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One hundred years of mutual health insurance

Regulations and administrative rules of the Staff Health Insurance Fund

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Regulations and Administrative Rules of the Staff Health Insurance Fund

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Contents

Regulations of the Staff Health Insurance Fund

Article 0.1

Objective

The objective of the Staff Health Insurance Fund of the International Labour Office (ILO), hereinafter referred to as "the Fund", shall be to provide, to the extent prescribed by these Regulations and by the Administrative Rules made thereunder, reimbursement of the expenses which may be incurred for health protection – including medical care in case of illness, accident and maternity and personal preventive care – by persons protected by the Fund.

Article 0.2

Headquarters

The headquarters of the Fund shall be at the International Labour Office.

Chapter I. Coverage

Article 1.1

Protected persons

1. The persons protected by the Fund shall comprise:

(a) insured persons, being persons insured in their own right, either compulsorily or voluntarily, as staff members, former staff members, or survivors of such persons;

(b) specified categories of members of insured persons' families (hereinafter referred to as "dependants"), covered either automatically or voluntarily.

2. Insured persons are liable to pay contributions, as prescribed, both in respect of their own insurance and in respect of their dependants, and shall normally receive the benefits due in respect either of themselves or of their dependants.

Article 1.2

Compulsorily insured persons

1. The following shall be compulsorily insured persons:

(a) Professional and General Service officials, other than part-time cleaning staff, who serve at the headquarters of the ILO and have an appointment for a term of at least six months or, by virtue of an extension of appointment, are expected to serve continuously for at least six months; in the latter case, coverage shall be effective as from the first day of the month following the official notification of such extension;

(b) Professional and non-local General Service officials serving at external offices of the ILO, subject to the conditions laid down in (a) above: Provided that such officials in any ILO liaison, branch or national correspondent's office may choose to affiliate to a health insurance scheme available at their duty station and either sponsored by the United Nations, a specialized agency or a related organization, [1] or approved by the Director-General of the ILO;

(c) local General Service officials serving at external offices of the ILO, subject to the conditions laid down in (a) above, in so far as they are not eligible for affiliation to a scheme available at their duty station and approved by the Director-General of the ILO;

(d) except in so far as they are compulsorily insured under a health scheme in the country of the duty station, officials appointed to field projects subject to the conditions laid down in (a) above;

provided that the above paragraphs shall not apply to a part-time official:

[1] The list of related organizations is provided under article 1.2.1 of the Administrative Rules.

(i) who, being an automatically covered dependant under article 1.5 or insured under another health insurance scheme, opts not to become an insured person under the present article; or

(ii) whose working week is less than half the normal working week of full-time officials at the same duty station.

2. An official compulsorily insured in virtue of paragraph 1 of this article who is loaned to another international organization and to whom, during the loan, the Staff Regulations of the ILO continue to apply, shall remain compulsorily insured: Provided that such official, if loaned for at least one year, may choose to affiliate for the period of the loan to a scheme sponsored by the receiving organization.

Article 1.3

Voluntarily insured persons

The following shall be entitled to be voluntarily insured persons:

(a) officials on leave without salary or with partial salary who were insured persons at the date of taking the leave;

(b) officials on secondment to other international organizations to whom the Staff Regulations of the ILO do not continue to apply and who were insured persons at the effective date of secondment, if application for voluntary insurance was made before such date;

(c) officials whose service has ceased, provided they were insured persons immediately prior to the date of such cessation and application for voluntary insurance was made before that date. Voluntary insurance under this paragraph shall be for a maximum of six months after cessation of service;

(d) former officials who have reached the age of 55 upon cessation of service, have had at least ten years' service with the United Nations or a specialized agency or a related organization [2] and have been, during the five years immediately preceding cessation of service, either insured persons of the Fund or otherwise protected against health risks by the ILO, if application for voluntary insurance was made and authorization to deduct the contributions from the pension signed before the effective date of cessation of service;

(e) former officials receiving a disability pension from the UNJSPF or other ILO pension scheme, who, at the effective date of cessation of service, were insured persons of the Fund or of another health insurance scheme approved by the Director-General of the ILO, if application for voluntary insurance was made and authorization to deduct the contributions from the pension signed within three months following the award of the disability pension;

(f) widows or widowers of officials or former officials who at the time of death were insured persons of the Fund or of another health insurance scheme approved by the Director-General of the ILO, if such survivors were automatically covered dependants at the time of the death and receive a survivor's benefit from the UNJSPF or other ILO pension scheme and

[2] The list of related organizations is provided under article 1.2.1 of the Administrative Rules.

if application for voluntary insurance was made and authorization to deduct the contributions from the pension signed within three months following notification by the Fund to the survivor of the provisions of this clause; if the official or former official died without leaving a widow or widower or upon the death of a widow or widower insured under this paragraph, these provisions shall apply in respect of any child who was at that time an automatically covered dependant and receives survivor's benefits from the UNJSPF or other ILO pension scheme. [3]

Article 1.4

Withdrawal of voluntarily insured persons

1. Voluntarily insured persons covered under article 1.3(d), (e) and (f) may withdraw from the Fund at three months' notice but, having done so, may not thereafter resume membership.

2. If such a voluntarily insured person becomes subject to compulsory health insurance coverage under a scheme of the United Nations or a specialized agency, voluntary insurance by the Fund shall be suspended as long as compulsory coverage continues.

Article 1.5

Automatically covered dependants

1. The spouse and children of a person insured under article 1.2 or article 1.3(a), (b) or (c) shall be covered automatically in the following cases:

(a) if family allowance is paid in respect of them under the Staff Regulations of the ILO or would be paid if the conditions of employment applicable to the insured person included provisions for family allowances corresponding to those contained in the respective Staff Regulations applicable to headquarters' staff;

(b) if, under the respective Staff Regulations, staff assessment is applied to the salary of the insured person at the family rate by reason of the spouse or child in question;

(c) in the case of a child who is not automatically covered by another health insurance scheme or medical care service, if a family allowance would be payable under the applicable Staff Regulations but is not paid only because of the receipt by the insured person or the insured person's spouse of an allowance of an equal or greater amount.

2. The spouse and children of a person insured under article 1.3(d) or (e) shall be covered automatically if and for so long as they would have qualified for automatic coverage under paragraph 1 of this article had the insured person continued to be an official of the ILO; provided that a spouse who, by reason of the level of his/her occupational earnings, was not automatically covered at the date of cessation of service of the insured person, or at any time thereafter ceases to be automatically covered, may subsequently qualify for automatic coverage only if the spouse

[3] Secondary dependants who were insured on 1 November 1983 by virtue of the provisions of article 1.3(f) in force prior to that date shall be entitled to continue such insurance.

has no entitlement to continued protection by any insurance scheme in respect of health protection or medical care service which was applicable to the spouse by reason of the occupational activity in question.

3. Children of widows or widowers insured under article 1.3(f) who were automatically covered under paragraph 1 of this article at the date of death of the insured person concerned shall, unless they are themselves qualified to be insured persons under article 1.3(f), continue to be automatically covered for so long as they would have qualified for such coverage under paragraph 1 of this article had the insured person continued to be an official of the ILO. For the purpose of this paragraph, a child born less than 300 days after the death of the official or former official concerned shall be assimilated to children automatically covered at the date of death.

4. This article shall be applied to persons insured under article 1.3(a), (b) and (c) as if the remuneration on which their contributions are assessed were received from the ILO.

Transitional provision. A parent who was automatically covered on 1 November 1983 under the provisions of article 1.5 in force prior to that date shall continue to be so covered so long as he/she satisfies the conditions laid down in those provisions. Such coverage shall cease if the insured person's spouse is covered automatically.

Article 1.6

Voluntarily covered dependants

1. Subject to paragraph 2, the following dependants may, if they do not qualify for automatic coverage in accordance with article 1.5, be voluntarily covered as protected persons for renewable periods of one year:

(a) the insured person's spouse;

(b) the insured person's children who are under 30 years of age, unmarried and not in regular full-time employment;

(c) the insured person's parents and parents-in-law, upon adequate evidence of continuous support in accordance with the criteria applied under the provisions of the respective Staff Regulations relating to family allowances for secondary dependants.

2. A request for protection of a person referred to in paragraph 1 shall be accepted only if it is submitted by the insured person in writing within a period of six months following his/her entry into the Fund or following the first day on which the person fulfils the conditions to qualify for voluntary protection, or following the official's reassignment to another duty station, whichever is later. Furthermore, a request for protection of a person referred to in paragraph 1(c) shall be accepted only if the concerned person is below 70 years old and has relocated to the duty station of the insured person within the last six months.

3. If coverage is interrupted, it may be resumed only if the Management Committee considers that bona fide and adequate reasons existed for the interruption.

4. In the event of the death of an insured person, the spouse, children, parents or parents-in-law who at the date of death were voluntarily protected under this article may become voluntarily insured as from that date, subject to the following conditions:

(a) at the said date of death they must have been protected persons for not less than one year;

(b) a child may become insured only if there is no surviving spouse and may remain insured only so long as satisfying the conditions stated in paragraph 1(b) of this article;

(c) application for such insurance must be made within three months of the date of death;

(d) article 1.5 and paragraph 1 of this article shall not apply to such insured persons;

(e) they shall pay contributions at the rate established pursuant to article 3.5 for voluntarily protected dependants;

(f) in all other respects they shall have the rights and obligations of persons insured under article 1.3.

5. In the event of divorce, a spouse who at the date of the divorce was automatically protected under article 1.5 or voluntarily protected under this article may continue to be protected as from that date, provided that he or she had been a protected person for not less than one year and applies for such insurance within three months of the divorce. Such insurance shall be subject to the conditions specified in paragraph 4(d), (e) and (f) of this article.

Article 1.7

Coverage in exceptional cases

In exceptional cases the Management Committee may, by unanimous decision, admit as a protected person an official, former official or dependant not otherwise eligible for coverage under these Regulations. In such cases the Management Committee shall prescribe the conditions for coverage.

Article 1.8

Coverage of officials of the International Training Centre of the ILO

1. Officials of the International Training Centre (ITC), Turin, shall be compulsorily insured persons if they have an appointment of the duration indicated in article 1.2, paragraph 1(a).

2. For the purposes of the application of article 2.9 (Employment injury), article 3.1 (Sources of financing) and article 3.7 (Deduction and transfer of contributions) of these Regulations, the said Centre shall have the obligations of a distinct employing organization.

3. Subject to the preceding paragraph, for the purposes of the application of these Regulations, the persons insured by virtue of this article shall be treated as if they were insured persons of the ILO and the term “ILO” shall be understood to include the ITC.

Chapter II. Benefits

Article 2.1

Free choice of medical practitioner, pharmacist and medical establishment

1. There shall be free choice of medical practitioner and pharmacist, as well as free choice of hospital, clinic or other medical establishment.

2. The Management Committee may prescribe or approve alternative arrangements for a particular area where it considers, in the light of special circumstances existing in that area, that such alternative arrangements would be more advantageous to the protected person and to the Fund.

3. For the purpose of these Regulations the term "medical practitioner" shall refer to physicians or dentists who are qualified and licensed to provide the various types of medical services referred to in the Schedule of Benefits in the country in which their professional services are used by a protected person.

Article 2.2

Ordinary benefits

1. Subject to the provisions of article 2.4, ordinary benefits shall be paid in respect of medical care in accordance with the Schedule of Benefits [1] and with the conditions therein specified as regards:

(a) any qualifying period or condition affecting periodicity of reimbursement;

(b) the rate of reimbursement;

(c) any limitation on the amount of benefit;

(d) any items of expenditure excluded from reimbursement;

(e) approval of treatment by the Medical Adviser.

2. Ordinary benefits shall be paid in respect of personal preventive care under conditions prescribed in the Administrative Rules.

3. In exceptional cases, the Management Committee may, by unanimous decision, accord reimbursement of expenses for health protection not provided for in this article. In such case, the Management Committee shall prescribe the conditions governing the benefits in question.

[1] Appendix I.

Article 2.3

Transfer of rights

For the purpose of completing the qualifying periods provided for under article 2.2 of these Regulations, a period immediately preceding protection by the Fund during which the person concerned was protected by a health insurance scheme of the United Nations or of a specialized agency, or was otherwise protected by the ILO against health risks, shall be regarded as equivalent to a period of protection under the Fund.

Article 2.4

Exclusion or limitation of liability for the payment of benefits

1. No benefits shall be paid:

(a) in respect of medical care in case of illness or injury deliberately contracted or inflicted upon him/herself by a protected person;

(b) in respect of medical care arising out of military service;

(c) in respect of medical care incidental to surgery for aesthetic purposes (except in so far as such surgery qualifies for payment of benefit under the conditions governing Code 1.2 of the Schedule of Benefits);

(d) in respect of medical care which the Medical Adviser considers to be useless, unnecessary or medically unsuitable;

(e) in cases in which a protected person fails to comply with the orders of the attending medical practitioner;

(f) in respect of medical reports, other than medical reports given for the purpose of pursuit of treatment, issued to administrative bodies, employers, etc.

2. Where, after consulting the Medical Adviser, the Management Committee considers that particular expenses in respect of which reimbursement is claimed are excessive, it may reduce accordingly the reimbursement that would otherwise be payable under these Regulations.

Article 2.5

Supplementary benefits

1. For the purposes of this article and article 2.6, except as otherwise provided, “approved expenses” mean the actual expenses in respect of which ordinary benefit is payable under article 2.2, provided that, in cases where the amount of ordinary benefit is limited by any condition laid down in these Regulations, only that part of the expenses which qualifies for ordinary benefit shall be treated as “approved expenses”.

2. For the purposes of calculating entitlement to supplementary benefit, account shall be taken of all items of expenditure in respect of which ordinary benefits are payable, except as otherwise stated in the Schedule of Benefits and in article 2.7.

3. Where approved expenses incurred in any calendar year by an insured person and his/her dependants protected by the Fund exceed an amount (the "threshold") specified in the Administrative Rules, a supplementary benefit shall be paid on the amount in excess of the threshold, at a rate fixed by the Administrative Rules.

4. Supplementary benefits shall normally be paid after the end of the calendar year to which they refer but may, at the discretion of the Management Committee, be paid during the course of such calendar year.

5. The Management Committee may from time to time vary the level of the threshold and the rate at which supplementary benefits are payable. The Management Committee may also fix a lower threshold for specified categories of insured persons.

Article 2.6

Maximum liability

1. The Fund shall not be liable to pay benefits in respect of approved expenses exceeding US$150,000.00 in any calendar year for any insured person and his/her dependants protected by the Fund. In exceptional circumstances and after considering the financial position of the Fund, the Management Committee may, by unanimous decision, authorize the payment of further benefits.

2. For the purposes of this article, where expenses qualify for payment of benefit under another health insurance scheme or medical care service, only the amount of benefit paid by the Fund shall be treated as "approved expenses".

Article 2.7

Protection by other health insurance schemes or services

1. Where the insured person or one of his/her dependants protected by the Fund is covered by another health insurance scheme, whether public or private, or by a public medical care service, the insured person is required:

(a) to indicate to the Executive Secretary of the Fund the name of the scheme or service concerned;

(b) in connection with every claim for benefit he/she submits to the Fund, to supply the Executive Secretary with a statement, together with supporting documents, listing the benefits received or to be received in respect of the expenditure in question from the scheme or service above-mentioned.

2. Where expenses qualify for payment of benefit under another health insurance or medical care scheme:

(a) if benefit is claimed from the Fund as primary insurer, the expenses shall qualify for supplementary benefit, subject to the limitation imposed by paragraph 3;

(b) if benefit is claimed from the other scheme as primary insurer, the expenses shall not qualify for supplementary benefit nor be taken into account in calculating the "threshold".

3. In no case shall the benefits paid by the Fund, together with such benefits as may be provided by the other health insurance scheme or by the public medical care service (after deduction of any allowances not intended to cover medical expenses) exceed the expenses incurred by the insured person.

Article 2.8

Third-party liability

1. The circumstances of any case of illness or accident of a protected person for which a third party is or may be fully or partly responsible shall be reported to the Fund as early as possible, in a manner specified in the Administrative Rules.

2. Where the Management Committee, or the Standing Subcommittee acting for that Committee, considers that third-party legal liability probably exists, it may, after consultation with those concerned, require the insured and/or the protected person concerned or his/her survivors:

(i) to assign his/her right of action, in a manner that may be specified in the Administrative Rules or in accordance with the directions of the Management Committee or the Standing Subcommittee, in which case the benefits under these Regulations shall be payable; or

(ii) to take the necessary action against the third party jointly or in close consultation with the Fund. In such a case, no benefit shall be payable with respect to medical costs for which a third-party is or may be liable.

3. Notwithstanding paragraph 2(ii) above, where the insured person or other persons concerned has taken such action as may be required by the Management Committee to obtain compensation from the third party, the benefits provided for under these Regulations shall be paid:

(i) in full, where no compensation is recovered from the third party;

(ii) after deduction of any compensation paid by the third-party with respect to heads of damage for which the above-mentioned benefits are paid;

(iii) the legal costs incurred in any action that may be required or approved by the Management Committee shall be equitably shared between the Fund and the insured person or other persons concerned in the manner decided by the Management Committee or the Standing Subcommittee, having regard to the amounts recovered for the Fund.

4. The insured and/or the protected person or his/her survivors shall give the Fund all necessary information and assistance in connection with such legal action. The insured and/or the protected person or his/her survivors shall not settle any such action or any claim against a third-party without the consent of the Fund.

Article 2.9

Employment injury

In the event of illness or accident attributable to the performance of the official duties of an insured person, in respect of which medical and allied expenses are payable by the employing

organization, benefits from the Fund in respect of such expenses shall not be due. However, benefits may be initially paid, subject to reimbursement by the insured person upon settlement of his/her claim by the ILO or the ITC.

Article 2.10

Payment of benefits

1. In accordance with article 1.1, paragraph 2, benefits shall normally be paid only to the insured person. In exceptional circumstances, payment may be made to the person who has actually paid the expenses in respect of which reimbursement is claimed.

2. Benefits shall become payable once the expenses giving rise to reimbursement have been paid by the insured person, unless the Executive Secretary authorizes reimbursement of a bill before its payment, taking into account the billing system applicable in the country where the medical expense is incurred. Bills exceeding US$1,000.00 paid in cash shall not be reimbursable unless exceptionally authorized by the Executive Secretary, taking into account specific requirements applicable by medical providers in the country where the expenses are incurred.

3. Normally, insured persons shall provide proof of payment of the expense for which they claim reimbursement. Where proof of payment is not submitted together with the request for reimbursement, the insured person may be called upon to furnish all necessary elements of proof.

4. Bills sent to the Fund more than 21 months after the date when they were made out or more than 27 months after the completion of the treatment to which they refer shall not entitle the insured person to receive benefits from the Fund. Bills sent to the Fund more than 9 months after an insured person has left the Fund shall not be reimbursed regardless of the date at which the treatment to which they refer was given or the date when they were made out.

5. Where doubts exist as to the authenticity or accuracy of a bill or as to entitlement to benefit, benefit shall not be paid unless and until the insured person provides information that satisfactorily removes such doubts.

6. Any sums in excess of the entitlements to benefits laid down in these Regulations paid by the Fund, shall be repaid to the Fund by the insured person, in the same manner as provided in article 2.10 *bis*, paragraph 2.

Article 2.10 *bis*

Agreements between the Fund and providers of services

1. The Fund may enter into agreements with providers of services in order to develop means which appear from time to time desirable for the proper administration of the Fund and prompt delivery of services. Such agreements may contain arrangements to guarantee bills and/or to make payment of the sums guaranteed directly to particular providers or classes of providers of services.

2. Where arrangements to pay benefits directly to providers are made, the following conditions shall apply:

(a) bills presented to the Fund by the provider shall be paid directly by the Fund to the provider;

(b) where the insured person is a serving official, the part of the bill for which he/she is responsible shall be paid to the Fund by the Organization employing the insured person and be deducted from his/her salary;

(c) any other insured person shall repay to the Fund the part of the bill for which he/she is responsible; if he/she fails to do so within one month of being requested, the Fund may set off the amount due to it against benefits payable to him/her or take other appropriate action.

3. Where arrangements in accordance with paragraphs 1 and 2 cannot be made, the Fund may exceptionally authorize an advance payment to the provider based on a pro-forma invoice. In such cases, the insured person remains responsible to settle any balance of the bill and to submit a claim for reimbursement to the Fund.

Article 2.11

Suspension and forfeiture of entitlements

1. By decision of the Management Committee, an insured person's entitlement to certain benefits may be suspended in whole or in part if the person does not comply with the provisions of these Regulations and the Administrative Rules, including:

(a) if the person or the person's dependant protected by the Fund refuses to undergo a medical examination as requested by the Management Committee or the Medical Adviser of the Fund; or

(b) if the person is in arrears in the payment of voluntary contributions.

2. Pending decision by the Management Committee in any of the cases referred to in paragraph 1, the Executive Secretary may provisionally suspend the payment of the benefits concerned for a period not exceeding four months and shall in such case inform the Chairperson of the Management Committee accordingly.

3. The insured person shall be informed of any decision to suspend his or her benefits.

4. If the Management Committee considers that the situation justifying the suspension of the payment of the benefits concerned is unlikely to be resolved within a reasonable time, it may decide that the entitlement is forfeited.

Article 2.11 *bis*

Fraud against the Fund

1. If, following an initial review, the Secretariat has a serious suspicion that an insured person or a dependant protected by the Fund fraudulently [2] obtained or attempted to obtain

[2] The term "fraud" is defined as any act or omission whereby an individual or entity knowingly misrepresents or conceals a fact (a) in order to obtain an undue benefit or advantage or avoid an obligation for himself, herself, itself, or a third party,

benefits to which the insured person was not entitled, the Executive Secretary shall report the case to the Treasurer and the Chief Internal Auditor. The case shall be dealt with in accordance with the Organization's applicable regulations and rules.

2. The payment of the benefits concerned by the alleged fraud shall be suspended in accordance with article 2.10, paragraph 5, and the insured person shall be informed accordingly. If and when the duration of the suspension becomes likely to exceed four months, the Secretariat shall inform the Management Committee, which may decide to maintain or to end the suspension of the benefits concerned.

Article 2.11 *ter*

Expulsion from the Fund or termination of coverage in case of fraud or arrears

1. The Management Committee may expel from the Fund a person voluntarily insured in accordance with article 1.3 or terminate the coverage of a person voluntarily covered in accordance with article 1.6 if:

(a) it is established following an investigation that the person fraudulently obtained or attempted to obtain benefits to which he or she was not entitled, or assisted another person to do so; or

(b) if the total amount of arrears in contributions due in respect of the person concerned exceeds, without valid reasons, the amount of contributions due for the last six months.

2. Expulsion from the Fund or termination of coverage under this article is without prejudice to the Fund's right to recover any funds due to it from the insured person concerned.

Article 2.12

Right of pre-emption for the Fund of appliances no longer needed

1. When an appliance to which this article applies and in respect of whose acquisition the Fund has paid benefit under Code 5.4 and Code 5.5 (Wheelchairs and other appliances) of the Schedule of Benefits is no longer needed, the insured person (or, in the case of death, his/her heirs or successors) shall so inform the Secretary of the Fund and offer the appliance to the Fund.

2. The Management Committee, by notice addressed to the insured person or other person concerned within 30 days of receipt of the offer, may decide to buy the appliance, on payment of the net amount (after receipt of ordinary benefit and the appropriate proportion of supplementary benefit) borne by the insured person at the time of its acquisition.

3. The Management Committee may dispose of the appliance on such terms as it may deem in the best interest of the Fund.

4. This article applies to:

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and/or (b) in such a way as to cause an individual or entity to act, or fail to act, to his, her or its detriment. (ILO Office Directive, *Anti-fraud and anti-corruption policy*, IGDS No. 69 (Version 3), of 19 October 2017).

(a) any appliance acquired at a cost of not less than US$500.00;

(b) any other appliance specified by the Management Committee by Administrative Rules or by decision notified to the insured person.

Article 2.13

Exchange rates

The Management Committee may from time to time, and for such duration as it may specify, establish the rate of exchange between the US dollar and specified other currencies to be applied in determining entitlements, maxima and contributions fixed in US dollars in these Regulations or any Administrative Rules.

Chapter III. Financing

Article 3.1

Sources of financing

1. The Fund shall be financed by contributions of the insured persons, as well as by contributions of the ILO and of the ITC in Turin with the rates indicated in article 3.6, applied in accordance with articles 3.2 to 3.5.

2. The full cost of administration of the Fund shall be borne by the ILO.

Article 3.2

Assessment in respect of officials and their automatically covered dependants

1. Contributions in respect of officials compulsorily insured under article 1.2 and in respect of their automatically covered dependants insured under article 1.5 shall be assessed on the basis of the official's remuneration and any pension as defined in article 3.3, paragraph 2. If an official works part time, contributions shall be assessed on the basis of the remuneration that official would receive if he/she were working full time.

2. Contributions in respect of officials on leave without salary or with partial salary who are voluntarily insured under article 1.3(a), in respect of officials whose service has ceased but who are voluntarily insured under article 1.3(c) and in respect of the automatically covered dependants of such voluntarily insured officials shall be assessed on the basis of the official's last remuneration and any pension as defined in article 3.3, paragraph 2.

3. Contributions in respect of officials on secondment voluntarily insured under article 1.3(b) and in respect of their automatically covered dependants shall be assessed on the basis of the remuneration the official receives from the organization to which he/she is seconded and any pension as defined in article 3.3, paragraph 2.

4. The term "remuneration" shall include, for purposes of this article, the official's base salary and all allowances that are paid to him/her on a regular and continuing basis but not other payments made under the Staff Regulations or Rules. The allowances and other payments which shall and shall not be taken into consideration in calculating contributions shall be determined by the Management Committee and included in the Administrative Rules.

Article 3.3

Assessment in respect of former officials and their automatically covered dependants

1. Contributions in respect of former officials who are voluntarily insured under article 1.3(d) or (e) and in respect of their automatically covered dependants insured under article 1.5 shall be assessed on:

(a) whichever from time to time is the higher of the following amounts:

(i) the pension (as hereinafter defined);

(ii) the amount of pension which the official would have received if he/she had contributed during 25 years to the applicable pension scheme; and

(b) any earnings derived from work for the ILO by the insured person.

2. For the purpose of this article the expression "pension" includes:

(a) all sums received by way of periodical payments, including any cost-of-living increase and any child benefit, whether by virtue of the insured person's own service or as a widow or widower of an official, under the Regulations of the United Nations Joint Staff Pension Fund (UNJSPF) and/or other ILO pension scheme, under the provisions of the Staff Regulations or other conditions of service of the ILO relating to compensation for employment injuries, and under any insurance maintained wholly or partly at the expense of the ILO in respect of non-service-incurred injuries; and

(b) all corresponding sums received by an insured person's spouse, if the spouse is automatically protected under article 1.5.

If all or part of any such entitlement has been taken in the form of a lump sum, the amount of contribution assessable in respect of the entitlement shall be calculated as if the whole of the entitlement had been taken in the form of periodic payments.

3. Contributions in respect of persons insured under article 1.3(d) who have deferred their pensions and in respect of their automatically covered dependants shall be based on the amount specified in paragraphs 1(a)(ii) and 1(b) of this article until the pension becomes payable.

Article 3.4

Assessment in respect of survivors and their automatically covered dependants

1. Contributions in respect of widows or widowers of officials or former officials who are voluntarily insured under article 1.3(f) and in respect of their automatically covered dependants insured under article 1.5 shall be assessed on:

(a) whichever from time to time is the higher of the following amounts:

(i) the pension (as defined in article 3.3, paragraph 2);

(ii) the amount of pension which the widow or widower would have received if the official or former official had contributed during 25 years to the applicable pension scheme; and

(b) any earnings derived by the insured person from work for the ILO.

2. Contributions in respect of surviving children of officials or former officials who are voluntarily insured under article 1.3(f) shall be assessed on the amount of the pension which they would have received if the official or former official had contributed during 25 years to the applicable pension scheme.

Transitional provision. For persons insured under article 1.3(d), (e) or (f) prior to 1 January 1989 and survivors of former officials who were insured under article 1.3(d) or (e) prior to that

date, the references to 25 years in article 3.3, paragraph 1(a)(ii) and article 3.4, paragraph 1(a)(ii) and paragraph 2 shall be replaced by references to 20 years.

Article 3.5

Contributions in respect of voluntarily protected dependants

Contributions in respect of dependants voluntarily protected under article 1.6 shall be fixed by the Management Committee, where appropriate by subgroups in such manner as to ensure that this group of protected persons is financially self-supporting within the Fund over time.

Article 3.6

Rates of contributions

1. Subject to paragraph 2 of this article, the rates of contribution shall be as follows:

Category of protected persons	To be paid by the insured person	To be paid by the Organization
	Contribution rates as from 1 January 2017	
Compulsorily insured (Articles 1.2, 1.5 and 3.2)	**3.55%**	**3.55%**
Automatically covered spouse	1.07%	1.07%
First automatically covered child	0.36%	0.36%
All other automatically covered children	0.36%	0.36%
Officials on leave without salary [1] (Articles 1.3(a) and 3.2)	**7.10%**	**0.00%**
Officials on leave with partial salary (Articles 1.3(a) and 3.2):		
(a) on remuneration paid	**3.55%**	**3.55%**
(b) on remuneration not paid [1]	**7.10%**	**0.00%**
Automatically covered spouse (on remuneration paid)	1.07%	1.07%
Automatically covered spouse (on remuneration not paid)	2.14%	0.00%
First automatically covered child (on remuneration paid)	0.36%	0.36%
First automatically covered child (on remuneration not paid)	0.72%	0.00%
All other automatically covered children (on remuneration paid)	0.36%	0.36%
All other automatically covered children (on remuneration not paid)	0.72%	0.00%

Category of protected persons	To be paid by the insured person	To be paid by the Organization
	Contribution rates as from 1 January 2017	
Officials on secondment (Articles 1.3(b) and 3.2)	**7.10%**	**0.00%**
Automatically covered spouse	2.14%	0.00%
First automatically covered child	0.72%	0.00%
All other automatically covered children	0.72%	0.00%
Officials whose contracts terminate (six months' coverage) (Articles 1.3(c) and 3.2)	**7.10%**	**0.00%**
Automatically covered spouse	2.14%	0.00%
First automatically covered child	0.72%	0.00%
All other automatically covered children	0.72%	0.00%
Former officials leaving service at age 55 or more, or for reasons of disability (Articles 1.3(d) and (e) and 3.3)	**3.55%**	**7.10%**
Automatically covered spouse	1.07%	2.14%
First automatically covered child	0.36%	0.72%
All other automatically covered children	0.36%	0.72%
Survivors of officials or former officials (Articles 1.3(f) and 3.4)	**3.55%**	**7.10%**
First automatically covered child	0.36%	0.72%
All other automatically covered children	0.36%	0.72%

[1] This provision may be varied by the decision of the ILO, in particular cases or categories of cases, to pay the Organization's contribution in respect of remuneration not paid.

2 The Management Committee may from time to time prescribe minima for contributions in respect of voluntarily insured persons.

3. As an exceptional measure, as from 1 July 1987, no contribution shall be payable, either by the insured person or by the organization, in respect of a former official or the survivor of an official or former official insured under article 1.3(d), (e) or (f), or in respect of the automatically covered dependants (insured under article 1.5) of a former official or of the survivor of an official or former official insured under article 1.3(d), (e) or (f), if the insured person's pension, as defined in article 3.3, paragraph 2, or the proportion of the last remuneration specified in article 3.3 or article 3.4 (as the case may be) does not exceed US$4,500.00 per annum. This paragraph shall cease to apply as from 1 January 1989, except for persons who were subject to it on 31 December 1988.

Article 3.7

Deduction and transfer of contributions

1. The contributions due, in respect of their own insurance, in respect of insurance for their automatically covered dependants (insured under article 1.5) and in respect of the voluntary coverage of dependants, from officials receiving remuneration from the ILO or the ITC shall be deducted by the financial services of the organization from such remuneration.

2. The contributions due, in respect of their own insurance, in respect of insurance for their automatically covered dependants (insured under article 1.5) and in respect of the voluntary coverage of dependants, from persons insured under article 1.3(d), (e) or (f) who receive a pension from the ILO or from the UNJSPF shall be deducted from that pension in accordance with the Administrative Rules.

3. The contributions due, in respect of their own insurance, in respect of insurance for their automatically covered dependants (insured under article 1.5) and in respect of the voluntary coverage of dependants, from other insured persons shall be paid in accordance with the Administrative Rules.

Article 3.8

Guarantee fund and measures to ensure financial equilibrium

1. There shall be a guarantee fund the amount of which at the end of any financial year, exclusive of any sums set aside for outstanding claims for benefits, shall not be less than one-sixth of the expenditure of the Fund during the last three financial years nor exceed one-half of the expenditure of the Fund during the last three financial years.

2. If at the end of any financial year the guarantee fund exceeds the maximum provided for in paragraph 1, the Management Committee shall take appropriate steps to reduce the guarantee fund to the prescribed level by increasing benefits and/or reducing contributions on the basis of an actuarial assessment.

3. If at the end of any financial year the guarantee fund has fallen below the minimum provided for in paragraph 1, the Management Committee shall take all appropriate steps to restore the financial equilibrium of the Fund and to bring the guarantee fund back to the prescribed level by increasing contributions and/or adjusting benefits.

4. If in each of any nine consecutive months expenditure of the Fund exceeds income and at the end of the last financial year the guarantee fund did not exceed the maximum provided for in paragraph 1, the Management Committee shall, within three months after the end of the ninth month of deficit, take all appropriate steps to restore the financial equilibrium of the Fund by increasing contributions and/or adjusting benefits on the basis of an actuarial assessment.

Article 3.9

Reinsurance

The Management Committee may, in agreement with the Director-General of the ILO, enter into such reinsurance arrangements as it deems appropriate.

Article 3.10

Actuarial review

An actuarial review of the Fund shall be made on each occasion that, at the end of any financial year, the guarantee fund has fallen below the prescribed minimum and in any case, at least once every three years.

Article 3.11

Accounts and investments

The financial services of the ILO shall be responsible for keeping the accounts of the Fund, holding its moneys and arranging for the investment of the insurance funds, in consultation with the Management Committee. They shall provide the Management Committee with a quarterly statement of accounts of the Fund, an annual report on the financial situation and on the investments made and such other information from time to time as the Management Committee may reasonably require, in accordance with the instructions of that Committee.

Chapter IV. Administration

Article 4.1

Management Committee

Responsibility for managing the Fund shall be with a Management Committee which shall be composed of six titular members and six substitute members, as follows:

- three titular members and three substitute members representing the insured persons of the ILO;
- three titular members and three substitute members representing the Director-General of the ILO.

The Medical Adviser of the Fund shall ex officio be a non-voting member of the Management Committee.

Article 4.2

Designation and term of office of the Management Committee

1. The insured persons of the ILO shall elect the members of the Management Committee representing them by secret ballot; only an insured person shall be eligible for election.

2. The members of the Management Committee representing the insured persons shall be elected for three calendar years. Rules for elections are set forth in Appendix II to these Regulations.

3. No insured person may serve simultaneously as a member of the Management Committee and as a member of the Secretariat of the Fund.

4. The Director-General of the ILO shall appoint the members of the Management Committee representing him/her. These members shall hold office at the discretion of the Director-General.

Article 4.3

Filling of vacancies on the Management Committee

1. A titular or substitute member representing the insured persons shall relinquish such membership on ceasing to be an insured person. He/she may also resign by written notice addressed to the Chairperson of the Management Committee.

2. If a place of titular member representing the insured persons falls vacant otherwise than by expiry of the term of office, the substitute member representing the insured persons who received the highest number of votes shall fill such place for the remainder of the term of office. Any place of substitute member which falls vacant shall be filled for the remainder of the term of office by the candidate who received the next highest number of votes.

3. If a vacant place of titular or substitute member representing the insured persons cannot be filled by application of paragraph 2, the Management Committee may fill it by co-opting an insured person until the holding of the next election.

Article 4.4

Chairperson and Vice-Chairperson

1. The Management Committee shall elect a Chairperson and a Vice Chairperson from its members.

2. If the Chairperson is a member of the Management Committee representing the insured persons, the Vice-Chairperson shall be a member representing the Director-General of the ILO and vice versa.

3. The Chairperson and Vice-Chairperson shall be elected for one calendar year and shall be eligible for re-election.

Article 4.5

Meetings of the Management Committee

1. The Chairperson shall convene the meetings of the Management Committee. He/she shall convene at least two meetings a year. He/she shall convene a meeting whenever requested to do so by the Standing Subcommittee or by at least four titular or substitute members.

2. The rights and responsibilities of substitute members at meetings shall be the same as those of titular members except that substitute members shall be entitled to vote only when replacing a titular member in his/her absence.

3. Any titular members representing the insured persons who are absent shall be replaced by the substitute members representing the insured persons, in the order of votes received at the election. The substitute member to replace a titular member representing the Director-General of the ILO who is absent shall be chosen by the titular and substitute members representing the Director-General present at the meeting.

Article 4.6

Decisions of the Management Committee

1. Except as provided in paragraph 2, decisions of the Management Committee shall be taken by a simple majority of the votes cast.

2. The approval of proposed amendments to these Regulations shall require a majority vote of the members representing the insured persons present at the meeting as well as a majority vote of the members representing the Director-General of the ILO present at the meeting.

3. No decision shall be valid unless at least three members representing the insured persons and three members representing the Director-General are present at the meeting.

Article 4.7

Responsibilities of the Management Committee

1. The Management Committee, in carrying out its general responsibilities for managing the Fund, shall in particular be responsible for:

(a) determining the policy of the Fund in the light of its objects;

(b) considering questions concerning the health insurance of ILO officials and of their dependants, including proposals made by the insured persons or by the ILO;

(c) drawing up and approving proposals for amendments to these Regulations;

(d) applying the measures provided for in these Regulations for maintenance of the financial equilibrium of the Fund;

(e) maintaining contact with insured persons, by means of general meetings, consultation in writing or otherwise;

(f) obtaining such medical, technical, actuarial and legal advice as it deems necessary from the services of the organization;

(g) making such Administrative Rules as may be necessary for the detailed application of these Regulations;

(h) interpreting these Regulations and ruling on any case referred to it by its Standing Subcommittee, or by an insured person in accordance with article 5.3;

(i) presenting an annual report on the operation of the Fund to the Director-General of the ILO and to the insured persons.

2. The Management Committee shall appoint a Standing Subcommittee to which it may delegate responsibility for certain aspects of the management of the Fund.

Article 4.8

Standing Subcommittee

1. The Standing Subcommittee provided for in article 4.7, paragraph 2, shall be composed of a limited number of titular or substitute members of the Management Committee, chosen by that Committee with due regard to balance of representation both as between insured persons and the Director-General of the ILO.

2. Members of the Standing Subcommittee shall serve as such at the discretion of the Management Committee, but only for as long as they remain titular or substitute members of the Committee.

Article 4.9

Chairperson of the Standing Subcommittee

The Chairperson of the Management Committee shall serve as Chairperson of the Standing Subcommittee. The Management Committee shall designate a substitute Chairperson of the Standing Subcommittee to serve in the absence of the Chairperson.

Article 4.10

Conduct of business of the Standing Subcommittee

1. The business of the Standing Subcommittee may be conducted either on file or by meetings. The Chairperson may convene meetings of the Standing Subcommittee as often as he/she deems necessary and shall convene such meetings whenever so requested by two members of the Standing Subcommittee.

2. Decisions taken by the Standing Subcommittee shall be unanimous.

Article 4.11

Responsibilities of the Standing Subcommittee

1. Subject to the general authority of and any particular directives from the Management Committee, the Standing Subcommittee shall be responsible for:

(a) administering such aspects of the management of the Fund as the Management Committee may delegate to it;

(b) interpreting these Regulations and the Administrative Rules of the Fund, subject to review by the Management Committee;

(c) supervising the work of the Executive Secretary of the Fund and ruling on any case referred to it by the Executive Secretary, or by an insured person in accordance with article 5.3.

2. The Standing Subcommittee shall submit to the Management Committee any question upon which it does not reach unanimous agreement as well as any cases on which, having regard to the importance of the issues raised, it considers that the decision should be taken by the Management Committee itself. It shall report on its activities, orally or in writing, at each meeting of that Committee.

Article 4.12

Executive Secretary of the Fund

1. After consultation of the Management Committee, the Director-General of the ILO shall appoint an ILO official to be Executive Secretary of the Fund.

2. The Executive Secretary shall be responsible for the current administration of the Fund in accordance with these Regulations and the Administrative Rules and subject to the general

authority of and particular directives from the Management Committee and the Standing Subcommittee.

3. In particular, the Executive Secretary shall:

(a) provide information concerning the provisions of these Regulations and the Administrative Rules, receive claims for benefit from insured persons, and settle such claims on the basis of the applicable regulations and rules, precedents and interpretations;

(b) submit medical questions arising in the processing of claims for benefit to the Medical Adviser to the Fund;

(c) submit to the Standing Subcommittee for decision cases giving rise to particular difficulties or problems in the application of these Regulations and the Administrative Rules and cases of complaint by an insured person of non-observance of these Regulations;

(d) submit to the Standing Subcommittee particulars of any anomalies encountered in the application of these Regulations;

(e) act as Secretary to the Management Committee and the Standing Subcommittee and prepare their correspondence;

(f) subject to the directions of the Chairperson, prepare and arrange the meetings of the Management Committee and the Standing Subcommittee, keep the minutes of such meetings, and prepare the draft of the annual report of the Management Committee;

(g) collect and assemble information regarding questions under study in accordance with the instructions of the Management Committee or the Standing Subcommittee;

(h) carry out the decisions of the Management Committee or the Standing Subcommittee;

(i) make arrangements for the election of members of the Management Committee in accordance with these Regulations; and

(j) supervise the work of the Secretariat of the Fund.

Article 4.13

Medical Adviser

There shall be a Medical Adviser to the Fund designated by the Management Committee in agreement with the Director-General of the ILO.

Article 4.14

Auditor

1. As part of the external audit of the ILO, the ILO's External Auditor shall review the revenues and expenditure of the Fund, any significant assets and liabilities recorded at year-end, as well as any other matters falling within his/her mandate as the ILO's External Auditor.

2. Findings from the ILO External Auditor's review shall be reported by the External Auditor to the Management Committee and the Director-General.

3. Compliance audits and audits in relation to the operations of the Fund shall be performed on a regular basis by the ILO Office of Internal Audit and Oversight; audit reports shall be submitted to the Management Committee and the Director-General.

4. For the purpose of carrying out their review or audit, the External Auditor of the ILO and the ILO Office of Internal Audit and Oversight shall have full, free and prompt access to the Fund's records and personnel.

Article 4.15

Consultation of insured persons

The Management Committee shall maintain contact with insured persons through such means as it deems appropriate, including:

(a) general meetings of insured persons as provided in article 4.16;

(b) consultation of and communication with insured persons in writing; and

(c) ad hoc consultation with persons representing particular groups of insured persons.

Article 4.16

General meeting

1. A general meeting of insured persons shall be convened by the Management Committee at regular intervals, at least once every two years; it shall also be convened on the request of a majority of the titular and substitute members of the Management Committee representing the insured persons or on the written request of 100 insured persons.

2. Every insured person shall be entitled to participate in a general meeting.

3. Any conclusions which may be reached at a general meeting shall be of an advisory nature. They shall be brought before the Management Committee at its next meeting for its consideration of any appropriate action.

Article 4.17

Amendments

1. Proposals for amendment to these Regulations shall be approved by the Management Committee in accordance with article 4.6, paragraph 2.

2. Any proposed amendment approved by the Management Committee shall be notified to the insured persons. Upon the written request of 200 insured persons received by the Management Committee within three weeks after such notifications, the Management Committee shall submit the proposed amendment in writing to the insured persons for vote. If the majority of the votes cast are against the proposed amendment and at least one third of all insured persons have voted, the amendment shall not be proceeded with.

3. No amendment shall take effect unless approved by the Director-General of the ILO.

Article 4.18

Arbitration Board

1. Upon the request of a majority of the members of the Management Committee representing the insured persons or of those representing the Director-General of the ILO, an Arbitration Board shall be constituted to consider a question which the Management Committee has been unable to resolve or on which a proposed amendment to these Regulations duly approved in accordance with paragraphs 1 and 2 of article 4.17 has not been approved by the Director-General.

2. A panel shall be maintained composed of not more than five persons nominated by the titular and substitute members of the Management Committee representing the insured persons and not more than five persons nominated by the titular and substitute members of that Committee representing the Director-General. Whenever an Arbitration Board is to be constituted in accordance with paragraph 1, the titular and substitute members of the Management Committee representing the insured persons and the titular and substitute members of that Committee representing the Director-General shall each select from the panel, to serve on the Arbitration Board, two of the persons nominated by them. These four persons shall designate a fifth member to serve as Chairperson of the Arbitration Board.

3. Decisions of the Arbitration Board shall be taken by a majority of its members, including the Chairperson, and shall be final and binding upon the Management Committee, the insured persons and the Director-General.

Article 4.19

Dissolution of the Fund

The dissolution of the Fund and the disposal of its assets may be decided on a proposal of the Management Committee submitted in writing to all insured persons for vote. Adoption of the proposal shall require a majority of the votes received within a period to be specified by the Management Committee but not to be less than four weeks from the date of the submission of the proposal to the insured persons. The dissolution of the Fund and the disposal of its assets thus decided shall not take effect until approved by the Director-General of the ILO.

Chapter V. Miscellaneous

Article 5.1

Interruption of protection or service

1. Subject to the provisions of this article, readmission of an insured person to the Fund after any interruption of the period of protection shall be treated as a first admission.

2. The following periods shall not be regarded as interrupting continuity of protection:

(a) any period during which the protected person was protected by a scheme of another international organization pursuant to the proviso to article 1.2, paragraph 2, or by reason of the secondment of an insured person to that organization;

(b) any period during which an insured person was on leave without salary or with partial salary but did not voluntarily continue insurance pursuant to article 1.3(a):

provided that benefits shall in no case be payable in respect of items of expenditure incurred during any period to which this paragraph refers.

3. A break of not more than 60 days in the period of protection by the Fund, in a period during which the person concerned was subject to another form of health protection referred to in article 1.3 or 2.3, in a period of service referred to in article 1.2, or between any such periods, shall not be regarded as interrupting their continuity: provided that:

(a) first admission of an insured person under article 1.2 shall be subject to the condition that the aggregate period of the latest appointment or extension of appointment and of earlier appointments in the ILO shall not be less than 180 days within a period of 9 months;

(b) benefits shall in no case be payable in respect of items of expenditure incurred during any break in protection.

4. Without prejudice to the provisions of paragraph 3, a person who within a period of not more than 12 months from ceasing to be protected by the Fund again becomes a protected person shall be treated as having completed on the date on which such new protection takes effect any qualifying period for entitlement to benefits provided for in these Regulations if he/she had been a protected person for at least 12 months immediately prior to the interruption of protection.

Article 5.2

Forms and authorizations

1. The Management Committee may prescribe the use of such forms as appear to it from time to time necessary for the proper administration of the Fund.

2. Insured persons shall comply with the requirements as prescribed.

Article 5.3

Review of decisions at the request of insured persons

1. An insured person may require a decision of the Executive Secretary concerning the insured person or his or her dependants to be reviewed by the Standing Subcommittee, if the request is filed within six months from the notification of the decision to the insured person.

2. If an insured person disagrees with a decision taken by the Standing Subcommittee in his or her case, he or she may request its review by the Management Committee within one month from the notification of the decision to the insured person.

Article 5.4

Disputes on questions of a medical nature

1. The Management Committee shall, in principle, accept the conclusions of the medical practitioner in attendance. It shall have the right, however, to have the patient re-examined by the Medical Adviser or a medical practitioner appointed by it, whenever this appears necessary and after notifying the medical practitioner in attendance.

2. If the conclusions of the medical practitioner in attendance and those resulting from the re-examination differ, or if an insured person contests other conclusions of the Medical Adviser, the insured person concerned may require that the case shall be considered by a committee composed of a medical practitioner designated by him/her, of the Medical Adviser and of a third medical practitioner designated by the first two. The parties shall be bound by the conclusions of this committee. Payments of the fees of the third medical practitioner shall be equally divided between the insured person and the Fund.

Article 5.5

Disputes on questions other than of a medical nature

1. In cases other than those required to be submitted to the committee specified in article 5.4, an insured person may require a decision of the Management Committee concerning the application to him or her of these Regulations to be referred to an Appeals Board if such request is filed within one month from the notification of the decision.

2. The Appeals Board shall be composed of insured persons of the Fund who are not members of the Management Committee or of the Secretariat, appointed by the Management Committee as follows:

(a) at least four persons chosen by the members of the Management Committee representing the insured persons;

(b) at least four persons chosen by the members of the Management Committee representing the Director-General;

(c) at least two persons chosen by decision of the Management Committee to serve as Chairpersons of the Appeals Board.

3. Each appeal shall be examined by a panel composed of two of the persons appointed under paragraph 2(a), two of the persons appointed under paragraph 2(b) and one of the Chairpersons appointed under paragraph 2(c).

4. The Appeals Board shall be assisted by a secretariat distinct from the Secretariat of the Fund, which shall receive any appeal, convene, in accordance with objective criteria, a panel of the Appeals Board to hear each appeal, and facilitate communications between the panel and the parties.

5. The Appeals Board shall take a reasoned decision on each appeal based on a thorough, objective and impartial examination of the case file and applying these Regulations.

6. The Appeals Board shall follow the procedure set out in the Administrative Rules, which shall ensure that the proceedings are conducted in a transparent and fair manner. The decisions shall be adopted by the majority of the members of the panel examining the appeal.

7. There shall be no further appeal from the decisions of the Appeals Board.

8. The expenses necessary for the proceedings of the Appeals Board, including the costs of the secretariat, shall be borne by the ILO.

Article 5.6

Effective date of these Regulations

These Regulations came into force on 1 April 1969. All amendments adopted up to 6 October 2021 in accordance with article 4.17 are incorporated in this reprint.

Appendix I

Schedule of benefits

Code	Items of expenditure	Benefits		Expenditure excluded from reimbursement (see also articles 2.1 and 2.4)	Qualifying conditions
		Ordinary (article 2.2)	**Supplementary** (article 2.5)		
1.	**PROFESSIONAL CARE** [1]				
1.1.	**DOCTOR'S SERVICES** [2]	80%	Yes		
	CONSULTATIONS with a physician (general practitioner or specialist), or in a hospital or clinic.				
	VISITS to home or institutions by a physician.				
	TREATMENTS given by a physician.			Treatments for aesthetic purposes. Treatments specified in Code 1.7.	
	CONSULTATIONS with a dietician.				Subject to medical prescription and approval by the Medical Adviser.

Code	Items of expenditure	Benefits		Expenditure excluded from reimbursement (see also articles 2.1 and 2.4)	Qualifying conditions
		Ordinary (article 2.2)	**Supplementary** (article 2.5)		
					Treatments are reimbursed in case of obesity (body mass index greater than 30), anorexia or metabolic disorders, if prescribed by a physician and carried out in a recognized facility, where appropriate.
1.2.	**SURGICAL OPERATIONS** Including surgeon's and anaesthetic services.	80%	Yes	Plastic surgery undertaken for aesthetic purposes, except for cases resulting from major injury, neoplasm or infection. If surgery is undertaken partially for aesthetic purposes, a corresponding proportion of expenses is excluded from reimbursement; such cases require the prior approval of the Medical Adviser who determines the proportion to be excluded. Surgery for aesthetic purposes is defined as surgery undertaken to improve a bodily disfigurement, which in itself does not cause any danger to life or health or any disability of bodily function.	
1.3.	**MEDICAL IMAGERY** Made or prescribed by a physician (or X-rays made or prescribed by a dentist).	80%	Yes		

Code	Items of expenditure	Benefits		Expenditure excluded from reimbursement (see also articles 2.1 and 2.4)	Qualifying conditions
		Ordinary (article 2.2)	**Supplementary** (article 2.5)		
1.4.	**LABORATORY SERVICES AND OTHER TESTS** Made or prescribed by a physician.	80%	Yes		
1.5.	**FUNCTIONAL REHABILITATION TREATMENTS** Prescribed by a physician and provided by a therapist who holds a diploma recognized by the administration of the country in which he or she is authorized to practise.	80%	Yes	Treatments performed by a therapist who does not hold a diploma recognized by the administration of the country in which he or she is authorized to practise.	Subject to a maximum and other conditions as prescribed in the Administrative Rule, including the list of treatments eligible for reimbursement. Subject to prescription prior to the beginning of treatment.
1.6.	**AT-HOME MEDICAL NURSING SERVICES FOR AN ACUTE CONDITION** (other than treatment specified in Code 2.6) Prescribed by a physician, including the services of a nursing assistant or carer, and including midwifery services.	80%	Yes	Non-medical care, such as housework, cooking, shopping, family help, etc. Care provided by unqualified personnel, except where provided under the supervision of the prescribing physician.	Subject to a maximum and other conditions as prescribed in the Administrative Rules.
1.7.	**PSYCHIATRY, PSYCHOANALYSIS OR PSYCHOTHERAPY** Consultations with a psychiatrist, and sessions of psychoanalysis or psychotherapy given or prescribed by a physician.	80%	Yes		Subject to a maximum and other conditions as prescribed in the Administrative Rules.

Code	Items of expenditure	Benefits		Expenditure excluded from reimbursement (see also articles 2.1 and 2.4)	Qualifying conditions
		Ordinary (article 2.2)	**Supplementary** (article 2.5)		
2.	**STAYS IN HOSPITALS AND OTHER INSTITUTIONS**			Plastic surgery or other treatment for aesthetic purposes – same conditions as for Code 1.2. Weight-loss treatment, except with prior approval by the Medical Adviser.	
2.1.	**COSTS OF HOSPITALIZATION IN A HOSPITAL ESTABLISHMENT, IN A COMMON WARD** For examination, diagnosis or curative treatment.	100%	No		Benefit is limited to 30 days per protected person per calendar year, unless the Medical Adviser certifies that accommodation is still for curative treatment and fixes the number of additional days.
2.2.	**COSTS OF ACCOMMODATION IN A HOSPITAL ESTABLISHMENT, IN A ROOM OTHER THAN A COMMON WARD** (other than in cases falling under Codes 2.1, 2.3 and 2.5) Accommodation in a recognized hospital or clinic for examination, diagnosis or curative treatment.	80%	Yes		Subject to a maximum per day and conditions prescribed in the Administrative Rules. Benefit is limited to 30 days per protected person per calendar year, unless the Medical Adviser certifies that accommodation is still for curative treatment and fixes the number of additional days.

Code	Items of expenditure	Benefits		Expenditure excluded from reimbursement (see also articles 2.1 and 2.4)	Qualifying conditions
		Ordinary (article 2.2)	**Supplementary** (article 2.5)		
2.3.	**COSTS OF ACCOMMODATION FOR CONVALESCENCE/FOLLOW-UP TREATMENT** Accommodation in a hospital, clinic or convalescent care facility for follow-up care, including cardiovascular re-education, or convalescence after hospitalization under Code 2.1 or 2.2.	80%	Yes	Stays in hotels.	Subject to a maximum per day, as prescribed in the Administrative Rules. Benefit is limited to 30 days per protected person per calendar year, unless the Medical Adviser certifies the continuing need for convalescence or follow-up treatment and fixes the number of additional days.
2.4.	**THERMAL CURES** Thermal treatment prescribed by a physician and delivered in a thermal establishment.	80%	No	Cost of accommodation. Thalassotherapy. Ayurveda. Therapeutic fasting. Detoxification cure. Rejuvenation cure.	Subject to conditions prescribed in the Administrative Rules. Subject to prior confirmation from the Medical Adviser that the thermal cure is part of a course of treatment of an already present pathology.

Code	Items of expenditure	Benefits		Expenditure excluded from reimbursement (see also articles 2.1 and 2.4)	Qualifying conditions
		Ordinary (article 2.2)	**Supplementary** (article 2.5)		
2.5.	**STAY IN A NURSING HOME** Stays in a hospital, clinic, nursing or retirement home, temporary or respite care unit or day centre. Stays prescribed by a physician (other than for purposes of treatment, examination or diagnosis or for cure or convalescence) primarily for the provision of long-term care which cannot be provided at home.	80%	Yes		Subject to a maximum per day and other conditions, as prescribed in the Administrative Rules.
2.6.	**LONG-TERM NURSING SERVICES AT HOME** Nursing care for chronic or non-curative conditions, including the services of a carer or nursing assistant, prescribed by a physician.	80%	Yes	Non-medical care, such as housework, cooking, shopping, etc. Care provided by unqualified personnel, except where provided under the supervision of the prescribing physician.	Subject to a maximum per month and conditions prescribed in the Administrative Rules.
2.7.	**MEDICAL CARE IN INSTITUTIONS COVERED BY CODES 2.2 and 2.3, OR RELATED TO HOSPITALIZATION AT HOME**	80%	Yes		

Code	Items of expenditure	Benefits		Expenditure excluded from reimbursement (see also articles 2.1 and 2.4)	Qualifying conditions
		Ordinary (article 2.2)	**Supplementary** (article 2.5)		
3.	**PRESCRIBED MEDICINES** Pharmaceutical supplies, including drugs and dressings prescribed by a physician or dentist.	80%	Yes	Products excluded by the Administrative Rules. Common home pharmacy and household supplies. Parapharmaceutical products.	Subject to prescription PRIOR to purchase. Subject to the conditions as prescribed in the Administrative Rules.
4.	**DENTAL CARE** [2] (i) Odonto-stomatological treatment and laboratory charges for dentures (other than X rays – Code 1.3). (ii) Orthodontic treatment, including apparatus.	80%	Yes		Subject to a maximum and other conditions as prescribed in the Administrative Rules.

Code	Items of expenditure	Benefits		Expenditure excluded from reimbursement (see also articles 2.1 and 2.4)	Qualifying conditions
		Ordinary (article 2.2)	**Supplementary** (article 2.5)		
	Benefit in respect of the following treatments shall be paid not under Code 4 but under the codes indicated: (a) Maxilo-facial surgery in the event of hospitalization shall be reimbursed under Code 2.2 and 2.7. (b) Maxilo-facial treatments *specified in the Administrative Rules* shall be reimbursed under Code 1.2.				For (a) and (b), subject to approval by the Medical Adviser.
5.	**PROSTHESES, MEDICAL APPLIANCES AND OTHER MEDICAL DEVICES** (acquisition, rental and repair)				
5.1.	**OPTICAL APPLIANCES** (including contact lenses)	80%	Yes	Sunglasses without correction. Maintenance. Delivery costs. Insurance.	Subject to a maximum and other conditions as prescribed in the Administrative Rules.
5.2.	**HEARING AIDS** (including maintenance)	80%	Yes	Batteries. Delivery costs. Insurance.	Subject to a maximum as prescribed in the Administrative Rules.

Code	Items of expenditure	Benefits		Expenditure excluded from reimbursement (see also articles 2.1 and 2.4)	Qualifying conditions
		Ordinary (article 2.2)	**Supplementary** (article 2.5)		
5.3.	**PROSTHETIC APPLIANCES** (except dentures) Prescribed by a physician, including maintenance.	80%	Yes	Delivery costs.	Subject to approval by the Medical Adviser.
5.4.	**WHEELCHAIRS AND SIMILAR EQUIPMENT** Prescribed by a physician, including maintenance, delivery and set-up.	80%	Yes		Subject to approval by the Medical Adviser.
5.5.	**OTHER APPLIANCES** Prescribed by a physician, including maintenance, delivery and set-up.	80%	Yes	Cost of acquisition, rental and repair of minor or auxiliary medical appliances.	Subject to approval by the Medical Adviser.
6.	**TRANSPORT COSTS**				
6.1.	**TRANSPORT IN CASE OF EMERGENCY** Transportation of the protected person by ground or air ambulance from the place of the emergency to nearest place of treatment.	80%	Yes	Transportation is excluded in the following cases: (a) transport for personal convenience to a location other than the nearest appropriate place of treatment; (b) conditions sustained during the practice of a high-risk sport.	Subject to the conditions as prescribed in the Administrative Rules.
6.2.	**TRANSPORT IN CASE OF HOSPITALIZATION OR OUTPATIENT TREATMENT**				

Code	Items of expenditure	Benefits		Expenditure excluded from reimbursement (see also articles 2.1 and 2.4)	Qualifying conditions
		Ordinary (article 2.2)	**Supplementary** (article 2.5)		
6.2.1.	Transportation of the protected person from one hospital facility to another, or to a medical convalescence centre.	80%	Yes	Transportation for personal convenience and transportation for the purpose of obtaining treatment for the condition that led to hospitalization, where such transportation is not medically justified.	Subject to approval by the Medical Adviser, payment for either medical ground or air transportation or transportation by taxi, subject to the limit specified in the Administrative Rules.
6.2.2.	Ground transportation of the protected person, from the place of hospital confinement to her/his place of residence.	80%	Yes	Transportation for personal convenience and transportation which is not medically justified.	Subject to approval by the Medical Adviser, payment for either medical ground transportation or transportation by taxi, subject to the limit specified in the Administrative Rules. Ordinary benefit paid once per hospitalization at the end of the period of hospital confinement.
6.2.3.	Transportation of the protected person between her/his place of residence and the place of treatment, following a period of hospitalization, for the purpose of follow-up treatment of the condition that led to hospitalization.	80%	Yes		Medically justified transportation, either to the same facility as that at which the initial treatment was received, or to the place of treatment closest to the protected person's residence. Subject to approval by the Medical Adviser, payment for either medical ground transportation or transportation by taxi, subject to the limit specified in the Administrative Rules.

Code	Items of expenditure	Benefits		Expenditure excluded from reimbursement (see also articles 2.1 and 2.4)	Qualifying conditions
		Ordinary (article 2.2)	**Supplementary** (article 2.5)		
6.2.4.	For the treatment of certain chronic illnesses or conditions specified in the Administrative Rules, transportation of the protected person between her/his principal residence and the place where treatment takes place or is prescribed.	80%	Yes		Payment for transportation by taxi, subject to the limit specified in the Administrative Rules. Subject to approval by the Medical Adviser.
6.3.	**OTHER TRANSPORT FOR MEDICAL PURPOSES** Travel for the purpose of obtaining medical care where adequate medical care cannot be obtained in the duty station or area of residence.	80%	Yes	(a) Transportation for the purpose of evacuation of the protected person for health reasons, where the cost of evacuation is covered by the organization employing the insured person or by the employer of the protected person. (b) Transportation within the duty station or area of residence, as defined in the Administrative Rules.	Subject to prior approval by the Medical Adviser and to the other conditions specified in the Administrative Rules.
7.	**FUNERAL COSTS** (including cremation)	100%	No		Subject to a maximum as prescribed in the Administrative Rules.
8.	**PREVENTION**				
8.1.	**PREVENTIVE EXAMS, PROCEDURES AND SCREENING**	100%	No		Subject to conditions prescribed in the Administrative Rules, including the list of exams, preventive procedures and screenings eligible for reimbursement.

Code	Items of expenditure	Benefits		Expenditure excluded from reimbursement (see also articles 2.1 and 2.4)	Qualifying conditions
		Ordinary (article 2.2)	**Supplementary** (article 2.5)		
8.2.	**VACCINES**	100%	No		Subject to the conditions as prescribed in the Administrative Rules, including the list of vaccines eligible for reimbursement. Subject to medical prescription.
8.3.	**CONTRACEPTION** Contraceptive pills and other contraceptive devices.	80%	Yes	Male condoms. Female condoms.	Subject to medical prescription.
9.	**ALTERNATIVE MEDICINES** Treatments performed by a therapist qualified to practise in the country where treatment takes place.	80%	No		Subject to a maximum and other conditions as prescribed in the Administrative Rules, including the list of treatments eligible for reimbursement.

Code	Items of expenditure	Benefits		Expenditure excluded from reimbursement (see also articles 2.1 and 2.4)	Qualifying conditions
		Ordinary (article 2.2)	**Supplementary** (article 2.5)		
10.	**MEDICALLY ASSISTED REPRODUCTION** Ovarian stimulation, artificial insemination, in vitro fertilization (IVF) with or without intracytoplasmic sperm injection (ICSI), including related laboratory examinations.	80%	No	Surrogacy. Transport costs to the place of treatment.	Subject to a maximum and other conditions as prescribed in the Administrative Rules.

[1] General: All prescriptions for care or medicines must be made prior to the date of the service or the purchase.

[2] According to article 2.1.3 of the Regulations, “Medical practitioner shall refer to physicians or dentists who are qualified and licensed to provide the various types of medical services referred to in the Schedule of Benefits in the country in which their professional services are used by a protected person”.

Appendix II

Rules for elections

Electorate and eligibility

1. Elections shall be held for the six members of the Management Committee representing the insured persons of the International Labour Office.

2. All insured persons of the organization concerned by each ballot shall be eligible, with the exception of the following:

(a) the Director-General of the ILO, as well as the members of his/her Office;

(b) members of the Fund Secretariat;

(c) all persons previously found responsible for fraudulent acts against the interests of the Fund, the ILO or the ITU;

(d) all persons declared ineligible, pursuant to a decision taken in application of the provisions of paragraph 22(d).

Organization of elections

3. The election of members of the Management Committee shall be organized by three electoral officers appointed amongst the insured persons by the Management Committee not later than 1 August of the year preceding the year in which the term of office of the persons to be elected is to begin.

4. The electoral officers may not be candidates in the election. Members of the Management Committee and members of the Fund Secretariat may not be appointed as electoral officers.

5. The electoral officers shall ensure that the present Rules are applied and that the election meets democratic electoral principles. They shall carry out their duties in an entirely impartial and independent manner. All decisions of the electoral officers shall be considered to be collectively endorsed. The Fund Secretariat shall implement the decisions of the electoral officers, who may request legal advice from the ILO as they deem necessary.

6. Within the limits of the present Rules, the electoral officers establish the detailed rules regarding the submission of candidatures, election publicity and voting procedures, with due consideration to the principle of equal opportunity between candidates, in particular with respect to means of communication.

7. Not later than 1 September, the electoral officers shall send to all insured persons a notice of election, together with such other document as may be appropriate. This notice shall detail the rules established according to paragraph 6. A period of at least five weeks shall be allowed for the nomination of candidates, as well as a second period of at least five weeks for voting, in order to enable insured persons in duty stations away from Geneva to vote.

8. Nominations shall be signed by at least ten insured persons and be accompanied by the signed acceptance of the candidates.

9. In support of their nomination, candidates may provide an individual statement of particulars relating to their qualifications and experience and commitments should they be elected, in keeping with the procedures established by the electoral officers.

10. The electoral officers shall verify the candidatures and supporting statements. This procedure is strictly confidential. The relevant services at the ILO shall provide the electoral officers with all the information required so that the present Rules can be applied. Candidatures failing to meet the requirements established in the present Rules, or received after the deadline, shall be rejected.

11. Should the electoral officers consider that a statement submitted according to Rule 9 fails to meet the requirements established in the notice of election, they shall request the candidate in question to amend the parts concerned within two working days, failing which the electoral officers shall either delete these parts or reject the entire statement.

12. Candidates are responsible for all other election publicity, whether undertaken by themselves or on their behalf. They refrain from any use of means of communication not accessible to all candidates.

13. Not later than 1 November, the electoral officers shall distribute to all insured persons voting slips bearing the names of all the candidates whose candidatures fulfil the conditions of the present Rules, together with any statements submitted under Rule 9.

14. In elections of members representing the insured persons, each insured person may vote for not more than six candidates. The three candidates who receive the highest number of votes shall be declared titular members and the three candidates with the next highest number of votes shall be declared substitute members.

15. The electoral officers shall count the votes and make a report on the number of votes cast for each candidate and on the results of the elections. In the event of an equal number of votes being recorded between candidates, the electoral officers shall decide by lot.

16. The electoral officers shall send a notice to all insured persons to announce the election results. A copy of the electoral officers' report shall be posted on the staff notice board and posted on the SHIF web site. The original shall be placed in the archives of the Fund.

17. The electoral officers may decide that voting will be conducted either partially or in full by electronic means. Such being the case, they apply the present Rules with the necessary adjustments.

Settlement of disputes

18. The electoral officers shall examine all comments and complaints concerning the organization of the election and election procedures, and shall take any measure they deem necessary to ensure the regularity of the election. Their decision is final, except when the election result is contested in accordance with the paragraphs below.

19. The election result may be appealed before the Appeals Board, provided for in article 5.5 of the Regulations, whose decisions cannot be further appealed.

20. To be receivable, any appeal against the election result must:

(a) be presented with reasons specified and submitted in writing to the Appeals Board by a candidate, or a person insured by the Fund who has a cause of action, or by the Management Committee; and

(b) be made within ten working days of the announcement of the election results.

21. The decision of the Appeals Board shall either:

(a) uphold the election result, without making a recommendation; or

(b) uphold the election result, with an accompanying recommendation that shall then be examined by the incoming Management Committee; or

(c) cancel the election completely or partially; the Chairperson of the outgoing Management Committee, as well as the Director-General of the ILO, shall be notified of this decision; or

(d) invalidate a candidate's election and, where appropriate, render him/her ineligible for a certain period.

22. The election shall not be completely or partially cancelled if it is clear that an observed irregularity did not influence the election results.

23. The Appeals Board shall reach a decision within 30 working days of its constitution. Should the Appeals Board be unable to reach a decision within this period, the appeal, together with an explanatory note on the reasons for the Board's failure to reach a decision within the given period, shall be sent to the Director-General of the ILO for decision. The decision reached by either the Appeals Board or the Director-General of the ILO is irrevocable.

24. Should the election be completely or partially cancelled, members of the outgoing Management Committee who represent insured persons shall remain in office for a sixth-month period commencing on the date the Chairperson of the Committee receives notification from the

Chairperson of the Appeals Board of the decision to cancel the election. During this period, the Management Committee shall deal with the day-to-day running of the Fund and organize new elections, full or partial as applicable, the results of which must be announced before the end of the six-month period.

Administrative Rules

Chapter I. (Coverage)

Article 1.2.1

(Compulsorily insured persons)

1. The list of related organizations at 15 May 2014: CTBTO, FAO, IAEA, ICAO, IFAD, IMF, IMO, ITU, OPCW, UNESCO, UNIDO, UPU, WHO, WIPO, WMO, WORLD BANK (group), WTO (Tourism) and WTO (Trade).

2. The list in paragraph 1 above also applies to subparagraph (d) of article 1.3 (Voluntarily insured persons) of the SHIF Regulations.

Article 1.3(c)

(Voluntary insurance after cessation of service)

1. Where an insured person applies for voluntary insurance under article 1.3(c) of the Regulations, he/she shall state the period for which such insurance is required. This period shall normally be fixed in complete months (with maximum of six months). In exceptional cases, the Secretary may accept an application for shorter periods, notably where it is likely that paragraph 3 of this Rule would apply.

2. The period fixed as above may not thereafter be extended.

3. If during the period in question the insured person becomes subject to compulsory health insurance, he/she may apply for refund of contributions in respect of the period of such insurance.

Article 1.5.1

(Automatically covered dependants)

1. Where an insured person, under the personal law to which he/she is subject, has more than one spouse, the following rules apply:

(i) only one spouse will be an automatically protected dependant, even if family allowance is divided among more than one spouse;

(ii) the automatically protected spouse will be the one to whom the official has been married the longest;

(iii) the official may apply for voluntary insurance under article 1.6.1(a) for the other spouses.

2. In accordance with article 1.5.1(a) of the Regulations, coverage is automatically extended to officials' dependants provided that family allowances would be paid if the conditions of employment applicable to the insured person concerned included provision for family allowances corresponding to those contained in the respective Staff Regulations applicable to headquarters' staff. This means:

(i) Where there is no family allowance for spouse payable under the rules governing the conditions of employment in the particular office, provided the spouse does not earn more than step 1 of level 1 of the General Service category scale for the office in question, the Fund covers him or her automatically.

(ii) Where the spouse's annual earnings exceed the above level, the official may apply for voluntary insurance under article 1.6.1(a).

(iii) Any child excluded from entitlement to family allowance merely because of a condition limiting the number of children in respect of whom an allowance can be paid shall nevertheless be automatically covered.

3. Where, under the relevant Staff Regulations or Rules, family allowance becomes payable retroactively, the dependant concerned shall be deemed to have been automatically protected as from the relevant date. The insured person and the employing organization shall pay contributions at the applicable rate on the amount of the allowance as from the same date. Any contribution which may have been paid in respect of the dependant during the period in question under article 3.5 (Contributions in respect of voluntarily protected dependants) shall be repaid to the insured person.

4. Where the retired spouse of an insured person who would otherwise be an automatically covered dependant maintains protection under the health insurance scheme applicable prior to retirement, the insured person, by notification to the Executive Secretary, may opt not to have the spouse treated as an automatically covered dependant, in which case the spouse's pension shall be disregarded in assessing the contribution of the insured person.

5. No one who is an insured person may at the same time be protected by the Fund under any other status.

Article 1.6

(Voluntarily covered dependants)

1. Subject to paragraph 2 below, where under the relevant Staff Regulations a family allowance is cancelled retroactively, the dependant concerned shall be deemed to have been voluntarily protected as from the relevant date. The insured person shall pay to the Fund contributions in respect of the dependant as from the same date in accordance with article 3.5. The contributions paid by the insured person and the employing organization during the period in question on the amount of the family allowance shall be repaid to them. The insured person may discontinue the voluntary protection of the dependant concerned, by notice to the Fund, at the end of the month following the cancellation of the family allowance; otherwise, the protection will continue in accordance with article 1.6.

2. In the cases referred to in paragraph 1 above the insured person may, on providing evidence that the dependant concerned has been insured under another health insurance scheme since the relevant date, discontinue retroactively to that date the protection of the dependant concerned by notice to the Fund. The insured person shall repay to the Fund any benefits paid in respect of the dependant concerned during the period in question, and the contributions paid by the insured person and the employing organization during that period on the amount of the family allowance shall be repaid to them.

3. Although voluntarily protected persons are generally to be covered for renewable periods of one year, protection will cease:

(a) if the insured person ceases to be protected;

(b) whenever the qualifying conditions mentioned in article 1.6 are no longer met (for example, when a child attains the age of 30 years, marries or takes up full-time employment).

4. In respect of children who are voluntarily protected under article 1.6.1(b) and in respect of parents or parents-in-law who are voluntarily protected under article 1.6.1(c), the insured persons may be required from time to time to certify that the conditions stated in this article continue to be satisfied.

Chapter II. (Benefits)

Article 2.4

(Exclusion or limitation of liability for the payment of benefits)

The exclusion from benefit of surgery for aesthetic purposes and incidental medical care provided for in article 2.4, paragraph 1(c), and in the Schedule of Benefits shall not apply to surgery or treatment made necessary by an accident or as a consequence of a surgical operation undergone for health reasons and qualifying for benefit.

Article 2.5.3

(Supplementary benefits)

1. The supplementary benefit threshold is set for each insured person at 25.0 per cent of relevant annual income, subject to the following:

(a) "relevant income" means the income on the basis of which each insured person's contributions are assessed, in accordance with the applicable provisions of articles 3.2, 3.3 or 3.4 of the Regulations. Relevant annual income is obtained by multiplying by 12 the full monthly relevant income;

(b) the threshold is set once a year, on 1 January, for the entire calendar year on the basis of the insured person's relevant income for the month of January;

(c) when protection begins after 1 January, the threshold for the balance of the calendar year is based on the insured person's relevant income for the month for which the first full monthly remuneration is received;

(d) when the insured person retires in the course of the month of January, the threshold for the balance of the calendar year is based on the relevant income for the month for which the first full monthly pension is received.

2. The supplementary benefit rate is set at 20.0 per cent.

3. The Management Committee shall regularly review the level of the supplementary benefits threshold and rate, at least every two years, before the start of each financial period of the ILO.

Article 2.8

(Third-party liability)

1. At the request of the member concerned, and upon presentation of the payment justification generally required for entitlement to benefit, the Fund shall advance an amount not exceeding the ordinary benefits and, if conditions are met, the amount of supplementary benefits that would be payable if third-party liability were not involved, which would be paid at the same time when other supplementary benefits are paid.

2. Subject to article 2.8, paragraph 3, such advances shall be repaid to the Fund at the time of the award of compensation or at such other date as may be decided by the Management Committee or the Standing Subcommittee acting for that Committee, where the required legal action has not been proceeded with or completed.

Article 2.10

(Payment of benefit)

1. Benefits shall generally be paid in the currency of the official's duty station. However, in exceptional circumstances, when unusually high expenses oblige an insured person to withdraw funds from a country other than that of his/her duty station, benefits may be paid in another currency.

2. By delegation of the Management Committee, the Executive Secretary may authorize reimbursement of bills presented beyond the time limits indicated in article 2.10.3 of the Regulations. In such cases the member concerned should make a special request giving the reasons for the delay.

Article 2.13

(Exchange rates)

1. The United States dollar (US$) maximum approved expense limits stated in Chapter VI (Schedule of Benefits) of the Administrative Rules shall be automatically adjusted by dividing those limits by the United Nations operational rate of exchange for the relevant month and multiplying the result by an exchange rate of reference for the US$ versus the Swiss franc (CHF) set by the Management Committee. However, the US$ maximum approved expense limit shall never be inferior to that stated in Chapter VI of the Administrative Rules.

2. The exchange rate of reference from 1 January 2009 is CHF1.30 to US$1.00.

3. The Management Committee may decide, in respect of Code 4 (Dental care) or of Code 5.1 (Optical appliances) of the Schedule of Benefits, to adjust the US$ approved expense year-end balances, using the same methodology as that applied for the adjustment of US$ approved expense limits.

Chapter III. (Financing)

Article 3.2.1

(Assessment in respect of officials and their automatically covered dependants)

The contributions due in respect of part-time officials and their automatically covered dependants insured under article 1.5 shall be assessed on their actual earnings (instead of notional full-time earnings) when, and for so long as, the official pays contributions under article 3.3 or article 3.4 of the Regulations (in which case the contribution will be assessed on the amount of the pension plus the earnings from part-time employment).

Article 3.2.4

(Remuneration)

A. Allowances which form part of remuneration for the purpose of calculating contributions:

- non-resident and expatriation allowance;
- family allowance and dependency benefits;
- language allowance;
- special post allowance;
- post adjustment;
- mobility incentives, hardship and non-family service allowances;
- special duty allowances (if paid on an annual basis).

Family allowances payable to an insured person at a reduced rate by virtue of the receipt of allowances by the insured person's spouse are assessed on the amount actually paid to the insured person.

(See also under articles 1.5 and 1.6 in respect of family allowances payable or cancelled retroactively.)

B. Payments which do not form part of such remuneration:

- settling in grant;
- compensation for overtime work;

- education grant;
- night differential;
- rental subsidy;
- repatriation grant;
- representation allowance;
- special duty allowance (if paid occasionally);
- travel and mission (daily subsistence allowance);
- all forms of termination indemnity including:
  - indemnity on reduction of staff;
  - indemnity in case of death;
  - payment in lieu of notice.

Article 3.3

(Assessment in respect of former officials and their automatically covered dependants insured under article 1.5)

Article 3.4

(Assessment in respect of survivors and their automatically covered dependants)

1. In accordance with articles 3.3 and 3.4, contributions assessed on pensions payable to former officials and survivors, in respect of their own insurance and in respect of insurance for their automatically covered dependants insured under article 1.5, shall be adjusted once a year on the basis of the pension payable for the month of October in each year, with effect from the beginning of the following year.

2. Where a former official who is voluntarily insured under article 1.3(d) is re-engaged by the ILO under conditions entailing compulsory insurance by the Fund, the assessment of contributions during the period of compulsory insurance will be governed by article 3.2 (Assessment in respect of officials and their automatically covered dependants). Upon completion of the period of compulsory insurance, the basis of assessment of contributions under article 3.3 will revert to that applicable prior to that period, without regard to the conditions of remuneration prevailing during that period.

3. Contributions under articles 3.3 and 3.4 shall be calculated on the basis of the pension in the currency by reference to which the pension entitlement is for the time being fixed.

4. For the purpose of calculating the pension which would have been received if an official or former official had contributed during 25 years to the applicable pension scheme, mentioned in article 3.3, paragraph 1(a)(ii), and article 3.4, paragraph 1(a)(ii), the following rules shall be applied:

(a) Where pension entitlements have arisen from more than one period of pensionable service, account shall be taken of the aggregate pension and the aggregate period of contributory service.

(b) The pension in respect of 25 years of contributory service shall be calculated on the basis of the actual pension received, divided by the actual years of contributory service and multiplied by 25, irrespective of any variations in the rate of accumulation of pension and of the person's age at the date of retirement. In the case of persons to whom the transitional provision to articles 3.3 and 3.4 applies (persons who retired prior to 1 January 1989 and their survivors), the reference to 25 years of contributory service and the multiplier of 25 shall be replaced by references to 20 years and a multiplier of 20.

5. For the purposes of application of article 3.3, paragraph 3 (concerning persons who have deferred their pension), the amount specified in paragraph 1(a)(ii) of that article shall be calculated by reference to the amount of the deferred pension to which the person concerned will be entitled.

Article 3.5

(Contributions in respect of voluntarily protected dependants)

▶ **Rates of contributions** (US$)

Category	Monthly contribution as of 1 July 2018	
Children under 30 years of age	3.55% of remuneration, subject to a maximum of	260.00
Spouses		650.00
Parents and parents-in-law		1 400.00

Article 3.7

(Contributions in respect of voluntary coverage)

1. Contributions due from persons who are voluntarily insured in accordance with article 1.3(d), (e) or (f) of the Regulations shall be deducted from the pension each month, under arrangements agreed with the pension funds concerned.

2. Contributions due from persons who are voluntarily insured in accordance with article 1.3(a) or (b) of the Regulations and, where deduction at source from the pension is not possible from persons insured under article 1.3(d), (e) or (f), shall be due quarterly in advance on 1 January, 1 April, 1 July, and 1 October, the first payment to be made in respect of the period from the beginning of voluntary insurance to the end of the next complete quarter.

3. Contributions due from persons who are voluntarily insured in accordance with article 1.3(d), (e) or (f) of the Regulations shall normally be paid in the currency of entitlement of the pension. Exceptionally, the Executive Secretary may accept payment in another currency.

4. Where the precise amount on which the contribution is to be assessed is not yet ascertained, the Executive Secretary of the Fund may fix a provisional amount, having regard to all known elements, and contributions shall be paid accordingly. The necessary additional payments or refund shall be made on the basis of the actual amount assessable once it has been ascertained.

5. Contributions due from persons voluntarily insured in accordance with article 1.3(c) of the Regulations shall be paid in advance for the whole period of protection chosen.

6. Arrangements may be made for the transmission of payments through an external office of the organization.

Chapter IV. (Administration)

Article 4.18

(Arbitration Board)

The composition of the panel provided for in article 4.18, paragraph 2, of the Regulations shall be reviewed and endorsed by the Management Committee at least at the beginning of every new term of office of the members representing the insured persons.

Chapter V. (Miscellaneous)

Article 5.1

(Interruption of protection or service)

For the purposes of application of article 5.1, paragraph 3, of the Regulations a period of protection under article 1.3(c) shall be assimilated to a period of service.

Article 5.2

(Forms and authorizations)

1. Insured persons shall submit claims for benefit under cover of form ILO 937, "Claim for reimbursement" or via personalized access to the secure website of the SHIF.

2. Claims for reimbursement submitted using form ILO 937 shall be accompanied by the original ibills and other supporting documents, and shall be in accordance with the conditions prescribed on the form.

3. Claims for benefit submitted via personalized access to the secure website of the SHIF shall be accompanied by electronic copies of the original bills and of the other supporting documents, and shall be in accordance with the conditions prescribed on the site. The original invoices and supporting documents shall be retained by the insured person for a period of five years from the date of reimbursement and shall be submitted to the SHIF upon request for administrative purposes or for verification.

Article 5.5

(Disputes on questions other than of a medical nature)

The members of the Appeals Board provided for in article 5.5, paragraph 2, of the Regulations shall be nominated for a term of three years, renewable once. If it is not possible to fill a vacancy in due time, the Management Committee may exceptionally extend the term of a member until the vacancy is filled.

Appendix I

(Schedule of Benefits)

Code 1.5

(Functional rehabilitation treatments)

1. (a) The maximum approved expenses are set at US$100.00 per session (i.e. ordinary benefit will be limited to US$80.00 per session). The maximum number of sessions reimbursed is set at 40 sessions per protected person per calendar year.

(b) The number of sessions may be exceeded for cases of rehabilitation after an accident, a major surgery, a neuromuscular disease, an osteoarticular pathology or a disability, where the Medical Adviser confirms the necessity and indicates the number of additional sessions.

(c) Once every 12 months a new prescription will be required in all cases.

2. Only the treatments listed below are eligible for reimbursement:

- physiotherapy/kinesitherapy;
- speech and language therapy;
- handwriting therapy;
- orthopty/optometry;
- ergotherapy;
- psychomotor therapy;
- lymphatic drainage (if lymphatic system affected);
- chiropody/pedicure for medical reasons.

Code 1.6

(At-home medical nursing services for an acute condition)

The maximum approved expenses are set at US$2,500.00 per protected person per calendar year (i.e. ordinary benefit will be limited to US$2,000.00 per protected person per calendar year), unless the Medical Adviser certifies that nursing is still for an acute condition.

Code 1.7

(Psychiatry, psychoanalysis or psychotherapy)

1. The maximum is set at 40 sessions or US$4,000.00 of approved expenses (i.e. ordinary benefit US$3,200.00), whichever comes first, per person per calendar year.

2. Subject to approval by the Medical Adviser, the maximum number of sessions or the maximum approved expenses may be increased to up to 20 additional sessions or an additional US$2,000.00 of approved expenses per calendar year (i.e. a maximum ordinary benefit of US$1,600.00).

Code 2.2

(Costs of accommodation in a hospital establishment, in a room other than a common ward)

1. The maximum approved expenses and maximum ordinary benefit for accommodation in a hospital or clinic for examination, diagnosis or curative treatment (reimbursable at 80 per cent under Code 2.2) shall be the cost of a semi private room, subject to the following ceilings:

Country	**Applicable from 1 April 2004**	
	Maximum approved expenses (US$ per day)	**Ordinary benefit** (US$ per day)
Canada, United States, Switzerland	500.00	400.00
All other countries	400.00	320.00

Where the institution in question offers only private accommodation, the accommodation costs applied as the basis for reimbursement shall be 80 per cent of the cost of the room.

2. When a global charge is made, a maximum approved expense of reference will be attributed to accommodation and the balance of the global charge to medical services. The ordinary benefit maximums stated in paragraph 1 above will, however, apply.

3. The maximum approved expense of reference from 1 July 2011 is US$550.00.

4. Where the maximum approved expense of reference exceeds one third of a daily global charge, one third of the global charge will be attributed to accommodation and the balance of the global charge to medical services. The ordinary benefit maximums stated in paragraph 1 above will, however, apply.

Code 2.3

(Costs of accommodation for convalescence/follow-up treatment)

1. The maximum approved expenses per day are set at US$200.00 (and the ordinary benefit per day is limited to US$160.00).

2. When a global charge is made, one-third of the global charge will be attributed to accommodation and two-thirds to medical care.

Code 2.4

(Thermal cures)

Benefit is limited to one thermal cure in any calendar year, with a maximum duration of three weeks and a minimum of 15 days of treatment.

Code 2.5

(Stay in a nursing home)

1. The maximum approved expenses for stays in a nursing home are set at US$150.00 per day (i.e. a maximum ordinary benefit of US$120.00).

2. Benefit in respect of stays in a nursing home is subject to approval by the Medical Adviser.

Code 2.6

(Long-term nursing services at home)

1. The maximum approved expenses for long-term nursing services at home are set at US$3,450.00 per month (i.e. a maximum ordinary benefit of US$2,760.00).

2. (a) Benefit in respect of long-term nursing services at home is subject to approval by the Medical Adviser.

(b) The nature of the nursing services required shall be indicated on a medical prescription.

Code 3

(Prescribed medicines)

1. Expenditure for items and supplies included in the following (non-exhaustive) list shall be excluded from reimbursement under Code 3:

- small adhesive dressings, or household bandages;
- distilled water and mineral waters;
- dentifrice (any kind);
- toothbrushes;
- toothpicks;
- cleaning tablets for dentures;
- personal hygiene products, such as cleaning cloths, talc, ear swabs, etc.;
- sea salt;
- bath salts;
- cotton wool;
- corn plasters;
- pedicure products;
- sunburn lotions;
- dietetic products;
- deodorants;
- shampoos and hair restorers;
- household disinfectants;
- special cosmetics, notably those for sensitive or allergic skin;
- cleaning liquid for contact lenses;
- alcohol, wine and liquors.

2. Where pharmacy items are purchased more than once, the prescription must specify clearly how many times or for which period they are to be repeated. A simple indication such as “to be repeated” will be considered as a prescription for one renewal only.

3. Once every 12 months a new prescription will be required in all cases.

4. Medication considered non-reimbursable in Switzerland and France in accordance with the list of officially recognized medication does not, in principle, give entitlement to benefits by the Fund unless it is established that they give entitlements to benefits within the scope of the

general health insurance system of the country, other than Switzerland or France, in which the products were prescribed.

Code 4

(Dental care)

1. No benefit shall be payable in respect of treatment undertaken within one year of protection.

2. Thereafter, the maximum approved expenses are set at US$1,500.00 per protected person per calendar year (i.e. ordinary benefit US$1,200.00).

3. The balance of approved expenses remaining at the end of any calendar year shall be carried over and added to the entitlement for the following year, subject to a maximum carry over from one year to the next of US$4,500.00 (i.e. ordinary benefit US$3,600.00).

4. The following treatments or procedures shall not be considered as dental care, but as medical care for the purpose of benefit:

(i) treatment of cranio-facial malformation;

(ii) facial fissure surgery;

(iii) orthognathic (jaw) surgery;

(iv) bone grafts not associated with dental care;

(v) treatment of temporomandibular joint dysfunction;

(vi) treatment of congenital dental agenesis.

Code 5.1

(Optical appliances)

1. No benefit shall be payable in respect of acquisition or repair within one year of protection.

2. Thereafter, the maximum approved expenses are set at US$320.00 per protected person per calendar year (i.e. ordinary benefit US$256.00).

3. Within the maximum specified in paragraph 2, benefit for frames shall not exceed US$100.00.

4. The balance of approved expenses remaining at the end of any calendar year shall be carried over and added to the entitlement for the following year, subject to a maximum carry over from one year to the next of US$960.00 (i.e. ordinary benefit US$768.00).

5. The Management Committee may authorize payment of benefit beyond the maximum where, as a result of surgery, the condition of the eyes requires changes of lenses.

Code 5.2

(Hearing aids)

1. No benefit shall be payable in respect of acquisition or repair within one year of protection.

2. The approved expenses shall be limited to US$3,750.00 (i.e. ordinary benefit US$3,000.00) per ear in the period of three calendar years.

Code 6.1

(Transport in case of an emergency)

1. An emergency is a sudden unexpected event requiring immediate medical intervention.

2. Transportation by ground or air ambulance, as appropriate, must be the only appropriate means of transportation in view of the seriousness of the medical condition and of the other circumstances of the emergency.

3. It is left to the discretion of the medical team providing the transportation to determine the nearest place of treatment.

4. A “high-risk sport” is a sport that carries an aggravated risk of fall, impact, injury or illness, including (but not limited to) winter sports, water and underwater sports other than swimming, aerial sports and activities involving the use (as pilot or passenger) of private aircraft, combat sports, shooting sports and activities, the use of motorized vehicles for sporting purposes, climbing, mountaineering or rock climbing. In such cases, it can reasonably be expected of the protected person that he/she take out insurance specifically covering cases of emergency.

Code 6.2

(Transport in case of hospitalization or outpatient treatment)

1. Repatriation, personal convenience and the right to a free choice of medical practitioner, pharmacist and medical establishment as per article 2.1 of the Regulations do not in themselves constitute medical justification for transportation.

2. For transportation by taxi, the maximum approved expenses are set at US$500.00 per one-way journey.

3. The chronic illnesses and conditions eligible for reimbursement under Code 6.2.4 are:

- kidney failure requiring dialysis;
- cancers requiring chemotherapy or radiotherapy;
- incapacitating neuro-degenerative conditions.

Code 6.3

(Other transport for medical purposes)

1. Repatriation, personal convenience and the right to a free choice of medical practitioner, pharmacist and medical establishment as per article 2.1 of the Regulations do not in themselves constitute medical justification for transportation.

2. “Area of residence” means the area contained within a 100 km radius of the protected person’s residence.

3. Benefits are subject to prior approval by the Medical Adviser, who:

(i) certifies that adequate medical care cannot be obtained in the duty station/area of residence;

(ii) identifies the nearest place at which adequate medical care can be obtained.

4. Travel costs shall be paid only if the care is obtained in the nearest place identified by the Medical Adviser under paragraph 2 above.

5. The Executive Secretary may however decide to reimburse costs for travel to a place other than the nearest place identified by the Medical Adviser, such decision being based either on the preservation of the health or safety of the protected person, or on the financial interest of the Fund.

6. Benefits are paid only in respect of the cost of the cheapest ticket by the cheapest means of transportation available. Preference should be given to public transportation.

Code 7

(Funeral costs)

The maximum benefit is set at US$750.00.

Code 8.1

(Preventive exams, procedures and screening)

1. Only the exams listed below are eligible for reimbursement at a rate of 100 per cent:

- prostate-specific antigen (PSA) and digital rectal exam every year from age 50;
- mammogram every two years from age 40;
- pap smear and pelvic exam every two years;
- faecal occult blood screening in stool every year from age 50;
- colonoscopy every five years from age 50.

2. The preventive procedures and screenings listed below are eligible for reimbursement at a rate of 100 per cent:

- dental scaling every year;
- HIV screening, subject to a maximum approved expense of US$100.00;
- hepatitis B and C screening, subject to a maximum approved expense of US$100.00;
- prenatal screening.

3. More frequent preventive exams, procedures and screenings listed above shall be reimbursed at a rate of 80 per cent.

Code 8.2

(Vaccines)

1. The vaccines listed below are eligible for reimbursement at a rate of 100 per cent:

- influenza;
- BCG (tuberculosis) and tuberculin tests;
- COVID-19

- diphtheria;
- haemophilus influenzae type b;
- hepatitis A;
- hepatitis B;
- herpes zoster (shingles);
- human papillomavirus;
- Japanese encephalitis;
- measles;
- meningococcal conjugate vaccines A, C, W135 and Y;
- mumps;
- pertussis (whooping cough);
- pneumococcal polysaccharide conjugate vaccine;
- poliomyelitis;
- rabies;
- rotavirus;
- rubella (German measles);
- tetanus;
- typhoid fever;
- varicella (chickenpox);
- yellow fever.

2. If billed separately, the physician’s or nurse’s fee will be reimbursed at a rate of 80 per cent.

Code 9

(Alternative medicines)

1. The maximum approved expenses are set at US$1,200.00 per protected person per calendar year (i.e. a maximum ordinary benefit of US$960.00 per protected person per calendar year).

2. Only the treatments listed below are eligible for reimbursement:

- acupuncture;
- chiropractic;
- Ayurvedic medicine;
- traditional Chinese medicine;
- mesotherapy;
- osteopathy.

Code 10

(Medically assisted reproduction)

The maximum approved expenses are set at US$30,000.00 per protected person for the entire period or periods of membership.