

ILO
STAFF HEALTH INSURANCE FUND (SHIF)

Notification of proposed amendments to the SHIF Regulations and Administrative Rules

Proposed amendments to the Regulations

- Article 1.6 (*Voluntarily covered dependants*)
- Article 2.4 (*Exclusion or limitation of liability for the payment of benefits*)
- Article 2.5 (*Supplementary benefits*)
- ~~Article 2.6 (*Maximum liability*)~~
- Article 2.7 (*Protection by other health insurance schemes or services*)
- Article 2.10 (*Payment of benefits*)
- Article 2.11 (*Suspension and forfeiture of entitlements*)
- Article 5.6 (*Effective date of these Regulations*)

Proposed amendments to Appendix I: Schedule of benefits

- Code 1.1 (*Doctor's services*)
- Code 1.4 (*Laboratory services and other tests*)
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- Code 1.7 (*Psychoanalysis or Psychotherapy*)
- ~~Code 1.8 (*Nutrition*)~~
- Code 2.7 (*Medical care in institutions covered by Codes 2.2 and 2.3, or related to hospitalization at home*)
- Code 5.2 (*Hearing aids*)
- Code 8.2 (*Vaccines*)

Amendments to the Administrative Rules

- Article 1.6 (*Voluntarily covered dependants*)
- Article 2.5.3 (*Supplementary benefits*)
- Article 2.10 (*Payment of benefits*)
- Article 5.2 (*Forms and authorizations*)
- Code 1.4 (*Laboratory services and other tests*)
- Code 1.5 (*Functional rehabilitation treatments*)
- Code 3 (*Prescribed medicines*)
- Code 4 (*Dental care*)
- Code 5.2 (*Hearing aids*)
- Code 5.5 (*Other appliances*)
- Code 6.2 (*Transport in case of hospitalization or outpatient treatment*)
- Code 8.1 (*Preventive exams, procedures and screening*)
- Code 8.2 (*Vaccines*)

Purpose of the circular

1. The purpose of this circular is to notify all persons insured under the ILO Staff Health Insurance Fund (SHIF) of proposed amendments to the SHIF Regulations under article 4.17 ("Amendments to the Regulations"), and to inform them of amendments to the Administrative Rules.
2. The SHIF Management Committee discussed in detail the proposed amendments at its 284th, 285th, 286th, 287th and 288th meetings and approved them at its 289th meeting on 27 August 2025. The proposed effective date of these amendments is 1 January 2026.
3. The proposed amendments are explained in detail below. All of the proposed amendments are appended to this circular, with the changes tracked.

Purpose of the amendments

4. The proposed amendments to the SHIF Regulations, to Appendix I (Schedule of benefits), and to the Administrative Rules, which fall within the authority of the Management Committee, are aimed at responding to recommendations from the External Auditors, clarifying administrative procedures, adjusting certain benefits and eliminating the maximum liability of the Fund.

Background and proposed Amendments to the Regulations

5. According to article 4.14 of the SHIF Regulations, "Findings from the ILO External Auditor's review shall be reported by the External Auditor". The External Auditor has recently made a number of recommendations to the SHIF Management Committee regarding article 2.5 (Supplementary benefits), article 2.7 (Protection by other health insurance schemes or services) and article 2.10 (Payment of benefits), requesting to update in the Regulations decisions of the SHIF Management Committee or of the Secretariat that were not entirely reflected in the Regulations. The amendments reflect the changes.
6. At the same time, under its mandate to ensure that the coverage provided by the Fund continues to meet the needs of all insured members, the Management Committee decided to propose certain amendments to its Regulations and Administrative Rules.
7. An important amendment is the elimination of article 2.6 (Maximum liability). While, the Management Committee has always authorized payment of further benefits when necessary, the article may inhibit access to healthcare of the SHIF insured in some countries. The Management Committee felt that article 3.8 of the SHIF Regulations provides a sufficient basis to safeguard the financial position of the Fund.
8. Some amendments aim at improving the reimbursement of some services provided in a pharmacy, such as consultations with a pharmacist and tests and vaccinations administered. A new code for Nutrition has been created (Code 1.8). The requirements for the reimbursement of psychoanalysis or psychotherapy sessions have been simplified (no more need for a medical prescription). Likewise, there is no more need for a medical prescription to be reimbursed for vaccines either; in addition, the list of vaccinations eligible for reimbursement at 100 per cent has been removed and all vaccinations will now be fully reimbursed.
9. The amendments also aim to clarify the conditions for reimbursing prescribed medicines (Code 3), exclude from reimbursement medical check-ups and wellness treatments when they are offered as a package and exclude anti-ageing treatments. While the amendments extend the list of items covered under hearing aids (Code 5.2), reimbursement of hearing aids are excluded from entitlement to supplementary benefits and the approved expenses specified

under that code will be for a five-year period instead of a three-year period. It is recalled that the coverage of hearing aids was significantly improved in 2022.

10. Another amendment seeks to remove the requirement for a child to be unmarried to remain voluntarily covered by the SHIF.
11. Finally, the amendments also clarify the rules for reimbursement of bills that are established in languages other than English, French, Italian or Spanish. They also give the option to the SHIF Medical Adviser to limit the quantities of medical appliances eligible for reimbursement, allow the SHIF to make periodic reimbursements for orthodontic treatment when payment is made at the beginning of treatment and reduce the time limit for submitting bills to 18 months (instead of 21 months) from its date of issuance and to 24 months (instead of 27 months) from the date of treatment.

Procedure

12. In accordance with article 4.17, paragraph 2, of the SHIF Regulations:

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.

Florian Léger
Executive Secretary
Staff Health Insurance Fund

24 October 2025

Proposed amendments to the SHIF Regulations and Administrative Rules

SHIF Regulations

(Note: Text in red and underlined shows additions or changes. Text in strikethrough shows deletions).

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 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;~~
- ~~(ba)~~ in respect of medical care arising out of military service;
- ~~(eb)~~ 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);
- ~~(dc)~~ 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;~~
- ~~(fd)~~ 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.~~

54. 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: to submit the primary insurance scheme's statement of benefit indicating the benefits received or to be received in respect of the expenditure in question.

~~(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 2.10

Payment of benefits

1. In accordance with article 1.1, paragraph 2, benefits shall normally be paid only to the insured person or to their estate. 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~~ should become payable once the treatment has been received and 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 expenses is-are incurred allows for the deferred payment of bills. ~~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 ~~27-24~~ 24-18 months after the date when they were made out or more than ~~27-24~~ 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.

7. 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 to medical providers in the country where the expenses are incurred.

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 insured person does not comply with the provisions of these Regulations and the Administrative Rules, including:

- (a) if the insured person or the insured 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 insured 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 5.6

Effective date of these Regulations

These Regulations came into force on 1 April 1969. All amendments adopted up to ~~6-27 October August 2021-2025~~ 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, including a psychiatrist), or in a hospital or clinic.			Medical check-up package ³ Wellness package ³	
	CONSULTATIONS with a pharmacist.				
	VISITS to home or institutions by a physician.				
	TREATMENTS given by a physician.			Treatments for aesthetic purposes. Anti-ageing treatments. Treatments specified in Code 1.7.	
	CONSULTATIONS with a dietician.				Subject to medical prescription and approval by the Medical Adviser. 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.

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)		
1.2.	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.	
1.4.	LABORATORY SERVICES AND OTHER TESTS Made or prescribed by a physician <u>or administered (without prescription) by a pharmacist.</u>	80%	Yes		<u>Subject to the conditions as prescribed in the Administrative Rules.</u>
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. <u>Therapies or treatments considered alternative or complementary in the country where they are administered.</u>	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, <u>except otherwise provided in the Administrative Rules.</u>

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)		
1.7.	PSYCHOANALYSIS OR PSYCHOTHERAPY Sessions of psychoanalysis or psychotherapy given or prescribed by a physician delivered by a psychotherapist, psychologist or clinical social worker who holds a diploma recognized by the administration of the country in which he or she is authorized to practise.	80%	Yes	<u>Coaching sessions</u>	Subject to a maximum and other conditions as prescribed in the Administrative Rules.
1.8.	<u>NUTRITION</u> CONSULTATIONS with a dietician <u>or nutritionist</u>	<u>80%</u>	Yes		Subject to medical prescription and approval by the Medical Adviser. Treatments are reimbursed in case of obesity (body mass index greater than 30), anorexia or metabolic disorders, <u>digestive system illnesses, food allergies or allergic reactions, and malnutrition</u> , if prescribed by a physician and carried out in a recognized facility, where appropriate.
2.7.	MEDICAL CARE IN INSTITUTIONS COVERED BY CODES 2.2 and 2.3, OR RELATED TO HOSPITALIZATION AT HOME	80%	Yes	<u>Anti-ageing treatments</u> <u>Medical check-up package ³</u> <u>Wellness package ³</u>	

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)		
5.2.	HEARING AIDS (including <u>hearing aid charger, binaural or monaural hearing aid fitting or service package, and maintenance</u>)	80%	Yes <u>No</u>	Batteries. Delivery costs. Insurance.	Subject to a maximum as prescribed in the Administrative Rules.
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 <u>and other conditions as prescribed in the Administrative Rules.</u>
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.

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".

³ Medical check-up package or Wellness package presenting an integrated bundle of services which is primarily preventive and not curative.

Administrative Rules

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.

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. However, if an official works part time, the relevant income shall be assessed on the basis of the part-time remuneration and not the income that the official would receive if he/she were working full time. 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 ~~three~~ two years, at the same time as the actuarial review referred to in article 3.10, before the start of each financial period of the ILO.

Article 2.10

(Payment of benefit)

1. Benefits shall ~~generally~~ be paid in the currency of the official's duty station or the currency of the official's salary account should it be different. 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 2.10.3-4 of the Regulations. In such cases the member concerned should make a special request giving the reasons for the delay.

3. Prepayment of services or treatments purchased as a package only give rise to reimbursement once the service or treatment has been completed.

4. In order for a bill to be reimbursable it must include, at a minimum, the patient's name, the date(s) and type(s) of treatment received and the name of the provider. The SHIF may ask for additional information that it judges necessary to calculate the benefit due.

Article 5.2

(Forms and authorizations)

1. Insured persons shall submit claims for benefit-reimbursement 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 bills and other supporting documents, and shall be in accordance with the conditions prescribed on the form.

3. Claims for benefit-reimbursement 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.

4. Translations shall be provided for invoices and supporting documents which are not established in English, French, Italian or Spanish. The translations may be done by the insured person.

Appendix I

(Schedule of benefits)

Code 1.4

(Laboratory services and other tests)

1. The following laboratory services or other tests administered by a pharmacist are reimbursable:

- Angina/sore throat test;
- Colorectal cancer screen test;
- COVID-19 test;
- Cystitis test;
- Influenza test;
- Iron levels test.

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 treatment type and 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;
- orthoptics/optometry;
- ergotherapy;
- psychomotor therapy;
- lymphatic drainage (if lymphatic system affected);
- chiropody/pedicure for medical reasons (prescription not required).

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. For the purposes of this paragraph, it is the active principal ingredient of the medication that shall be compared and not only the commercialized name.

5. If one size or dosage of a medication gives entitlement to benefits by the Fund then all sizes or dosages of the same medication shall give entitlement to benefits by the Fund.

Code 4

(Dental care)

1. 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).

2. 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).

3. 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.

4. In the case of orthodontic treatment, if the provider is unable to establish invoices by dates of treatment and the insured has furnished an invoice for the entire period of orthodontic treatment prior to completion of treatment, the SHIF may make periodic reimbursements against the invoice.

Code 5.2

(Hearing aids)

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 ~~five~~three calendar years.

Code 5.5

(Other appliances)

The SHIF may, after consulting with the SHIF Medical Adviser, limit the quantities of medical appliances eligible for reimbursement.

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;
- physical disability.

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 to diagnose congenital disease or serious conditions.

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

4. Routine pregnancy blood tests, ultrasounds and doctor visits do not fall under preventive exams, procedures and screenings and 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;~~
- ~~• 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~~injection fee will be reimbursed at a rate of 80 per cent.