to recognise a change in the state of dependence is taken by the Third-Party Administrator on the advice of the medico-social panel and is communicated in writing to the Member concerned. The effective date of a change in the state of dependence is determined by analogy with Article X 2.03.

**X 2.05
RULE CONCERNING
NON-CONCURRENCE
OF BENEFITS**

¹ In accordance with Article V 2.02, the amount of any benefit of the same nature received as a result of compulsory membership of a national social security scheme will be deducted from the long-term care allowance set out in Section 4.

² Members are required to inform the Third-Party Administrator if they are in receipt of such benefits as soon as possible.

Section 3 - Contributions**X 3.01
CONTRIBUTIONS**

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

Section 4 - Benefits**X 4.01
BENEFITS**

¹ In the event of recognition of a state of dependence, a daily allowance, the amount of which is defined in Article A IV 1.01, will be paid monthly to the Member concerned.

² The ceilings for the paramedical benefits listed in Annex I B 6 c (home nurse), B 6 d (psychologists/psychotherapists for adults) and B 6 e (medical auxiliaries other than those mentioned in points 6 a to 6 d) are modified in accordance with Article A IV 1.02.

Chapter XI - Allowance for the reduced earning capacity of a family member

Section 1 - Eligibility

XI 1.01 DEFINITION OF REDUCED EARNING CAPACITY

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

XI 1.02 ELIGIBLE PERSONS

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

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

XI 1.03 CONDITIONS FOR ENTITLEMENT TO THE ALLOWANCE

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

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

Section 2 - Procedure for applying for the allowance

XI 2.01 APPLICATION FOR THE ALLOWANCE

¹ The allowance for reduced earning capacity may be applied for at any time provided that the conditions set out in this Chapter are met. The application may be submitted by the eligible person him- or herself or by a third-party representing him or her.

² If the application is accepted, the effective date will be the first day of the month in which the application was submitted. The allowance may be paid retroactively for a maximum period of 12 months if the person concerned proves that the conditions justifying the payment were met continuously.

XI 2.02 ASSESSMENT OF THE APPLICATION

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

XI 2.03 RECOGNITION OF ENTITLEMENT TO THE ALLOWANCE

¹ Within the six weeks following receipt of the application in the form set out above, the Third-Party Administrator informs the person concerned and, where applicable, the CHIS Manager, of its decision in writing. If the decision is favourable, the level of the allowance and the date from which it is payable are specified.

² The Third-Party Administrator is entitled to defer the decision by a maximum of one year after medical treatment is completed if the medical report leaves doubts as to whether the reduced earning capacity is permanent and as to its extent.

Section 3 - Contributions

XI 3.01 CONTRIBUTIONS	No additional contribution is required for this benefit.
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Section 4 - Benefits

XI 4.01 FULL ALLOWANCE	The eligible person is entitled to the full reduced earning capacity allowance if he or she is diagnosed as having at least a two-thirds reduction in earning capacity.
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XI 4.02 HALF ALLOWANCE	The eligible person is entitled to half the reduced earning capacity allowance if he or she is diagnosed as having at least a 50% reduction in earning capacity.
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XI 4.03 AMOUNT OF THE ALLOWANCE	The reduced earning capacity allowance is equal to the minimum allowance that the disability insurance scheme of the Swiss Confederation would pay in the same circumstances, regardless of the State of residence of the eligible person.
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XI 4.04 NON-CONCURRENCE OF BENEFITS	<p>¹ In accordance with Article V 2.02, the amount of any benefit of the same nature received as a result of compulsory membership of a national social security scheme will be deducted from the reduced earning capacity allowance.</p>
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² Members are required to inform the Third-Party Administrator if they are in receipt of such benefits as soon as possible.

³ However, the disabled orphan's pension, granted under the Rules of the CERN Pension Fund, may be paid concurrently with the benefits covered by this Chapter.

Section 5 - Modifications to or termination of benefits

XI 5.01 CHANGE IN WORKING OR EARNING CAPACITY	<p>¹ The Third-Party Administrator must be notified immediately of any change in working or earning capacity. Such a notification will give rise to a new assessment in accordance with the procedure set out in Article XI 2.02.</p>
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² A recognised restoration of or improvement in working capacity will result in a corresponding reduction in or termination of the reduced earning capacity allowance. Any allowance paid to which the person concerned is not entitled must be repaid in accordance with Article V 4.01.

³ A recognised deterioration in working capacity will result in a corresponding increase in the allowance. Where the reduction in earning capacity is at least two-thirds, a full allowance will be paid.

XI 5.02 EFFECTIVE DATE OF A CHANGE	A change in the level of reduced earning capacity will take effect from the day on which the change was medically certified.
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XI 5.03 PROOF AND MEDICAL EXAMINATION	The Third-Party Administrator may at any time request any proof it deems necessary and have the Member concerned examined at the Scheme's expense by a medical practitioner of the Third-Party Administrator's choice. At the request of the Member concerned, the Member's own medical practitioner may be present at such an examination.
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XI 5.04 REFUSAL TO UNDERGO REHABILITATION MEASURES	The reduced earning capacity allowance may be withdrawn temporarily or permanently if the Member concerned evades or objects to rehabilitation measures that he or she may reasonably be expected to undergo and that are likely to bring about a significant improvement in his or her earning or working capacity.
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XI 5.05 TERMINATION OF ENTITLEMENT	The reduced earning capacity allowance will be paid as long as the person concerned remains a Member and as long as the conditions set out in Articles XI 1.02 and XI 1.03 are met. Payment will cease on the last day of the month in which the entitlement ceases and, in all cases, as soon as the person concerned has reached the CERN retirement age.
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Chapter XII - Reference Salaries

- XII 1.01
REFERENCE SALARY I** Reference Salary I is the basic monthly remuneration specified in the contract of employment or association with CERN on the basis of a 40-hour working week.
- XII 1.02
REFERENCE SALARY II** Reference Salary II is the salary at the mid-point of Grade 6 in CERN's salary grid.
- XII 1.03
REFERENCE SALARY III** ¹ Reference Salary III is the Member's last Reference Salary I at the time of his or her departure from the Organization. It is indexed annually at the same rate as the indexation of pensions.

² For beneficiaries of a surviving spouse's pension or an orphan's pension, the deceased Member's Reference Salary III is reduced by the same proportion as the pension, in accordance with the Rules and Regulations of the Pension Fund. If a partial surviving spouse's pension has been acquired, the deceased Member's Reference Salary III is reduced in the same proportion as the full surviving spouse's pension, without taking account of the fact that the acquisition is partial.
- XII 1.04
REFERENCE SALARY IV** Reference Salary IV is the basic monthly remuneration specified in the contract of employment with the Organization, on the basis of the actual duration of the working week.
- XII 1.05
REFERENCE SALARY V** Reference Salary V is:
- a. for the calculation of the Member's contribution, Reference Salary VI as set out in Article XII 1.06 below, taking into account all income, including the CERN pension;
 - b. for the calculation of the Organization's contribution, the amount of the CERN pension of the Member concerned.
- XII 1.06
REFERENCE SALARY VI** Reference Salary VI is determined on the basis of the spouse's gross monthly income, with reference to income brackets, as follows:
- a. if the spouse's gross monthly income is less than 2500 CHF, Reference Salary VI is 0 CHF;
 - b. if the spouse's gross monthly income is more than or equal to 2500 CHF, Reference Salary VI is the mid-point of the 2000-CHF income bracket into which the gross monthly income falls⁴;
 - c. if the spouse's gross monthly income exceeds the highest salary in CERN's salary grid, Reference Salary VI is the mid-point of the income bracket into which the highest CERN salary falls, which constitutes the highest value of Reference Salary VI.

⁴ For example, for a gross monthly income in the bracket ranging from 6500 CHF (inclusive) to 8500 CHF (exclusive), Reference Salary VI is 7500 CHF.

Chapter XIII - Operation of the Scheme

Section 1 - Governance

XIII 1.01 CHIS MANAGER

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

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

XIII 1.02 STRATEGIC ADVISOR

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

- a. analyses the reports on the financial position of the Scheme and its reserve fund and the associated long-term projections, as well as the contributions and benefits statistics, submitted by the Manager;
- b. in collaboration with the Manager, analyses developments in the health insurance systems in the Member States and other intergovernmental organisations;
- c. draws up proposals for adjustments to the Scheme needed to ensure that it achieves its objectives and remains in long-term financial balance and that its conditions are competitive with those of the health insurance schemes of the intergovernmental organisations used as comparators;
- d. in agreement with the Director-General, submits these adjustment proposals to the CHIS Board in preparation for subsequent discussion at the Standing *Concertation* Committee (SCC).

XIII 1.03 CHIS BOARD

¹ The CHIS Board is a sub-group of the SCC responsible for the preparatory work preceding discussion at the SCC on the adjustment proposals submitted to the Board by the Strategic Advisor in accordance with Article XIII 1.02.

² The CHIS Board is chaired by the Strategic Advisor and also comprises:

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

³ To allow it to successfully fulfil its mandate, the CHIS Board shall be regularly informed of, among other matters, statistics relating to the Scheme's expenses, its financial position, the quality of service provided by the Third-Party Administrator and any significant issues arising in the course of the Scheme's operation.

⁴ The CHIS Board establishes its own working procedures.

Section 2 - Reserve Fund

XIII 2.01 RESERVE FUND

¹ CERN has set up a reserve fund for its Health Insurance Scheme. The capital of this reserve fund is formally separate from the rest of the Organization's assets.

² For accounting reasons, the reserve fund is divided into the following two separate headings:

- a. Provisions and reserves of the Health Insurance Scheme. These provisions and reserves comprise at least the following:
 1. provision for reimbursements incurred and not yet claimed (20% of all anticipated reimbursements for the year);
 2. provision for catastrophic risk (30% of all anticipated reimbursements for the year);
 3. reserve against a possible future deficit of the Scheme (at least 20% of all anticipated reimbursements for the year, with no upper limit).
- b. Capitalised reserves of the long-term care fund.

³ Actuarial studies must be conducted regularly in order to monitor the evolution of the Scheme's resources and expenditure, taking into account the contributions, the anticipated expenditure and the assets of the reserve fund.

Section 3 - Auditing

XIII 3.01 INTERNAL AND EXTERNAL AUDITORS

¹ CERN's internal and external auditors may, on their own initiative, examine all or part of the CERN Health Insurance Scheme.

² In order to be able to carry out this task, the auditors are given access to all documents and supporting documentation, confidential or otherwise, required to verify the transactions shown in the Third-Party Administrator's financial records.

³ On request, the auditors will also be given access to the Third-Party Administrator's internal written instructions.

⁴ The auditors are not given access to the Members' personal medical data.

Chapter XIV - Settlement of disputes

Section 1 - Challenging a decision

XIV 1.01 GENERAL

¹ Where a decision relating to the application of the Rules has an adverse effect on a Member, he or she may challenge it by:

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

² All decisions concerning disputes relating to the Health Insurance Scheme are taken by the Director-General.

³ Requests for review and internal appeals are handled individually. Several individual requests for review or several individual internal appeals may nonetheless be submitted and handled collectively if they are identical.

XIV 1.02 NON-SUSPENSION

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

XIV 1.03 EXTENSION OF DEADLINES

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

Section 2 - Requesting a review

XIV 2.01 PROCEDURE FOR REQUESTING A REVIEW

¹ In order to reach an amicable agreement, a Member may request a review of a decision relating to the application of these Rules.

² Such requests must be submitted:

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

XIV 2.02 FORM OF THE REQUEST FOR A REVIEW

¹ The request for a review must be signed by the Member concerned, or by his or her representative if the Member is incapacitated, and sent by registered mail.

² It must include:

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

**XIV 2.03
ADMISSIBILITY OF
THE REQUEST FOR A
REVIEW**

¹ When the party who took the challenged decision receives a request for a review, he or she first examines its admissibility and may declare it inadmissible if, in particular, it:

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

² The party who took the challenged decision must issue an opinion on the admissibility of the request for a review within the 30 calendar days following receipt of the request.

³ If the party who took the challenged decision rejects a request for a review on the grounds that it is inadmissible, he or she must justify this decision in writing and inform the Member and the Manager of the Scheme accordingly. The challenged decision thus becomes final.

**XIV 2.04
DECISION RESULTING
FROM A REVIEW**

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

Section 3 – Appeal

**XIV 3.01
PROCEDURE FOR
LODGING AN APPEAL**

¹ An appeal regarding health insurance matters may be lodged only after completion of the review procedure.

² The Member concerned must lodge the appeal in writing to the Director-General within the 60 calendar days following notification of the new decision taken in accordance with Article XIV 2.04.

**XIV 3.02
FORM OF THE APPEAL**

¹ The letter of appeal must be signed by the Member concerned, or by his or her representative if the Member is incapacitated, and sent to the Director-General by registered mail.

² It must include:

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

**XIV 3.03
ADMISSIBILITY OF
THE APPEAL**

¹ When the Director-General receives a letter of appeal, he or she first examines its admissibility and may declare the appeal inadmissible if, in particular, it:

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

² The Director-General must rule on the admissibility of the appeal within 30 calendar days of receiving the letter of appeal.

³ If the Director-General rejects an appeal on the grounds that it is inadmissible, he or she must justify this decision in writing. The challenged decision thus becomes final.

**XIV 3.04
DETERMINING THE
NATURE OF THE
DISPUTE**

¹ If the appeal is deemed to be admissible, the Director-General determines whether the dispute is of an administrative or a medical nature.

² Any dispute concerning the allowance for reduced earning capacity or recognition of a state of dependence is deemed to be of a medical nature.

³ In disputes of an administrative nature, the Director-General convenes the Health Insurance Litigation Board, in accordance with Article XIV 3.05, within the 30 calendar days following receipt of the letter of appeal.

⁴ In disputes of a medical nature, a medical practitioner is appointed in accordance with Article XIV 3.08.

**XIV 3.05
SETTLEMENT OF
DISPUTES OF AN
ADMINISTRATIVE
NATURE**

¹ The Health Insurance Litigation Board, hereinafter referred by its French acronym “CLAM”, is competent to examine any appeal against a decision of an administrative nature concerning health insurance matters.

² The CLAM is composed of three members, who are normally members of the CHIS Board.

³ Two permanent members and their alternates are appointed for a renewable term of two years, as follows:

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

⁴ Within the 10 calendar days after the CLAM has been convened, the two permanent members choose, by mutual agreement, the Chair of the CLAM, who is normally also a member of the CHIS Board.

⁵ If no agreement has been reached within the set time limit, the third member of the CLAM is the Chair of the CHIS Board or any other member of that Board chosen by the Chair.

⁶ The CLAM begins to examine the case within the 30 calendar days after its composition has been finalised.

**XIV 3.06
PROCEDURE OF THE
CLAM**

¹ The procedure is conducted in writing. However, at its discretion, the CLAM may hear the Member or any other person able to give the CLAM the benefit of his or her expertise.

² The CLAM may initiate any investigation procedures that it deems necessary for examination of the case.

³ The Chair represents the CLAM in all procedural steps.

⁴ The CLAM:

- a. examines the documents that are submitted to it by the parties (the Member concerned and the Organization);
- b. consults the Third-Party Administrator, the Manager or any expert, if it deems this necessary.

⁵ The conclusions of any expert consulted are communicated to the parties for comments.

⁶ Where an expert assessment requested by the CLAM entails expenses, the Chair of the CLAM informs the Director-General beforehand. The Director-General decides whether such expenses must be borne by the Scheme.

⁷ When the Chair of the CLAM deems that all the relevant information has been obtained, he or she closes the investigation procedure and informs the parties thereof.

**XIV 3.07
REPORT BY THE
CLAM**

¹ The CLAM draws up a report and forwards it to the Director-General within the 30 calendar days following the closure of the investigation procedure.

² This report includes the following elements:

- a. the main arguments of the parties;
- b. a summary of the conclusions of any experts consulted;
- c. the CLAM's considerations;
- d. the recommendation of the CLAM, approved by the majority of its members.

**XIV 3.08
SETTLEMENT OF
DISPUTES OF A
MEDICAL NATURE**

¹ If the Director-General has determined that the dispute is of a medical nature, it will be examined, within the 30 calendar days after the appeal is lodged, by a medical practitioner jointly appointed by the medical practitioner chosen by the Member concerned and the one chosen by the Organization.

² If the parties fail to agree on the choice of medical practitioner, the appointment will be made by any competent medical authority in the Canton of Geneva.

³ The medical practitioner begins to examine the case within the 30 calendar days following his or her appointment.

⁴ The medical practitioner may initiate any investigation procedures that he or she deems necessary for examination of the case.

⁵ The medical practitioner:

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

⁶ In the event of a dispute concerning the allowance for reduced earning capacity or recognition of a state of dependence, the medical practitioner must consult, respectively, a rehabilitation specialist with a good knowledge of Swiss federal legislation on disability or a practitioner specialising in geriatrics and long-term care.

⁷ Communication of information and documents of a medical nature is strictly limited to the minimum required for the proper handling of the dispute.

⁸ The fees of the medical practitioner and of any expert consulted are borne by the Scheme.

**XIV 3.09
REPORT BY THE
MEDICAL
PRACTITIONER**

¹ The medical practitioner draws up a report and forwards it to the Director-General within the 30 calendar days following the closure of the investigation procedure.

² This report includes the following elements:

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

**XIV 3.10
FINAL DECISION BY
THE DIRECTOR-
GENERAL**

¹ The Director-General notifies the Member concerned of his or her decision in writing, enclosing a copy of the report submitted by the CLAM or by the medical practitioner, within the 30 calendar days following receipt of the report. If the decision is not in line with the recommendation of the CLAM or of the medical practitioner, the Director-General will indicate the reasons. The Director-General will inform the CHIS Manager and the Strategic Advisor of his or her decision.

² The decision of the Director-General is final.

**XIV 3.11
APPEAL TO THE
ILOAT**

A complaint against a final decision taken in accordance with Article XIV 3.10 may be lodged with the ILOAT in accordance with the latter's Statute and Rules.

Annex I - List of benefits

BENEFITS	REIMBURSEMENT RATE	REIMBURSEMENT BONUS (pursuant to Article A II 1.02)	PRIOR AUTHORISATION OR OPINION BY THE THIRD-PARTY ADMINISTRATOR (Chapter VI Section 3)	CEILING FOR EXPENSES (Article VII 3.05)	OTHER CONDITIONS
A. CONSEQUENCES OF OCCUPATIONAL ILLNESSES AND ACCIDENTS	100%				Only for members of the personnel who are Compulsory Members of the Scheme. Without limit or ceiling, but subject to prior approval or opinion for the benefits concerned, as set out in B below. Any supplements for hospitalisation in a single-bed ward are borne exclusively by the Member.
B. HEALTH INSURANCE					
1. Doctors' fees	General rule	YES			
2. Pharmaceutical costs	General rule	YES			Medication must be prescribed and must be recognised in the State where it was prescribed. The cost of non-reimbursed medication is not included in the calculation of the Costs Borne by the Insured Member (FCA).
3. Medical imaging	General rule	YES			
4. Laboratory work and analyses	General rule	YES			
5. Medical treatment and miscellaneous examinations	General rule	YES			Including outpatient treatment at a hospital.
6. Treatment given by:					
a) Speech therapists	General rule	YES		13 300 CHF per calendar year	Excluded from the Reduced Health Insurance cover.
b) Psychologists/psychotherapists for children aged up to 18 years	General rule	YES		25 000 CHF per calendar year	Excluded from the Reduced Health Insurance cover.

BENEFITS	REIMBURSEMENT RATE	REIMBURSEMENT BONUS (pursuant to Article A II 1.02)	PRIOR AUTHORISATION OR OPINION BY THE THIRD-PARTY ADMINISTRATOR (Chapter VI Section 3)	CEILING FOR EXPENSES (Article VII 3.05)	OTHER CONDITIONS
c) Home nurses	General rule	YES	YES	68 CHF per day	In the case of recognised long-term dependence, the daily limit is replaced by the monthly limit (see Article A IV 1.02). Excluded from the Reduced Health Insurance cover.
d) Psychologists/psychotherapists for adults	General rule	YES		6 000 CHF per calendar year	In the case of recognised long-term dependence, the annual limit is replaced by the monthly limit (see Article A IV 1.02). Excluded from the Reduced Health Insurance cover.
e) Medical auxiliaries other than those mentioned in points 6 a) to d)	General rule	YES		3 300 CHF per calendar year	In the case of recognised long-term dependence, the annual limit is replaced by the monthly limit (see Article A IV 1.02). Excluded from the Reduced Health Insurance cover.
7. Prevention	100%				Exclusively for the examinations and treatments listed in Article A II 1.03.
8. In-patient hospital treatment (cost of accommodation and treatment)					
a) Hospitalisation in a public hospital, other than in a private or semi-private ward	100%				Supplement for a single-bed ward borne exclusively by the Member.
b) Hospitalisation in an unapproved private hospital	80%				
c) All other hospitalisations	General rule				
d) Cost of accommodation in a hospital for one of the two parents whose presence is required by the hospitalisation of their child of less than ten years of age	70%			132 CHF per day	

BENEFITS	REIMBURSEMENT RATE	REIMBURSEMENT BONUS (pursuant to Article A II 1.02)	PRIOR AUTHORISATION OR OPINION BY THE THIRD-PARTY ADMINISTRATOR (Chapter VI Section 3)	CEILING FOR EXPENSES (Article VII 3.05)	OTHER CONDITIONS
e) Cost of accommodation in a hospital for a family member, other than one of the two parents, whose presence is required by the hospitalisation of a child of less than ten years of age	70%		YES	132 CHF per day	In the absence of prior approval, the Third-Party Administrator may exceptionally grant reimbursement if the attending doctor at the hospital considers the presence of this family member necessary.
9. Courses of thermal spa therapy and stays in convalescence and rehabilitation facilities, in a respite care home or in a unit for those waiting for space to become available in a suitable institution					In accordance with Chapter VI Section 4.
a) Cost of board and accommodation for thermal spa therapy	100%		YES	10 CHF per day	
b) Cost of board and accommodation for a convalescence stay	100%		YES	80 CHF per day	
c) Cost of board and accommodation in a rehabilitation facility	100%		YES	120 CHF per day	Cost of board and accommodation in a specialised social rehabilitation facility, e.g. in an alcohol or drug abuse rehabilitation centre.
d) Cost of board and accommodation in a respite care home or in a unit for those waiting for space to become available in a suitable institution	General rule		YES		Benefit cannot be cumulated with the daily long-term care allowance Excluded from the Reduced Health Insurance cover.
e) Medical and pharmaceutical costs	General rule	YES			
10. Optical and ophthalmological expenses					
a) Corrective glasses (lenses and frame) and contact lenses, including disposable lenses	General rule			500 CHF per calendar year, which can be cumulated over 3 years	On prescription Excluded from the Reduced Health Insurance cover.

BENEFITS	REIMBURSEMENT RATE	REIMBURSEMENT BONUS (pursuant to Article A II 1.02)	PRIOR AUTHORISATION OR OPINION BY THE THIRD-PARTY ADMINISTRATOR (Chapter VI Section 3)	CEILING FOR EXPENSES (Article VII 3.05)	OTHER CONDITIONS
b) Refractive surgery	General rule		YES	2 000 CHF per eye for the entire period of cover	No reimbursement within the first 12 months of membership of the Scheme. Excluded from the Reduced Health Insurance cover.
11. Hire or purchase of auxiliary appliances such as orthopaedic appliances, prostheses other than dental prostheses, hearing aids, oxygen extractors, dialysis machines, etc.	General rule		YES	11 000 CHF per calendar year, which can be cumulated over 2 years	On prescription. Excluded from the Reduced Health Insurance cover: prostheses, orthopaedic appliances and hearing aids.
12. Hire or purchase of auxiliary appliances designed to foster personal autonomy in the case of recognised disability, reduced earning capacity or dependence.	General rule		YES	11 000 CHF per calendar year, which can be cumulated over 2 years	On prescription. This includes the following appliances: <ul style="list-style-type: none"> • wheelchairs; • supplementary automatic sanitary installations where the Member is unable to wash himself or herself without one; • stair lifts for use by patients at home; • electric beds (with base, but excluding mattress and other accessories) for use at home; • adaptation of the Member's place of residence: installation of support rails, elimination of doorsteps, construction of ramps over doorsteps, modification of door frames, installation of luminous signals for the deaf and those suffering from serious hearing impairment, emergency call systems for the deaf and blind; • adaptation of a vehicle to allow the Member to travel.

BENEFITS	REIMBURSEMENT RATE	REIMBURSEMENT BONUS (pursuant to Article A II 1.02)	PRIOR AUTHORISATION OR OPINION BY THE THIRD-PARTY ADMINISTRATOR (Chapter VI Section 3)	CEILING FOR EXPENSES (Article VII 3.05)	OTHER CONDITIONS
13. Dental treatment, prostheses and orthodontics	General rule		YES*	3 300 CHF per calendar year, which can be cumulated over 3 years	* Subject to prior opinion if the total costs exceed 25% of the annual ceiling, except in emergencies. Dental prostheses excluded from the Reduced Health Insurance cover.
14. Infertility treatment	General rule		YES	30 000 CHF for the entire period of membership	Excluded from the Reduced Health Insurance cover.
15. Transport costs: in an ambulance or medical vehicle (exceptionally by taxi)					
a) from the place of residence or the site of the accident to the nearest suitable hospital, or any other means of transport used in an emergency	General rule				
b) from one hospital to another	General rule		YES		
c) to a rehabilitation facility	General rule		YES		
d) any other medically essential transport	General rule		YES		
16. Indemnity in the event of death					
a) of a staff member	NA			14 000 CHF	3 times the basic salary of the Member
b) of a family member	NA				1600 CHF
C. LONG-TERM CARE (LTC) ALLOWANCE					See Chapter I and Annex IV.
D. ALLOWANCE FOR REDUCED EARNING CAPACITY OF A FAMILY MEMBER					See Chapter XI.

Annex II - Reimbursement rate

A II 1.01

REIMBURSEMENT RATE UNDER THE GENERAL RULE

The reimbursement rates, which depend on the costs borne by the member (FCA) as defined in Article II 5.02, cumulated by the Member over a calendar year, are as follows:

Cumulated Costs Borne by the Member (FCA)	Reimbursement rate
up to 500 CHF inclusive	80%
over 500 CHF, up to 3 000 CHF inclusive	90%
3 000 CHF	100%

A II 1.02

REIMBURSEMENT BONUS

To encourage the use of healthcare providers in Member States where health costs are the least onerous, the 80% and 90% reimbursement rates are increased by 5 percentage points for certain outpatient treatments (defined in the table in Annex I) if they are dispensed in one of the following Member States:

Austria, Belgium, Bulgaria, Czech Republic, Finland, France, Germany, Greece, Hungary, Israel, Italy, Netherlands, Poland, Portugal, Romania, Serbia, Slovak Republic, Spain, Sweden and the United Kingdom.

A II 1.03

REIMBURSEMENT OF PREVENTIVE MEASURES

Certain preventive examinations and treatments are reimbursed at the rate of 100%, namely:

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

A II 1.04

REIMBURSEMENT OF SERIOUS CASES

Expenses under categories B1 to B5 of the table in Annex I are reimbursed at the rate of 100% if they are associated with a serious case, as defined in Article VII 3.08.

Annex III - Contribution rates

A III 1.01 CONTRIBUTION RATES

¹ The contribution rates to be applied to the reference salary of the Main Member are shown in the table below, together with the breakdown of the contribution between the Main Member (M) and the Organization (O).

² The contribution rate applicable to any supplementary contributions payable for a Subsidiary Member is the same as the rate applicable to the Main Member concerned.

	Normal health insurance	Reduced health insurance	Insurance for occupational illnesses and accidents	Long-term care	
Total rate	11.77%	5.885%	0.12%	Pensioners: 1.60% Non-pensioners: 0.80%	
Compulsory Main Member	M: 4.06% O: 7.71%		O: 0.12%	M: 0.80%	
CERN pensioner				M: 0.80% O: 0.80%	
CERN pensioner benefitting from a surviving spouse's pension acquired on or after 1 January 2021	M: 11.77%				M: 1.60%
Other Post-Compulsory Main Member					M: 0.80%
Voluntary Member		M: 5.885%			

A III 1.02 ADJUSTMENT OF THE CONTRIBUTION RATE

¹ The contribution rates defined above may be examined in the framework of each five-yearly review of CERN's employment conditions, taking into account the past and anticipated future evolution of:

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

² If necessary, a proposal to adjust the contribution rates is submitted to the CERN Council.

Annex IV - Long-term care benefits

A IV 1.01 DAILY ALLOWANCE

¹ The amount of the daily allowance, which depends on the level of dependence, is as follows:

- a. Low-level dependence: 48 CHF
- b. Moderate dependence: 72 CHF
- c. High-level dependence: 120 CHF

² The daily allowance is not paid during hospital stays.

A IV 1.02 CEILINGS FOR PARAMEDICAL BENEFITS

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

- a. Low-level dependence: 1 100 CHF per month
- b. Moderate dependence: 1 650 CHF per month
- c. High-level dependence: 2 750 CHF per month

A IV 1.03 REVIEW OF BENEFITS

¹ The amounts of the daily allowances may be reviewed by the Director-General each year in accordance with the evolution of the cost of stays in a specialised institution.

² The specific ceilings may be reviewed at the same time as the ceilings for the other benefits.