DECISION OF THE GOVERNING BOARD OF THE ETF ON THE ADOPTION OF IMPLEMENTING RULES TO THE STAFF REGULATIONS - REIMBURSEMENT OF MEDICAL EXPENSES

THE GOVERNING BOARD OF THE ETF

HAVING regard to the Staff Regulations of Officials and the Conditions of Employment of Other Servants of the European Communities (CEOS), laid down by Council Regulation (EEC, EURATOM, ECSC) No 259/68 last amended by Council Regulation (EC, EURATOM) No 1558/2007 of 17 December 2007,, and in particular Articles 5, 7 and 32 of the Staff Regulations applicable by analogy to other Servants (articles 10 and 15 of the CEOS),

HAVING regard to Council Regulation (EC) N° 1360/90 of 7 May 1990 establishing the European Training Foundation, and notably article 14 thereof,

HAVING regard to Council Regulation (EC) N° 2063/94 of 27 July 1994 and notably article 8 thereof, modifying the rules governing the personnel of the ETF and submitting the latter to the rules and regulations applicable to the Officials and Other Servants of the European Communities,

HAVING regard to the decisions of the Commission setting up implementing rules for the application of the amended Staff Regulations of officials of the European Communities and the Conditions of Employment of other servants of the Employment Communities;

AFTER the consultation of the Staff Committee of the ETF and in agreement with the Commission pursuant to article 110 of the Staff Regulations;

HAS ADOPTED THE FOLLOWING

Article 1

The Commission decision of 2 July 2007 laying down general implementing provisions for the reimbursement of medical expenses shall apply by analogy to the staff of the ETF.

Article 2

These implementing provisions shall enter into force with effect from the date of signature of the Chair.

Date

Odile Quintin
Chair of the Governing Board

ANNEX

C(2007)3195.

COMMISSION DECISION

of 2 July 2007

laying down general implementing provisions for the reimbursement of medical expenses

THE COMMISSION OF THE EUROPEAN COMMUNITIES,

Having regard to the Staff Regulations of Officials and the Conditions of Employment of Other Servants of the European Communities, laid down by Council Regulation (EEC, Euratom, ECSC) No 259/68[1], and in particular Article 72 thereof,

Having regard to the joint rules on sickness insurance for officials of the European Communities, adopted by common accord by all the Community institutions, which entered into force on 1 December 2005, and in particular Article 52 thereof,

Having regard to the opinion of the Management Committee for the Joint Sickness Insurance Scheme,

After consulting the Staff Committee,

Having regard to the opinion of the Staff Regulations Committee,

Whereas:

HAS DECIDED AS FOLLOWS:

Article 1

The annex to this Decision constitutes the general implementing provisions for the reimbursement of medical expenses.

Article 2

This Decision shall enter into force on 1 July 2007.

Article 3

The annexes to the rules, as last amended on 26 January 1999, and all the interpreting provisions, administrative notices and circulars shall be repealed when these general implementing provisions enter into force.

One-off medical treatment that pre-dates the entry into force of these general implementing provisions shall be reimbursed under the conditions laid down in the annexes to the rules, as last amended on 26 January 1999.

[1] OJ L 56, 04.03.1968, p. 1. Regulation last amended by Commission Regulation (EC, Euratom) No 2104/2005 (OJ L 337, 22.12.2005, p. 7).

Medical treatment which began before the entry into force of these general implementing provisions and continues after that date shall be reimbursed either according to the conditions laid out in the annexes to the rules, as last amended on 26 January 1999, or in accordance with these general implementing provisions, depending on the date of treatment

Done at Brussels, 2 July 2007

For the Commission
Member of the Commission

ANNEX

General definitions

Under Article 72 of the Staff Regulations and the joint rules on the sickness insurance cover for officials of the European Communities, which entered into force on 1 December 2005 (hereafter the "joint rules"), the Sickness Insurance Scheme common to the institutions of the European Community (hereafter the "JSIS" or " Scheme") covers the medical expenses of its beneficiaries resulting from illness, accidents and confinement and contributes to funeral expenses.

Beneficiaries of the JSIS

The Scheme's **beneficiaries** are the **members –** i.e. officials, temporary and contract staff, and persons in receipt of a retirement pension or termination of service allowance and, in certain cases, members of the institutions – **and those covered by their insurance**, subject to the conditions and limits laid down by the joint rules (Articles 2 to 18) and by Title I of these general implementing provisions.

Rate of reimbursement

The Scheme provides for the reimbursement of up to 80% of the expenses incurred.

The rate of reimbursement rises to 85% in the case of:

- medical consultations and visits,
- surgical operations,
- hospitalisation,
- pharmaceutical products,
- radiology, analyses,
- laboratory tests,
- prostheses on medical prescription, with the exception of dental prostheses, which are reimbursed at the rate of 80%.

In cases of tuberculosis, poliomyelitis, cancer, mental illness and other illnesses recognised by the appointing authority as of comparable seriousness, and for screening and confinement, the rate of reimbursement rises to 100% without any ceiling, subject to certain exceptions specified in these general implementing provisions.

Medical expenses in the event of an accident or occupational disease entailing the application of Article 73 of the Staff Regulations are covered up to the rates of 80% and 85%, the remaining 20% or 15% being covered by the provisions of Article 73 of the Staff Regulations on insurance against the risk of accident and occupational disease.

Medical prescriptions

A medical prescription is a document containing the name and official details of the prescriber, the full name of the patient, the medical treatment (type and number of sessions) or name of the medicine(s) being prescribed. It must be dated and signed by the prescriber. The prescription will, by definition, pre-date the start of the treatment. In order to qualify for reimbursement the prescription must be dated no earlier than 6 months before the date of the first treatment or the purchase of the medicines.

Prior authorisation

Certain medical services specified in these general implementing provisions require prior authorisation in order to qualify for reimbursement, i.e. this is a pre-requisite for reimbursement. In all but emergency cases, members must submit their requests for prior authorisation to the Settlements Office before starting treatment, using the special form and enclosing a detailed medical prescription or a full medical report, depending on the treatment involved. A decision will be taken on the request after consulting the Medical Officer, who will assess the medical case for the treatment.

The Medical Officer may, in some cases, contact the prescribing practitioner and/or the patient before issuing an opinion.

Serious illness

A serious illness is one recognised as such by decision of the appointing authority after consulting the Medical Officer and on the basis of the criteria set out in Title III, Chapter 5 of these general implementing provisions.

Expenses incurred in connection with a serious illness are reimbursed at the rate of 100% without a ceiling, except in a few cases that are duly specified in these general implementing provisions (such as home nursing services and dental expenses). A limit may also be placed on the reimbursement of these expenses if the prices charged are excessive (see definition of excessive costs).

Ceilings for reimbursement

Article 20 of the joint rules provides for reimbursement ceilings to be set by these general implementing provisions in order to ensure the financial stability of the Scheme. The reimbursement rate is then applied to the expenses actually incurred. If the resulting amount is less than the ceiling set for the treatment, this is the amount that will be reimbursed. If the resulting amount exceeds the ceiling, the reimbursement paid will be limited to the ceiling. The ceiling for reimbursement is defined as the maximum amount that may be reimbursed for a given treatment.

Excessive costs

If the costs significantly exceed the amounts normally charged in the country where the treatment was provided, the portion of costs deemed excessive may be excluded from the reimbursement, pursuant to Article 20 of the joint rules, even if no ceiling for reimbursement has been set and even in the case of a serious illness.

The portion of the costs deemed excessive will be determined on a case-by-case basis by the Settlements Office after consulting the Medical Officer. The Medical Officer will determine the exact nature of the medical treatment in order to enable the Settlements Office to compare the rates being charged.

The specific case of countries with high medical costs is dealt with using reimbursement-level coefficients (see Title III, Chapter 8).

Opinion of the Medical or Dental Officer

The opinion of the Medical or Dental Officer is a medical opinion delivered on the basis of the medical data relating to the patient in that Officer's possession, information supplied by the patient's own doctor, the results of medical and scientific research and, if necessary, after consulting the

Medical Council. Medical or Dental Officers will be consulted in connection with requests for prior authorisation in all the cases provided for by these general implementing provisions and at the request of the heads of the Settlements Offices for specific questions.

Medical and Dental Officers will issue opinions only in situations specifically provided for in the joint rules and in these general implementing provisions, and within the limits provided for therein.

Opinion of the Medical Council

The Medical Council of the JSIS consists of one Medical Officer from each institution and the Medical Officers from each Settlements Office. It is consulted by the bodies provided for by the joint rules, viz. the Management Committee, the Central Office and the Settlements Offices, on any medical issue arising in connection with the administration of the Scheme.

The Medical Council will reach a decision based on the latest scientific literature and, if necessary, after consulting specialists and leading medical authorities in the field in question.

The Medical Council must substantiate its opinions.

Title I – ENTITLEMENT

Chapter 1 - Members

1. 1. CONTRACT STAFF – THIRD INDENT OF ARTICLE 2(1)

1.1. On their entry into service contract staff must inform the appointing authority whether they wish to maintain their sickness insurance under their previous national social security scheme, by virtue of Article 112 of the Conditions of Employment of Other Servants of the European Communities, or to join the JSIS. They must communicate this information by the date of entry into service at the latest.

1.2. Contract staff will automatically become members of the JSIS on the first day of the month following that in which their authority empowered to conclude contracts of employment ceased to pay a contribution to their previous national social security scheme.

2. 2. GAINFUL EMPLOYMENT – FIFTH, SIXTH AND SEVENTH INDENTS OF ARTICLE 2(3); ARTICLES 6, 7 AND 9

2.1. Members must declare any gainful employment they undertake to their Settlements Office and must inform it of any changes in such employment.

2.2. When they cease to engage in gainful employment, those in receipt of an early or deferred retirement pension, or of the allowance provided for in Articles 41 or 50 of the Staff Regulations, and those whose service has been terminated under Council Regulations No 1746/02, 1747/02 or 1748/02 may be readmitted to the JSIS by applying to their Settlements Office and producing documentary evidence that they have ceased to be employed.

2.3. Those in receipt of the types of income referred to in the second paragraph of Article 13 of the joint rules, with the exception of pensions, are deemed to be gainfully employed.

Those in receipt of a non-university research fellowship, attendance and directors' fees and income from intellectual property rights are also deemed to be gainfully employed.

2.4. Persons who are gainfully employed on a continuous or occasional basis and whose annual taxable income is less than 20% of the annual basic salary in grade AST2/1, multiplied by the correction coefficient for the country in which the income is received, may, on request, continue to benefit from primary cover under the JSIS provided they

produce evidence that they cannot be covered by a legal or statutory sickness insurance scheme under the legal or statutory provisions of the country in which they are or were gainfully employed or their country of residence.

2.5. Members must send their Settlements Office official documentary evidence of their income each year (such as a tax certificate or other document drawn up by the competent national authorities).

If the Settlements Office finds that a member has earned an annual taxable income from gainful employment that is more than 20% of the annual basic salary in grade AST 2/1, multiplied by the correction coefficient for the country in which the income is received, and has not declared it in writing to the Settlements Office, cover will be suspended for the duration of the gainful employment, and any medical expenses reimbursed during that period will be recovered pursuant to Article 33 of the joint rules.

3. 3. COVER WHILE ON LEAVE ON PERSONAL GROUNDS – SEVENTH INDENT OF ARTICLE 2(3)

3.1. Members who wish to remain covered by the JSIS while on leave on personal grounds must apply to do so to their appointing authority or authority empowered to conclude contracts of employment before the end of the first month of such leave. The authority will transmit the request to the Settlements Office.

3.2. Members renewing their leave on personal grounds who wish to remain covered by the JSIS must inform their appointing authority or authority empowered to conclude contracts of employment before the end of the first month of the extension of their leave. The authority will transmit the request to the Settlements Office.

3.3. Members on leave on personal grounds who are gainfully employed may not benefit from sickness insurance cover. However, if they cease to be gainfully employed but remain on leave on personal grounds, members may, within 30 days of ceasing to be gainfully employed, apply to their appointing authority or authority empowered to conclude contracts of employment to be covered once again by the JSIS.

3.4. Members who remain covered by the JSIS and have dependent children aged 18 to 26 must send the Settlements Office proof that their children are attending an educational establishment every year, by 31 October, in order to justify their cover under the JSIS.

4. 4. MEMBERSHIP OF EX-RECOGNISED PARTNERS – ARTICLE 2(4)

By analogy with surviving divorced spouses, ex-recognised partners who receive a survivor's pension are also members of the Scheme.

5. 5. PROOF OF CONTRIBUTION TO THE SCHEME – ARTICLE 3(4) AND (5); ARTICLES 5, 6, 7, 8, 9 AND 10

Every three months, at least, the institutions must send the Central Office a list of paid-up members covered by these provisions.

Failure to produce such a list may not lead to any interruption in entitlement to cover.

6. 6. UNEMPLOYMENT – ARTICLE 11

Members receiving Community unemployment benefits must inform their Settlements Office in writing of any change in their private address or family circumstances (marriage, partnership, birth, death, divorce, dissolution of partnership).

It is not enough for the purposes of this requirement for members simply to indicate a new address on their claims for reimbursement.

Chapter 2 – Persons covered by members' insurance

1. RECOGNITION OF PARTNERSHIP – SECOND INDENT OF ARTICLE 12

In the case of partnerships that are not recognised for the purpose of benefiting from household allowance but can be for the purpose of sickness insurance, pursuant to the second paragraph of Article 72(1) of the Staff Regulations, members must request coverage from their Settlements Office, enclosing a document providing official evidence of the status of non-marital partner.

2. PRIMARY COVER FOR SPOUSE OR RECOGNISED PARTNER – ARTICLE 13

2.1. Spouses or recognised partners whose income from gainful employment is less than 20% of the annual basic salary in grade AST2/1 may benefit from primary cover under the JSIS provided they produce evidence that they cannot be covered by a legal or statutory sickness insurance scheme under the legal or statutory provisions of the country in which they are or were gainfully employed or their country of residence. This cover will be reviewed each year.

2.2. If a national social security scheme imposes a probation period during which the payment of contributions does not entitle the contributor to any reimbursements, the JSIS will continue to cover the spouse or recognised partner during this period.

2.3. Spouses or recognised partners who are gainfully employed may, exceptionally, receive primary cover under the JSIS if they are unable to join a legal or statutory sickness insurance scheme or if the premium for taking out sickness insurance amounts to at least 20% of their income from employment.

3. TOP-UP COVER FOR PERSONS COVERED BY MEMBERS' INSURANCE – ARTICLES 14 AND 16

3.1. General provisions

Full cover for the same risks means cover providing the same benefits as those referred to in Article 1 of the joint rules.

Any change in the circumstances of the spouse, recognised partner or dependent children must be notified immediately in writing to both the competent Settlements Office and the competent appointing authority/authority empowered to conclude contracts of employment.

3.2. Spouse and recognised partner (Article 14)

a) For the purpose of determining the rights of spouses/recognised partners to top-up cover under the JSIS in countries where no correction coefficient exists, the coefficient for Belgium will be used.

b) The JSIS will intervene in the reimbursement of expenses in its capacity as top-up scheme only if the procedures of the primary scheme have first been applied. Those benefiting from top-up cover under the JSIS must use the European health insurance card or equivalent declaration issued by their primary scheme when travelling within the European Union and the countries participating in the system.

3.3. Dependent children eligible for reimbursement of medical care under another legal or statutory sickness insurance scheme (second paragraph of Article 16(1) of the joint rules).

The JSIS acts as a top-up scheme for children whose primary cover is provided by another legal or statutory scheme, but can act as the primary scheme for all care provided abroad or for private medical care in countries with national health services, regardless of the reason for the primary scheme's refusal to reimburse such costs.

In this case, the member simply has to prove that the primary scheme has refused to reimburse the expenses in question.

The JSIS may authorise the direct billing of hospital costs for a child benefiting from top-up cover if the member demonstrates that the primary scheme will not reimburse any of the expenses in question.

4. DIVORCE - DISSOLUTION OF PARTNERSHIP – ARTICLE 15

4.1. The maximum period of cover provided for in Article 15(1) of the joint rules will start on the date on which the divorce or dissolution of the partnership is entered in the registry of births, marriages and deaths.

An extension beyond that 12-month period can be granted only in the case of a serious illness contracted and declared before the entitlement to cover expired or in the case of a pregnancy which began and was declared before the end of the period of cover.

4.2. The provisions of Article 15(2) of the joint rules also apply to spouses.

4.3. Where official divorce proceedings or proceedings to dissolve a partnership have been instituted, the member's spouse or partner may be given direct access to the JSIS for themselves and/or their dependent children with the authorisation of the member or following a judicial decision.

5. DEPENDENT CHILDREN – ARTICLE 16

5.1. Where cover for a dependent child under another scheme would require additional contributions to be paid by the person whose insurance creates the entitlement under the other scheme, the child will benefit from primary cover under the JSIS.

5.2. It is for the member to prove (by producing correspondence or some other document) that it is not possible for the child to be covered under another scheme or that such cover would entail contributions over and above those paid by the person affiliated to the other scheme.

5.3. If two parents who are members of the Scheme share custody of a child, each can submit requests for reimbursement of the child's medical expenses. However, requests for prior authorisation and estimates and requests for the reimbursement of the medical expenses resulting from them must be submitted by one and the same parent.

5.4. In the event of official separation, divorce or dissolution of a partnership, children previously insured for top-up cover will receive primary cover from the JSIS.

6. OTHER DEPENDENT PERSONS – ARTICLE 17

6.1. Primary cover only may be granted.

6.2. If the person concerned can be covered by another legal or statutory scheme, there is no possibility of top-up cover being provided.

However, if the person's right to cover by the other scheme cannot be transferred to another country and/or requires the payment of additional contributions over and above those required by that scheme, the person may receive primary cover under the JSIS.

The same applies when cover is possible only on a voluntary basis subject to payment of contributions.

6.3. The member must produce the necessary documentary evidence to support a request for cover for a person to be treated as a dependent child.

7. EXTENSION OF COVER FOR DEPENDENT CHILDREN AND OTHER DEPENDENT PERSONS - ARTICLE 18

7.1. If, during the extension provided for in Article 18 of the joint rules, the beneficiary enters gainful employment within the meaning of Article 2 of the joint rules, cover under the JSIS will be suspended. If this gainful employment ceases, cover will be provided again, until the end of the initial period of 12 months.

If a national social security scheme imposes a probation period during which the payment of contributions does not entitle the contributor to any corresponding reimbursement of expenses, the JSIS will continue to cover the beneficiary during this period, until the end of the 12-month extension.

Members who wish to extend their cover must apply in writing to their Settlements Office.

An extension cannot be granted automatically, even where a tax reduction is granted.

Chapter 3 – Provisions common to members and persons covered by members' insurance

1. Extension of a member's cover in the event of serious illness, pregnancy or confinement - Articles 7 and 10

An extension of cover will be granted to a member whose entitlement has expired only if all the following conditions are met:

a. the member pays one half of the contribution to the Scheme calculated by reference to the most recent updated basic salary for their grade and step;

b. the serious illness was contracted before the termination of their employment and notified before their entitlement to cover expired, or the pregnancy began before the termination of their employment and was notified to the institution before the end of their period of cover;

c. the former official is not gainfully employed and the former temporary or contract staff member cannot be covered by another legal or regulatory sickness insurance for the medical expenses associated with the serious illness or pregnancy even if they pay a contribution;

d. the period of validity of the decision recognising the serious illness has not expired;

e. the member undergoes a medical examination.

2. Situation of those covered by a member's insurance whose entitlement has expired – Articles 12, 15, 16, 17 and 18

In the event of serious illness or pregnancy, an extension of cover will also be granted to spouses, ex-spouses, recognised partners or ex-recognised partners whose entitlement has expired, but solely for the medical expenses associated with serious illness or the costs associated with pregnancy and confinement, provided that all the following conditions are met:

a. the serious illness was contracted and notified before the entitlement to cover expired, or the pregnancy began and was notified to the institution before the end of their period of cover;

b. the person is not gainfully employed and cannot be covered by another legal or statutory sickness insurance for the corresponding expenses, even if they pay a contribution;

c. the period of validity of the decision recognising the serious illness has not expired;

d. the person undergoes a medical examination.

Subject to the same conditions, an extension of cover for the medical expenses associated with a serious illness or the costs associated with pregnancy and confinement will also be granted to

those persons treated as a member's dependent children within the meaning of Article 2(4) of Annex VII to the Staff Regulations.

Title II - RULES ON REIMBURSEMENT

7.

Chapter I – Medical consultations and visits

8.

1. GENERAL POINTS AND DEFINITIONS

9. CONSULTATIONS AND VISITS CONSIST, IN PRINCIPLE, OF AN INTERVIEW WITH THE PATIENT, A CLINICAL EXAMINATION AND, IF NECESSARY, THE PRESCRIPTION OF CERTAIN TREATMENT.

10. CONSULTATIONS TAKE PLACE IN THE DOCTOR'S SURGERY, WHEREAS VISITS INVOLVE THE DOCTOR GOING TO THE PATIENT'S HOME, THE PLACE WHERE THE PATIENT IS STAYING OR THE HOSPITAL AND EXCLUDE EXAMINATIONS CARRIED OUT IN THE DOCTOR'S OWN SURGERY.

Consultations or visits are deemed to include the following:

- commonly used diagnostic techniques (measurement of blood pressure, speculum examination, vaginal or rectal examination, smear (excluding analyses));
- taking blood for tests;
- qualitative urine tests (albumin and glucose);
- intravenous, intramuscular, subcutaneous and intradermic injections;
- vaccinations;
- small dressings;
- writing a brief medical certificate;
- any appointment costs and the doctor's travel costs.

11. OTHER MEDICAL EXAMINATIONS AND PROCEDURES CARRIED OUT DURING THE CONSULTATION OR VISIT AND DETAILED MEDICAL REPORTS WHICH ARE INVOICED SEPARATELY ARE REIMBURSED ACCORDING TO THE RELEVANT PROVISIONS.

Reimbursement of successive and/or repetitive consultations may be refused, after consulting the Medical Officer, if no reason is given for them or if the need for them is not recognised.

2. **Reimbursement**

2.1. Medical consultations and visits

- The fees for consultations/visits by a general practitioner are reimbursed at the rate of 85%, with a ceiling of €35, and at the rate of 100% in the case of serious illness.
- The fees for consultations/visits by a specialist are reimbursed at the rate of 85%, with a ceiling of €50, and at the rate of 100% in the case of serious illness.
- The fees for emergency visits, night visits, visits during weekends or public holidays, defined according to local custom and the legislation in force, are reimbursed at the rate of 85%, and at the rate of 100% in the case of serious illness.
- The medical history taken by a homeopathic doctor during the first visit and invoiced separately from the visit is reimbursed at the rate of 85%, with a ceiling of €35.
- Consultations with and opinions given by the patient's doctor over the telephone, by letter or e-mail are reimbursed at the rate of 85%, with a ceiling of €10.

2.2. Leading medical authority

A leading medical authority is a specialist doctor with an international reputation in a particular medical field, who heads a research team and is the author of publications.

If a consultation with one or more leading medical authorities is deemed necessary by the Medical Officer, it will be reimbursed at the rate of 85%, with a ceiling three times higher than that for the consultation of a medical specialist, and at the rate of 100% in the case of serious illness.

The reimbursement of consultations of leading medical authorities is limited to two per year for the same condition.

3. **Non-reimbursable expenses**

The following are not reimbursable:

- consultations carried out on an Internet site;
- fees for appointments which the patient failed to attend;
- the costs of sending medical reports that are invoiced separately;
- consultations, examinations and technical procedures carried out for non-therapeutic or administrative reasons, such as:

- expert report ordered by the court;
- examination for insurance purposes;
- examination of professional competence;
- aptitude test for obtaining a pilot's licence;
- examinations carried out as part of occupational medicine (pre-recruitment medical, annual medical).

Chapter 2 - Hospitalisation and surgical operations

1. Hospitalisation

1.1. Definitions

Hospitalisation is taken to mean stays in a hospital or clinic for the purpose of:

- undergoing treatment for medical conditions or surgery, or giving birth, including stays of one day;
- rehabilitation or functional re-education following a medical condition or surgical operation resulting in invalidity;
- undergoing treatment for psychiatric conditions;
- receiving palliative care.

The following are not considered as hospitalisation and do not qualify for any reimbursement:

- stays in an institution without a multidisciplinary medical, technical and logistical infrastructure;
- stays in sheltered housing, supervised or supported accommodation without a medical and/or paramedical infrastructure;
- stays in a hospital or clinic or other type of establishment for fitness or rejuvenation treatment.

1.2. Prior authorisation

Prior authorisation based on a medical report is required for the following:

- stays of more than 6 months for the treatment of medical conditions or surgical operations;
- stays for plastic surgery;

- stays for rehabilitation or re-education which do not follow hospitalisation for a medical condition or a surgical operation (for example orthopaedic, neurological or rheumatological), or, if they do follow such a period of hospitalisation, stays of more than 2 months;
- stays of more than 12 months in a psychiatric hospital;
- stays in clinics specialising in screening and diagnosis (general check-up);
- costs of person accompanying the patient.

1.3. Reimbursement

Rate of reimbursement

Hospitalisation for a surgical operation or medical treatment is reimbursed at the rate of 85%.

The rate of reimbursement rises to 100%:

- *in the case of a serious illness;*
- *for stays of 3 or more consecutive days in intensive care, even if the stay is not directly connected with a serious illness and for the entire duration of the stay;*
- *for stays in a hospital palliative care unit;*
- *in the event of prolonged hospitalisation, for accommodation costs beyond 30 consecutive days, after consulting the Medical Officer.*

Reimbursement conditions

In order to qualify for reimbursement, the hospitalisation must be the subject of a medical report to the Medical Officer of the Settlements Office.

- Accommodation costs

Accommodation costs relating to board and lodging, service and taxes are reimbursed on the basis of expenses actually incurred and according to the relevant invoicing rules applicable in the country of hospitalisation. If the accommodation costs are included in the all-in charge for a day in hospital, the reimbursement will be made as an aggregate amount.

Accommodation costs will depend on the type of room chosen. They will be reimbursed up to the price of the least expensive single room in the hospital.

Accommodation costs will be reimbursed only for the period of hospitalisation that is medically required to carry out the procedures or provide the treatment in the country of hospitalisation.

- Costs of diagnosis and treatment

  In addition to the costs of surgical operations referred to in point 2 below, the costs of the following services will be reimbursed at the rate of 85%, or 100% in the case of serious illness:

  - the costs of the operating theatre, plaster room and dressing room and other costs of treatment relating to the surgical operation;
  - medical fees for visits and consultations;
  - laboratory analyses and tests, x-rays;
  - medicines, the costs of prostheses, orthoses and other orthopaedic instruments and appliances, provided that these expenses are directly related to the surgical operation and/or hospitalisation;
  - diagnosis or treatment.

- Cost of stay for person accompanying the patient

  The accommodation costs of an accompanying family member staying in the insured person's room or on the hospital premises may, exceptionally, be reimbursed at the rate of 85%, with a ceiling of €40 per day, if the patient is under the age of 14 or requires special assistance from a family member because of the nature of the condition or on other duly substantiated medical grounds. The reimbursement of the costs of an accompanying family member is subject to a prescription from the patient's doctor and prior authorisation.

  The accommodation costs of a child who is being breastfed and has to accompany its mother in hospital may also qualify for such reimbursement.

2. **Surgical operations**

The costs of surgical operations are reimbursed at the rate of 85%, or 100% in the case of serious illness. These costs consist of all the fees of the surgeon, the surgeon's assistant(s) and the anaesthetist.

In the case of reimbursement at the rate of 85%, the costs are reimbursed up to the limit of the ceilings for each operation, with a ceiling according to the category of operation:

Category	Reimbursement at 85% Ceiling (€)

A1	**535**
A2	**735**
A3	**1 350**
B1	**2 000**
B2	**2 600**
C1	**4 250**
C2	**5 350**
D1	**10 000**
D2	**Not applicable.**

A list of surgical operations by category is given in Annex I.

Surgical operations that do not appear on this list may be treated as equivalent to operations of comparable importance and the costs thereof reimbursed on that basis on the recommendation of the Medical Officer.

In the case of an **exceptionally difficult operation**, reimbursement may be granted up to the ceiling for the category immediately above that fixed for the operation in question, after consulting the Medical Officer.

Where the rules on invoicing provide for higher fees for **emergency operations** the costs associated with such operations will be reimbursed at the rate of 85%, or 100% in the case of serious illness, subject to the proviso that the total reimbursement for the surgical operation in question may not exceed the ceiling provided for the category immediately above that of the operation in question.

Corrective or restorative plastic surgery may be reimbursed, particularly in the case of serious illness, deformity or accident, subject to **prior authorisation** granted after consulting the Medical Officer. Plastic surgery which is considered to be purely cosmetic will not be reimbursed.

Chapter 3 - Services associated with dependence

The reimbursement of services associated with dependence – stays in an institution and the costs of carers – excluding residential drug rehabilitation, depends on the insured person's degree of dependence.

The degree of dependence is determined according to the following table, on the basis of the lowest score obtained on one of the two questionnaires in the Annex, to be completed by the patient's doctor:

Score	Degree of dependence
91-100	**5**
75-90	**4**
50-74	**3**
25-49	**2**
0-24	**1**

Values 1 to 4 on the dependence scale are taken into consideration for the purpose of reimbursing expenses, with 1 being the highest level of dependence. Level 5 dependence does not create any entitlement to reimbursement.

1. **Permanent or long-term residence in paramedical and other establishments**

1.1. Definitions

The following are reimbursed under this heading:

a) residence in a convalescent or nursing home approved by the competent authorities and having a medical and/or paramedical infrastructure for the elderly or the disabled;

b) continuous and permanent residence in a psychiatric home approved by the competent authorities and having a medical and/or paramedical infrastructure;

c) residence in an establishment for rehabilitation or functional re-education in cases where the request for prior authorisation for reimbursement under the heading of hospitalisation has been refused (see Title II, Chapter 2, point 1.2); ;

d) continuous, long-term residence in a psychiatric hospital for more than 12 months where the request for prior authorisation for reimbursement as hospitalisation has been refused (see Title II, Chapter 2, point 1.2);

e) stays in a day centre;

f) stays in a non-hospital drug rehabilitation centre.

1.2. Prior authorisation

Prior authorisation based on a medical report to the Medical Officer as specified in 1.3 below is required in order for the costs of residence and treatment in any of the establishments listed at 1.1 to qualify for reimbursement.

The fact that authorisation under the heading of hospitalisation (see Title II, Chapter 2) has been refused does not affect whether or not authorisation is granted under the present heading.

1.3. Reimbursement

Costs which still have to be met by the beneficiary do not qualify for the special reimbursement provided for in Article 24 of the joint rules.

a) *Convalescent and nursing homes*

The request for prior authorisation must be accompanied by a medical report justifying the need for residence in the home and specifying the nature of the care required by the patient, and by the two forms in the Annex, duly completed by the patient's doctor.

Authorisations are granted for a maximum of 12 months and are renewable.

All of the costs of treatment and accommodation are reimbursable at the rate of 85%, or 100% in the case of serious illness, with a ceiling of €36 per day for accommodation costs.

If all items are aggregated on the invoice so that it is not possible to separate the costs of treatment from the accommodation costs, the costs will be divided according to the degree of dependence in the proportions given in the following table:

Degree of dependence	**Costs of treatment**	**Accommodation costs**
4	**30 %**	**70 %**

3	**50 %**	**50 %**
2	**60 %**	**40 %**
1	**70 %**	**30 %**

In such cases the accommodation costs will be subject to the same ceiling of €36 per day.

b) *Residence and treatment in a psychiatric home are reimbursable at the rate of 85%, or 100% in the case of serious illness, under the same conditions as those applying to convalescent and nursing homes.*

Authorisations are renewable, subject to a detailed report by the patient's doctor, for periods determined by the Settlements Office.

11.1. *c) Continuous residence and treatment in a rehabilitation or functional re-education establishment or psychiatric hospital are reimbursable at the rate of 85%, or 100% in the case of serious illness, under the same conditions as those applying to convalescent and nursing homes.*

If all items are aggregated on the invoice so that it is not possible to separate the costs of treatment from the accommodation costs, the costs will be divided according to the proportions for level 1 degree of dependence.

11.2. d) Stays in a day-care centre and the treatment provided there are reimbursable under the following conditions:

- Daytime attendance only at a convalescent or nursing home for the elderly or a neurological or psychiatric day centre: the costs of accommodation and treatment are reimbursed under the same conditions as permanent residence in an establishment as referred to in a) above, with a ceiling of €18 per day for accommodation costs.

- Attendance at a child guidance clinic: treatment only is reimbursable as provided for in the relevant provisions.

e) Stays in a non-hospital drug rehabilitation centre, or equivalent establishment, and the medical treatment provided are reimbursed at the rate of 85% only, with a ceiling of €36 per day for the accommodation costs.

11.3. *If all items are aggregated on the invoice so that it is not possible to separate the costs of treatment from the accommodation costs, the costs will be divided according to the proportions for level 1 degree of dependence.*

Reimbursement is limited to a total stay of 6 months in a 12-month period.

2. **Carers**

2.1. General provisions

a) Definitions

The services provided by carers consist mainly of nursing care in the patient's home for several hours a day or the whole day and/or night.

Individual nursing tasks (injections, dressings, etc.) are reimbursed under the conditions laid down in Title II, Chapter 9.

The services of adults who look after children who are ill at home while their parents are away are not regarded as services provided by carers.

b) Requirements

- Prior authorisation is required for the services provided by carers.

  The request for prior authorisation must be accompanied by a medical report stating the duration of the services, the nature and frequency of the treatment to be provided and the two forms in the Annex, duly completed by the patient's doctor.

  Authorisation will be granted if the services are deemed to be strictly necessary by the Medical Officer of the Settlements Office, who will evaluate them according to the degree of dependence of the insured person. The reimbursement of care services is authorised only for patients whose degree of dependence is rated as 1, 2, 3 or 4.

- Carers must be legally entitled to practise their profession.

  In countries where the profession of carer is not regulated and/or if it is impossible to find an officially approved carer (e.g. approved by the Red Cross), the patient's

doctor must specify on the prescription the name of the person who will provide the services and declare that this person is properly qualified to do so.

In the case of carers who are not attached to an official organisation (e.g. the Red Cross) or do not operate within an officially recognised private framework, proof of the contractual tie (a duly completed employment contract and/or insurance contract for the job as carer) must be sent to the Settlements Office.

The social charges relating to employment contracts and/or the insurance premiums are included in the costs of carers and are reimbursable under this heading.

- Invoices must comply with the law of the country in which they are issued.

Failure to produce the requisite documents will mean that prior authorisation cannot be granted and the corresponding services cannot be reimbursed.

2.2. Reimbursement

Costs are reimbursed at the rate of 80%, or 100% in the case of serious illness, up to a maximum amount (see below), regardless of the number of people providing care.

No reimbursement is made in respect of the carer's travel expenses, board and lodging, or any other ancillary costs.

The portion of expenses not reimbursed do not qualify for the special reimbursement provided for in Article 24 of the joint rules.

- **Temporary home care**

The costs of home care for a maximum period of 60 days are reimbursed at the rate of 80%, with a ceiling of €72 per day, or at the rate of 100% in the case of serious illness, with a ceiling of €90.

- **Long-term home care**

Beyond 60 days, the costs of home care are reimbursed at the rate of 80%, or 100% in the case of serious illness, subject to the ceilings set out in the following table, minus

an amount equal to 10% of the member's basic income (salary, retirement pension, invalidity pension or benefit, allowance provided for in the fourth and fifth indents of Article 2(3) of the joint rules).

Degree of dependence	**Ceiling for reimbursement**
4 and 3	**50% of the basic salary of an official in grade AST 2/1**
2 and 1	**100% of the basic salary of an official in grade AST 2/1**

Authorisations are granted for a maximum of 12 months and are renewable.

- **Services of carers in hospital**

These costs are reimbursable only in public institutions where the healthcare infrastructure is insufficient to provide routine care. In such cases the costs of a carer employed on a prescription issued by the patient's doctor are reimbursed at the rate of 80%, subject to prior authorisation granted after consulting the Medical Officer, with a ceiling of €60 per day. In the case of serious illness, such costs are reimbursed at the rate of 100%, with a ceiling of €75 per day.

Concerns Mr/Mrs/Ms …… Personnel No: ……..

I. FUNCTIONAL INDEPENDENCE EVALUATION

ITEM	DESCRIPTION	SCORE
FEEDING	– Independent, can serve self from table/tray, takes a reasonable time to finish eating – Needs help, e.g. for cutting up food – Incapable of feeding self	10 □ 5 □ 0 □
BATHING	– Can take bath unaided – Incapable of bathing self	5 □ 0 □
PERSONAL TOILET	– Can wash face, comb hair, brush teeth, shave (plug in shaver) – Can do none of the above	5 □ 0 □
DRESSING/ UNDRESSING	– Independent. – Can tie shoelaces, use fasteners, put on braces – Needs help, but can do at least half of the task within a reasonable time – Can do none of the above	10 □ 5 □ 0 □
CONTINENCE OF BOWELS	– No accidents. Can use a suppository/enema when necessary – Occasional accidents. Needs help with suppositories/enemas -Incapable of using suppositories/enemas	10 □ 5 □ 0 □
BLADDER CONTROL	– No accidents. Can manage urine collection devices when necessary – Occasional accidents and needs help with collection devices – Incapable of using the equipment	10 □ 5 □ 0 □
GETTING ON AND OFF TOILET	– Can get on and off alone, or use a commode. Able to handle clothes, wipe self, flush toilet, empty commode – Needs help balancing, handling clothes or toilet paper – Can do none of the above	10 □ 5 □ 0 □
TRANSFERS FROM BED TO CHAIR/ WHEELCHAIR AND BACK	– Independent, can put brake on wheelchair and lower foot-rest – Minimal help or supervision needed – Can sit but needs major help for transfers – Completely dependent	15 □ 10 □ 5 □ 0 □
WALKING	– Can walk 50 metres without assistance. Can walk with crutches, but does not use wheeled devices – Can walk 50 metres with help – Can propel wheelchair independently for 50 metres, only if unable to walk – Incapable of walking	15 □ 10 □ 5 □ 0 □
ASCENDING/ DESCENDING	– Independent. Can use crutches – Needs help or supervision	10 □ 5 □

STAIRS	– Incapable of using stairs	0 □

SUM TOTAL OF THE ABOVE ../100

The doctor must **tick a box** for each of the above items.

P.T.O. and complete

II. EVALUATION OF SPATIAL AND TEMPORAL AWARENESS

STATE OF PATIENT	EVALUATION OF OCCURRENCE OF PROBLEMS	SCORE
1. DIFFICULTIES IN EXPRESSION Making self understood through speech and/or signs	– always – occasionally, rarely – never	0 □ 5 □ 10 □
2. VERBAL DISRUPTION Shouting out for no reason and/or disturbing others by shouting and/or crying	– always – occasionally, rarely – never	0 □ 5 □ 10 □
3. LOSS OF SOCIAL INHIBITIONS Inappropriate behaviour at the table/meal times, taking clothes off at inappropriate times, urinating in inappropriate places, spitting…	– always – occasionally, rarely – never	0 □ 5 □ 10 □
4. TEMPORAL ORIENTATION	– completely disoriented – occasionally – no problem	0 □ 5 □ 10 □
5. AGITATED BEHAVIOUR Difficulty with interpersonal relationships, emotional disturbance and/or self-harming and/or psychomotor agitation (deambulation, fugue, etc.)	– always – occasionally, rarely – never	0 □ 5 □ 10 □
6. NOCTURNAL BEHAVIOUR Wandering around, disturbing others, confusing day and night	– always – occasionally, rarely – never	0 □ 5 □ 10 □

7. SPATIAL ORIENTATION	– completely disoriented – occasionally – no problem		0 □ 5 □ 10 □
8. DESTRUCTIVE BEHAVIOUR Violence towards physical surroundings/objects: clothes, furniture, reading material etc., and/or aggressive to others	– always – occasionally, rarely – never		0 □ 5 □ 10 □
9. MEMORY LOSS	(a) short-term	YES NO	0 □ 5 □
	b) long-term	YES NO	0 □ 5 □
10. RECOGNITION OF FAMILIAR PEOPLE Loss of ability to recognise…	close family (children, spouse)	YES NO	0 □ 5 □
	friends, acquaintances, etc.	YES NO	0 □ 5 □

GRAND TOTAL OF ALL ITEMS	…./100

The doctor must **tick a box** for each of the above items.

..…… .....……...

Date Doctor's signature and stamp

Chapter 4: Pharmaceutical products

1. Definition

For the purpose of the JSIS a pharmaceutical product is:

- a proprietary substance which is registered as a medicinal product and has a marketing authorisation; or

- a magistral formula produced under the responsibility of a pharmacist, the composition of which appears on the medical prescription or on the pharmacist's invoice and the components of which have been proved to be effective and safe; or

- a homeopathic preparation, proprietary herbal remedy or mother tincture that has been scientifically proved to be effective and safe.

2. Reimbursement

The pharmaceutical product must be prescribed by the doctor for a recognised medical indication and in doses consistent with normal therapeutic guidelines. It is dispensed by a pharmacist, a doctor or any other approved body or system authorised to dispense medicines.

If national legislation allows people with a qualification other than that of a doctor (e.g. a dentist, midwife, nurse, Heilpraktiker) to prescribe pharmaceutical products, these will also qualify for reimbursement under the conditions laid down by the Scheme in those countries where such practices are officially recognised and regulated by law.

The composition of a magistral formula must be shown on the medical prescription or the pharmacist's invoice and be included with the claim for reimbursement.

In the event of claims for reimbursement of products in doses which significantly exceed the normal therapeutic recommendations, the portion of the product regarded as excessive will not be reimbursed, after consulting the Medical Officer.

3. Reimbursement conditions

Pharmaceutical products are reimbursed at the rate of 85%, or 100% if prescribed for a serious illness.

However, other reimbursement conditions apply to the following:

- narcotic drugs used during withdrawal treatment or substitution treatment for drug addicts qualify for reimbursement at the rate of 100% for a maximum of 6 months – see point 4.1;

- the special diet foods referred to in point 4.3b), for which reimbursement at the rate of 85% or 100% will apply to 40% of the expenses incurred, which corresponds on average to the price difference between these products and normal products;

- pharmaceutical products used for the treatment of nicotine dependency, where reimbursement will be limited to a total of €200 for all treatment during the insured person's lifetime.

4. Products reimbursable subject to prior authorisation

4.1. Prior authorisation based on a medical report is required for the following products:

- slimming products;
- anti-ageing hormonal treatment that is not justified by an objective hormonal deficiency;
- growth hormones;
- products used in the symptomatic treatment of male erectile disorders, when impotence is the result of a serious illness, accident or a prostate operation; the maximum amount reimbursed for this category of drugs in any 12-month period is €400;
- narcotic drugs used during withdrawal treatment or substitution treatment for drug addicts; these products qualify for a special reimbursement at the rate of 100% for a maximum of 6 months.

4.2. Prior authorisation based on a medical report is required for proprietary substances which are authorised for sale as pharmaceutical products but are used for a medical indication other than the recognised one (off-label use), for the same purposes as the products listed in point 4.1.

This provision also applies to hair loss treatments.

4.3. Prior authorisation based on a medical report is required for certain dietary and hygiene products if they are deemed to be essential for survival.

Such products are reimbursed even if they are not purchased in a pharmacy, from a doctor or from any other approved body or system authorised to dispense medicines.

The products in question are:

a) special products for enteral or parenteral feeding, which qualify for reimbursement at the rate of 85%, or 100% in the case of serious illness;

b) - high-calorie or high-protein liquid nutrition prescribed after radiotherapy, chemotherapy or major surgery;

- special milk consisting of extensively hydrolysed semi-elemental formulas used in cases of prolonged diarrhoea associated with severe allergy to cow's milk or soya or in cases of anaphylactic shock, intestinal malabsorption or inflammatory bowel disease;

- special foods used in the treatment of metabolic diseases.

The reimbursement rate for these 3 categories of product will apply to 40% of the expenses incurred, which corresponds on average to the price difference between these products and normal products.

c) disinfection or hygiene products essential for the treatment of certain serious illnesses, such as nosocomial infections.

5. Non-reimbursable products

The following products will not be reimbursed:

5.1. products for cosmetic, hygienic, aesthetic or dietary purposes or for personal comfort, with the exception of the situations referred to in point 4 above;

5.2. tonic wines and beverages, organotherapy products, trace elements in catalytic doses which are authorised for sale as pharmaceutical products but which have not been proved to be effective and/or safe.

6. Information for members

Two lists of the main pharmaceutical products that are and are not reimbursable will be updated regularly and notified to members.

Products that appear on neither list may be reimbursed after consulting the Medical Officer.

Chapter 5 - Dental care, treatment and prostheses

1. Preventive care and treatment

The costs of preventive dental and oral hygiene care, x-rays, treatment and surgery are reimbursed at the rate of 80%, with a ceiling of €750 per calendar year per insured person, on condition that the treatment is provided by practitioners registered by the competent national authorities.

In the case of a serious illness such as cancer, insulin-dependent diabetes, valvulopathy (a remote consequence of dental infections) which affects or has repercussions for the buccal cavity, expenses will be reimbursed at the rate of 100%, subject to the joint approval of the Medical Officer and the Dental Officer, up to a ceiling of €1 500. This ceiling will also apply in the case of problems in treating hyperactive children or pregnant women.

The amount covers the following treatment:

- consultation
- intra-oral x-ray;
- panoramic x-ray and teleradiography performed in the dentist's surgery (*);
- fluoride treatment;
- sealing pits and fissures;
- scaling and polishing;
- fillings (**);
- reconstruction, core build-up (with screw or tenon), resin inlays and facets;
- devitalisation and root filling;
- normal extraction, incision of abscess, esquillectomy;
- surgical extraction, impacted tooth, apectomy, root amputation, frenectomy(***);
- local or loco-regional anaesthetic.

After consultation with the Dental Officer, treatment that is not included on this list may be reimbursed at the rate of 80%, or 100% in the case of serious illness, up to the amount of the annual ceiling.

(*) The same examinations and maxillofacial scans performed in a hospital are reimbursed at the rate of 85%.

(**) The costs of systematically removing all silver amalgam fillings and replacing them will not be reimbursed unless the fillings are damaged or are a recurrent source of problems.

(***) The extraction of an impacted wisdom tooth carried out in hospital under general or local anaesthetic will be reimbursed subject to the limits and conditions laid down for surgical operations in category A2. If an additional extraction is performed during the same procedure, the reimbursement per tooth will be limited to half of the reimbursable amount for category A2 surgical operations.

2. Periodontal treatment

The costs of periodontal treatment which has been authorised by the Settlements Office after presentation of a detailed estimate and consultation of the Dental Officer will be reimbursed at the rate of 80%, with a ceiling of €350 per sextant, i.e. €2 100 for the whole mouth, over a period of 10 years. A second reimbursement may be authorised under the same conditions 6 years after the end of the 10-year period.

The costs of x-rays will be reimbursed separately, in accordance with point 1 above.

3. Orthodontic treatment

The costs of orthodontic treatment (dentofacial orthopaedics) are reimbursed at the rate of 80%, with a ceiling of €3 300 for the overall treatment (including cephalometric analysis, study models, photos, costs of retention), on condition that prior authorisation for the treatment has been obtained from the Settlements Office, on presentation of an estimate and after consultation of the Dental Officer. The costs of x-rays will be reimbursed separately, in accordance with point 1 above.

Orthodontic treatment must start before the patient's 18th birthday, except in the case of serious disease of the buccal cavity, maxillofacial surgery, maxillofacial trauma or serious problems of the temporomandibular joint diagnosed by x-ray and clinical examination.

Authorisation may be granted for a second course of treatment under the same conditions as above, in the following cases:

- if the patient moves to another country and has to use another practitioner who is unable to continue the current treatment using the same therapeutic technique; authorisation will only be granted if documentary evidence of the patient's change of place of residence is provided and if the new treatment immediately follows the previous one;
- if the patient's practitioner dies or closes down the practice;
- agenesis of 5 or more teeth in the upper jaw or 5 or more teeth in the lower jaw (excluding wisdom teeth);
- major maxillofacial surgery with osteosynthesis (trauma or tumours);
- serious problems of the temporomandibular joint.

4. Dental occlusion

The costs of treating problems of dental occlusion (bite) are reimbursed at the rate of 80% with a ceiling of €450 for the overall treatment, on condition that prior authorisation for the treatment has been obtained from the Settlements Office, on presentation of an estimate and after consultation of the Dental Officer.

Such treatment, which will be reimbursed only once, comprises:

- the preliminary study, excluding the x-rays reimbursed in accordance with point 1 above;
- occlusal splint/night guard;

- check-ups on the appliance;
- occlusal equilibration sessions.

5. Dental prostheses

The costs of dental prostheses for which prior authorisation has been obtained after presentation of an estimate and consultation of the Dental Officer will be reimbursed at the rate of 80%, up to the limit of the maximum reimbursable amounts laid down in the following table. In emergencies, when an estimate could not be produced, only the costs of the temporary prostheses will be reimbursed.

Type of treatment	Ceiling (€)
1. a) Fixed prostheses	
Gold or ceramic inlay, inlay core	**250**
Cast crown, telescopic crown, ceramo-metallic crown or element, ceramic facet	**250**
Attachment (Dolder bar: by pillar)	**250**
Temporary crown or pontic tooth (*)	**30**
b) Repair of fixed prostheses	
Removal or replacement of fixed elements (by element)	**50**
Repair of crowns or elements of bridgework (with the exception of temporary crowns and elements) by element	**90**
2. a) Removable prostheses	
Resin base plate, occlusal splint/night guard (excluding bleaching guard)	**200**
Tooth or clasp on resin plate	**50**
Complete upper or lower denture	**800**
Temporary resin base plate	**90**
Temporary tooth or clasp on resin plate	**30**
Metal plate (with clasps)	**400**
Tooth on metal plate (up to maximum of 10)	**100**
b) Repair of removable prostheses	
Repair of resin plate, addition (replacement) of one tooth or clasp on resin or metal plate(*)	**60**
Rebasing (partial or full/resin or metal plate)	**150**

(*) For temporary crowns and repairs on metal base (chrome – cobalt) the ceilings are doubled.

Authorisation to replace removable or fixed prostheses that have already been the subject of reimbursement by the Scheme will be granted only after a period of 6 years has elapsed. The reimbursement will be made in accordance with the conditions laid down above.

However, in exceptional circumstances, for example in the event of trauma or serious illness (such as cancer of the jaw) affecting or having repercussions on the buccal cavity and making it impossible to wear the existing dental prosthesis, the replacement periods may be reduced, after consulting the Dental Officer, on presentation of detailed medical grounds and an estimate.

6. Implantology

6.1. Prior authorisation by the Settlements Office is required for implant treatment and may be obtained on presentation of an estimate and after consultation of the Dental Officer.

6.2. Reimbursement is limited to 4 implants in the upper jaw and 4 in the lower jaw, i.e. a maximum of 8 implants per insured person throughout the person's lifetime.

6.3. The costs of implants are reimbursed at the rate of 80%, with a ceiling of €550 per implant. The costs of implants consist of:

- the preliminary study, excluding the x-rays that are reimbursed separately;
- the synthetic bone graft;
- the material implanted: implant, abutment, membrane and disposable sterile material;
- local anaesthetics administered by the practitioner;
- the surgical procedure to place the intra-osseous implant;
- uncovering the implant several months after osteo-integration.

6.4. In the case of implants carried out in hospital, which are also subject to prior authorisation, the costs of accommodation, general anaesthetic and other ancillary costs will be reimbursed under the conditions laid down for each heading, with the exception of the practitioner's fees and the treatment referred to in 6.3 above.

6.5. After prior authorisation, the costs relating to autogenous bone grafts – which must be carried out by a maxillofacial surgeon – will be reimbursed at the rate of 85%, up to the ceiling for surgical operations in category B.1. The costs of accommodation and other ancillary costs will be reimbursed under the conditions laid down for each heading.

7. Serious illness

In the case of a serious illness affecting or having repercussions on the buccal cavity, expenses associated with the treatment provided for in points 2 to 6 will be reimbursed at the rate of 100% subject to the joint approval of the Medical Officer and the Dental Officer, up to an amount of twice the ceiling provided for each treatment.

8. Special provisions

In the case of treatment requiring prior authorisation, the JSIS's official estimates should be used, except in emergencies or cases of *force majeure*. Except where national regulations make this impossible, bills must follow the same model as the estimates. Both bills and estimates must show the separate amounts for each treatment and the number of the teeth treated.

The estimates for orthodontic or periodontal treatment, fixed prostheses and implants must be accompanied by x-rays and/or study models. The Dental Officer may carry out or arrange for a physical examination of the patient if he or she considers this necessary.

The treatment specified in the estimates must be started within 12 months of the date on which it was authorised. This period may be extended by way of an exception, after consulting the Dental Officer.

The costs of treatment for purely aesthetic purposes (such as tooth whitening, systematic replacement of silver amalgam fillings, veneers on intact incisors, tooth jewellery) are not reimbursed.

Chapter 6 - Medical imaging, analyses, laboratory tests and other forms of diagnosis

12.

1. **General provisions**

The costs of such procedures are reimbursed at the rate of 85 %, or 100 % in the case of serious illness.

2. **Analyses and tests requiring prior authorisation**

Prior authorisation is required for the following:

- Analyses carried out in connection with:
  - anti-ageing treatment;
  - multiple hormone treatment;
  - allergies and food intolerance;
  - genetic tests other than for investigating a specific condition.

- New techniques for tests, analyses or medical imaging, the costs of which do not qualify for reimbursement in at least one European Union Member State.

3. **Non-reimbursable analyses**

The following are not reimbursable:

- Analyses carried out in connection with:
  - measuring oxydative stress;
  - micronutrition;
  - floculation tests.

- The cost of analyses and tests deemed to be non-functional and/or unnecessary after consulting the Medical Officer. Non-functional analyses and tests are considered to be those that have not been scientifically validated as effective and safe.

4. Information for members

Two lists of the main analyses, categories of analysis and tests that are and are not reimbursable will be updated regularly and notified to members.

Analyses and tests that appear on neither list may be reimbursed after consulting the Medical Officer.

Chapter 7 – Pregnancy, confinement and infertility

1. Reimbursable treatment and services relating to pregnancy

1.1. Definition and general points

Pregnancy is deemed to be the period between fertilisation and confinement.

Consultations, physiotherapy (pre-and post-natal) and all other examinations and treatment relating to pregnancy carried out by doctors, midwives, physiotherapists and/or other healthcare practitioners are reimbursed in accordance with the provisions laid down for each of these services.

Charges for the availability of practitioners (telephone or other) during the period of pregnancy are not reimbursed.

1.2. Specific points

Analyses and medicines prescribed by a midwife are reimbursed in those countries where such practices are officially recognised and regulated by law.

Monitoring carried out by a midwife is reimbursed without a medical prescription.

Pre- and post-natal physiotherapy sessions, on medical prescription, are not included in the maximum number of sessions allowed under Title II, Chapter 8 of these general implementing provisions. However, they are reimbursed on the same conditions.

Group sessions in preparation for confinement, carried out by a physiotherapist or midwife on medical prescription, are reimbursed at the rate of 80%, with a ceiling of €15 per session.

The costs of haptonomy sessions and swimming pool charges are not reimbursed.

2. Reimbursable treatment and services and relating to confinement

2.1. Definition

Confinement is deemed to be birth from the 22nd week of pregnancy.

2.2. Confinement in hospital

The following are reimbursed at the rate of 100%:

- the fees of doctors who assist at a normal or difficult birth, twin birth or birth by caesarean section;

- the fees of a midwife and anaesthetist, the charges for a labour room, the fees for the services of a physiotherapist during the confinement and other expenses relating to services directly connected with the confinement;

- the costs of hospital accommodation and care for mother and baby for a maximum of ten days or for the entire stay if there are medical complications directly connected with the confinement;

- the costs of neonatal accommodation and care for the baby.

Accommodation costs will depend on the type of room chosen. They will be reimbursed up to the price of the least expensive single room in the hospital.

If the all-in charge for a day in hospital comprises the cost of the stay and all or part of the costs of confinement, assistance, tests and other expenses relating to the confinement, reimbursement is at the rate of 100% overall.

Excessive costs within the meaning of Article 20(2) of the joint rules will be determined according to the relevant invoicing rules applicable in the country where the confinement took place, after consultation of the Medical Officer.

2.3. Home confinement

For home confinements the following are reimbursed at the rate of 100% for a maximum of ten days:

- the fees of the doctor and/or midwife relating to the confinement;
- the costs of the nurse and other medical auxiliaries:
- all other medical expenses directly connected with the confinement.

If there are medical complications, the period of reimbursement may be extended, after consultation of the Medical Officer. If such complications require a stay in hospital for mother and/or baby, the costs of accommodation and care are reimbursed at the rate of 100%.

Where a number of medical and other services are provided by one service that brings together various practitioners, such as medical auxiliaries, the costs of all the services are reimbursed as a whole with no distinction between them.

The costs of home help are not reimbursed.

2.4. Confinement at a birthing centre or at an approved non-hospital centre

If the confinement takes place at a "birthing centre" or at a non-hospital centre approved by the competent health authorities,

- the fees for the confinement are reimbursed on the same conditions as a home confinement;

- additional costs relating to follow-up and accommodation are reimbursed for a maximum of 24 hours after the confinement.

Expenses following the confinement for services provided at home by nurses and medical auxiliaries are reimbursed at the rate of 100% for a maximum of ten days including the stay away from home.

If there are medical complications for mother and/or baby directly connected with the confinement, the period of reimbursement is extended, after consultation of the Medical Officer. If such complications require a stay in hospital, the costs of accommodation and care are reimbursed at the rate of 100%.

Excessive costs within the meaning of Article 20(2) of the joint rules, of a stay at a birthing centre or non-hospital centre will be determined by comparison with the costs of a hospital stay in the country where the confinement took place.

3. Reimbursable treatment relating to infertility

3.1. The costs of in vitro fertilisation resulting from sterility connected with a pathological condition of the member or his/her spouse or partner will be reimbursed subject to prior authorisation on the following conditions:

- the maximum number of attempts authorised is five per child;

- treatment is reimbursed provided that it begins before the mother's 45th birthday.

Cover is provided after reimbursement has been sought from the primary scheme of the spouse or recognised partner.

The following are reimbursed at the rate of 85 %:

- the costs of retrieval of the oocyte or spermatocyte, fertilisation and culturing, subject to a ceiling corresponding to that for category B1 surgical operations.
- the costs of stimulation, tests, analyses, laboratory work and conservation (of oocytes and spermatocytes).

The costs of pre-implantation genetic diagnosis on the embryo are reimbursed subject to prior authorisation if a disease or genetic abnormality has been identified in a relation of the first or second degree.

The costs of egg donation (costs of stimulation and retrieval from the donor, excluding all other costs) are reimbursed subject to prior authorisation in the case of pathological sterility of the mother, for example following chemotherapy, radiotherapy or bilateral

ovariectomy, excluding voluntary sterilisation unless resulting from a proven pathological condition.

3.2. Treatment for male infertility, provided it does not result from previous voluntary sterilisation, is reimbursed at the rate of 85% as follows:

a) surgical operations subject to a ceiling corresponding to the category of the surgical operation:

- vaso-vasostomy: category B1
- epididymo-deferential anastomosis: category B1
- ejaculatory duct resection: category B1
- varicocele repair: category A2

b) artificial insemination with sperm from the patient or from a donor,

c) in vitro fertilisation including with intra-cytoplasmic sperm injection (ICSI) subject to the conditions laid down in paragraph 3.1.

d) removal of sperm (deferential, epididymal or testicular) and preparation for ICSI, subject to a ceiling corresponding to category A2 surgical operations.

NB: Improving sperm quality is dealt with in the chapter on medicines and penile implants are dealt with in the chapter on prostheses.

Chapter 8 – Miscellaneous treatments

1. General provisions

1.1. The costs of the treatments listed under point 2 below, prescribed by a doctor or, in the case of psychotherapy or similar treatments, by a psychiatrist, neuropsychiatrist or neurologist, are reimbursed at the rate of 80%, up to the ceiling for each type of treatment, or 100% in the case of serious illness, up to twice the ceiling normally applied.

1.2. The maximum number of sessions that can be reimbursed over a calendar year is specified for each type of treatment. Unless stated otherwise, the costs of a higher number of sessions may be reimbursed, subject to prior authorisation, in the case of recognised serious illness, post-operative or post-traumatic rehabilitation or reduced mobility.

1.3. Medical prescriptions must be drawn up before the start of treatment and dated less than six months before the date of the first treatment. They must include at least the following information:

- the patient's name,
- the reason for the treatment,
- the type of treatment and the number of sessions prescribed.

Other specific information or conditions listed under point 2 may be required, depending on the treatment.

1.4. Treatments must correspond to the treatments specified on the medical prescription and must be carried out by professionally qualified and legally recognised practitioners.

1.5. Invoices must be drawn up by the practitioners themselves, except in the case of treatment at a hospital, rehabilitation centre or at a thermal cure centre, if prior authorisation has been obtained for such a cure.

Invoices from establishments such as beauty salons, fitness centres, hotels, and thalassotherapy and balneotherapy centres are not reimbursed.

1.6. The following are not reimbursed: treatment for aesthetic purposes, swimming pool subscriptions, enrolment fees for sports or fitness centres.

1.7. Any treatment not listed under point 2 is subject to prior authorisation.

2. Special provisions

MP: Medical prescription required

PA: Prior authorisation required

A. Treatments for which a medical prescription is required						
	Type of treatment	MP	PA	Maximum number of sessions per year / (12 months)	Ceiling 80% (€)	Comments
A 1	Aerosol therapy	**x**		**30**	**--**	
A 2	Consulting a dietician	**x**		**10**	**25**	
A 3	Kinesitherapy, physiotherapy and similar treatments[2]	**x**		**60**	**25**	
A4	Medical chiropody	**x**		**12**	**25**	

[2] Similar treatments such as medical massage, remedial gymnastics, mobilisation, occupational therapy, mechanotherapy, traction, mud baths, hydromassage, hydrotherapy, electrotherapy, diadynamic currents, microwave therapy, ionisation, short-wave therapy, special forms of electrotherapy, infrared rays, ultrasound, etc.

B. Treatments that must be carried out by a doctor or in a hospital

	Type of treatment	MP	PA	Maximum number of sessions per year / (12 months)	Ceiling 80% (€)	Comments
B 1	Acupuncture	**x**		**30**	**25**	**Carried out by a practitioner legally authorised to perform this kind of treatment**
B 2	Mesodermal treatment	**x**	**x**	**30**	**45**	**- Carried out by a doctor or in a hospital (doctor's fees included in the ceiling of €45 per session)** **- A higher number of sessions per year cannot be allowed**
B 3	Ultraviolet radiation	**x**	**x**		**35**	

C. Treatments for which a medical prescription is required and which are, in certain cases, subject to prior authorisation

	Type of treatment	MP	PA	Maximum number of sessions per year / (12 months)	Ceiling 80% (€)	Comments
C 1	Full psychological examination/assessment by a single practitioner	**x**			**150**	

	Chiropractic/osteopathy	**x**		**24**		**A higher number of sessions per year may be allowed only subject to PA. Cranial, energetic and visceral osteopathy and micro-osteopathy are not reimbursed.**
C 2	• People aged 12 or over				**40**	
	• Children aged under 12	**x**	**x**	**24**		
	Speech therapy **(medical report drawn up by ENT doctor or neurologist)**				**35**	
	• Children aged up to 12	**x**		**180 over one or more years**		**Serious neurological disorders: more than 180 sessions subject to prior authorisation**
	• Children aged between 13 and 18	**x**	**x**	**30 for the entire treatment**		
C 3	• People aged over 18	**x**	**x**			**This concerns:** **- children suffering from serious deafness or neurological disease** **- adults suffering from neurological or laryngeal disease**
	Logopaedic assessment					

				40		
	Type of treatment	MP	PA	Maximum number of sessions per year / (12 months)	Ceiling 80% (€)	Comments
C 4	Psychomotor therapy, graphomotor therapy	**x**		**60**	**35**	
	Psychotherapy			**30 all types of session**	**60** **90** **25**	• **Individual session** • **Family session** • **Group session** **Extra sessions above the maximum number per year may be allowed subject to PA**
C5	Carried out by • doctor specialising in psychiatry, neuropsychiatry or neurology • psychologist or psychotherapist	**x**	**x**			○ **Prescription by psychiatrist, neuropsychiatrist or neurologist** ○ **First 10 sessions may be prescribed by a general practitioner**

- **For children aged under 15 the prescription may be drawn up by a paediatrician**

D. Treatments always subject to prior authorisation

Type of treatment	MP	PA	Maximum number of	Ceiling 80%	Comments

				sessions per year / (12 months)	(€)	
D 1	Multidisciplinary neuropsychological assessment	**x**	**x**		**600**	**On the basis of a medical report by a neuropaediatrician or psychiatrist**
D 2	Hyperbaric chamber	**X**	**x**		**--**	
D 3	Lymphatic drainage	**x**	**x**	**20 /12 months**	**25**	**In case of serious illness, no limit on number of sessions and no ceiling**
D 4	Endermology not for aesthetic purposes	**x**	**x**	**5 / 12 months**	**--**	**Treatment of deforming scars**
D 5	Hair removal	**x**	**x**		**Maximum amount reimbursed equivalent surgical operation** **- Cat. A1** **- Cat. A2**	**Only in the case of pathological hirsutism of the face** **- Cat. A1 for non-extensive cases** **- Cat. A2 for extensive cases**
D 6	Ergotherapy	**x**	**x**	**--**	**--**	
D 7	Laser: Laser or dynamic phototherapy (dermatology)	**x**	**x**	**20**	**--**	

D 8	Orthoptic	**x**	**x**	**20 /12 months**	**35**	**Prescription by doctor specialising in ophthalmology, naming the orthoptist**

	Type of treatment	MP	PA	Maximum number of sessions per year / (12 months)	Ceiling 80% (€)	Comments
D 9	Multidisciplinary functional rehabilitation in an out-patient clinic	**x**	**x**	**--**	**--**	
D10	Rehabilitation using MedX machine, treatment using the "David Back Clinic" or back school method	**x**	**x**	**24 renewable, normally once**	**40**	
D11	Shock wave therapy (rheumatology)	**x**	**x**	**--**	**--**	
D12	Any other unspecified treatment	**x**	**x**	**--**	**--**	

Chapter 9: Medical auxiliaries

The fees for treatment by medical auxiliaries are reimbursed at the rate of 80%, or 100% in the case of serious illness, on condition that the treatment was prescribed by a medical practitioner and provided by a person legally authorised to exercise the profession.

If the insured person is receiving home care, prior authorisation is required for additional skilled treatments such as injections or complicated dressings, which cannot legally be provided by the carer.

Chapter 10 - Cures

Section 1 – Convalescent and post-operative cures

1. General

Convalescent and post-operative cures qualify for reimbursement subject to prior authorisation on condition that:

1. they are carried out under medical supervision in convalescent centres with an appropriate medical and paramedical infrastructure; all other types of centre are excluded;

2. they commence within three months of the operation or illness for which they have been prescribed, except where there is a medical contra-indication duly justified in the report accompanying the medical prescription and accepted by the medical officer.

The authorisation may be renewed in the event of a relapse or a new illness.

2. Conditions for obtaining prior authorisation

The application for prior authorisation must be sent to the Settlements Office together with a medical prescription drawn up within the last three months by a medical practitioner who has no links with a cure centre. The prescription must be accompanied by a detailed medical report explaining why the cure is necessary.

A cure cannot be authorised until it has been recognised as necessary by the Medical Officer on the basis of the medical report mentioned above.

Authorisation will not be granted retroactively. The Scheme will not reimburse any treatments, examinations or consultations carried out in a cure centre if the cure has not been authorised.

3. Rules on reimbursement

The following expenses are reimbursed:

- Accommodation costs:

  The cost of accommodation is reimbursed at the rate of 80% for a maximum period of 28 days per annum, with a ceiling of €36 per day. In the case of a cure prescribed in connection with a serious illness such costs are reimbursed at the rate of 100%, with a special reimbursement ceiling of €45 per day.

  These expenses cannot be considered to be hospital expenses.

- Treatment costs:

  The cost of treatment is reimbursed separately in accordance with the provisions laid down in these general provisions.

- Cost of stay for person accompanying the patient:

  In exceptional circumstances, the accommodation costs of an accompanying person may be reimbursed at the rate of 85%, with a ceiling of €40 per day, subject to presentation of a medical prescription and with prior authorisation, in the following cases:

  - for a family member staying in the same room, or within the establishment offering the cure, if the person following the cure is under the age of 14 or requires special assistance because of the nature of the condition or on other duly substantiated medical grounds,

  - for a child who is being breastfed and has to accompany its mother on the cure.

  In all other cases the accommodation costs of an accompanying person are not reimbursed.

4. Excluded from reimbursement

Travel expenses.

5. Reimbursement conditions

Claims for reimbursement must be accompanied by invoices setting out the accommodation costs and treatment costs separately, and a report from the establishment's doctor listing the treatments followed drawn up at the end of the cure and addressed to the Medical Officer of the Settlements Office.

Section 2 – Thermal cures

1. General

A thermal cure is a stay of not less than ten days and not more than 21 days at a specialist establishment providing treatment under medical supervision using water taken from a spring before it has lost its biological and pharmacodynamic properties which derive from its richness in ions and oligoelements.

A stay in a paramedical centre approved by the national health authorities and specialising exclusively in the treatment of chronic illnesses can be considered to be equivalent to a thermal cure.

To qualify for reimbursement, the cure must be authorised in advance by the Settlements Office after consulting the Medical Officer and take place in a centre approved by the national health authorities.

Authorisation for a cure is limited to:

- one cure a year, up to a maximum of eight cures in the lifetime of the beneficiary, for each of the following categories of pathology:

    1. rheumatism and sequellae of trauma to bones or joints
    2. phlebology and cardio-arterial diseases
    3. neurological diseases
    4. disorders of the digestive tract and related structures, and metabolic disorders
    5. gynaecological disorders and disorders of the kidneys and urinary tract
    6. dermatology and stomatology
    7. diseases of the respiratory tract

- one cure a year provided that it is taken in connection with the treatment of a serious illness or in the case of severe psoriasis which does not respond to conventional treatment.

Cures such as thalassotherapy and fitness cures are not considered to be thermal cures qualifying for reimbursement.

2. Conditions for obtaining prior authorisation for a thermal cure

Applications for prior authorisation must be submitted to the Settlements Office at least six weeks before the anticipated date of commencement of the cure and must indicate the dates of the cure and the name and address of the establishment. It must be accompanied by a prescription from a medical practitioner who has no links with a cure centre and a detailed medical report drawn up within the last three months explaining why the cure is necessary.

The detailed medical report must include:

- the patient's medical history and details of treatments undergone during the previous year for the medical condition for which the cure is necessary; it must describe the most recent progress in the patient's condition and explain the medical grounds for prescribing the cure;
- the duration of the cure, the nature of the thermal treatment to be followed and the type of establishment in relation to the disorder in question, bearing in mind that only a centre approved by the national health authorities may be considered.

Authorisation is granted if the thermal cure is recognised as strictly necessary by the Medical Officer on the basis of the medical report mentioned above and on condition that the insured person has followed the treatments prescribed in the course of the year, that these treatments have proved insufficient and that the cure has proven therapeutic value.

Authorisation will not be granted retroactively and the Scheme will not reimburse any treatments, examinations or consultations carried out in a cure centre if the cure has not been authorised.

3. Rules on reimbursement

The costs of treatment and medical supervision as part of a thermal cure will be reimbursed at the rate of 80%, with an overall ceiling of €64 a day. In the case of a cure prescribed in connection with a serious illness, such costs are reimbursed at the rate of 100%, with a special overall ceiling of €80 per day.

The cost of accommodation for an accompanying person may be reimbursed subject to a medical prescription and prior authorisation:

- for a family member staying in the same room, or within the establishment offering the cure, if the person following the cure is under the age of 14 or requires special family assistance because of the nature of the condition or on duly substantiated medical grounds,

- for a child who is being breastfed and has to accompany its mother on the cure.

To qualify for reimbursement, the cure must include at least two appropriate treatments a day and may not be interrupted, except on presentation of a certificate from the establishment's doctor in support of the interruption on medical grounds or for urgent family reasons (death or serious illness of a family member, etc.).

Treatment costs which remain the responsibility of the beneficiary **qualify for the special reimbursement provided for in Article 24 of the joint rules**.

4. Excluded from reimbursement

The following are not reimbursed as part of a cure:

- travel expenses,
- board, lodging and meals,
- costs ancillary to treatment,
- treatments which are not eligible under the joint rules, such as sea, lake and/or sand baths, thalassotherapy, sauna, solarium, non-medical massages, fitness sessions, yoga sessions, reflexology, shiatsu and similar treatments,
- tests, examinations and other services not directly related to the disorder concerned,
- treatments using thyme or mistletoe extracts, ozonotherapy, oxygenation, own blood treatment, procaine and any other similar treatment or product.

If the cure has not been authorised, reimbursement of the cost of treatment is possible provided that the requirements set out in the general implementing provisions are met, namely:

- an original prescription from a medical practitioner who has no links with a cure centre, dated within the previous six months, and mentioning the diagnosis and the number and type of treatments;

- a detailed invoice corresponding to the medical prescription and indicating the dates and number of sessions and the cost per treatment.

Where treatment is given in an approved thermal cure centre, invoices drawn up directly by the establishment are accepted.

Where treatment is given in an establishment which has not been approved, physiotherapy is the only type of treatment that qualifies for reimbursement, and only on condition that the treatment is provided by a qualified physiotherapist and that the corresponding invoice clearly indicates the physiotherapist's qualifications.

Chapter 11 – Prostheses, orthopaedic appliances, and other medical equipment

1. Sight

1.1. Spectacles

a) General

Reimbursement of the cost of spectacles is limited to two pairs, consisting of a frame and corrective lenses regardless of type:

- either one pair of spectacles with single vision lenses for near vision and one pair of spectacles with single vision lenses for distance vision,
- or one pair of spectacles with multifocal or progressive lenses and, if necessary, one pair of spectacles for correcting short or long sight.

The Scheme will not reimburse the following:

- spectacles with non-corrective lenses,
- sun-glasses,
- spectacles for work on a computer screen for staff in active employment.

b) Minimum renewal periods

Except in the case of a medically attested change in dioptre or axis of 0.50 or more, the renewal period for reimibursement is two years (one year for children under 18) from the date on which the previous pair of spectacles in the same category was purchased.

c) Reimbursement conditions

The cost of spectacles with corrective lenses prescribed by an ophthalmologist or an ophthalmic optician is reimbursed at the rate of 85%, subject to the following ceilings:

- frames: €120

- lenses:

€110 per single vision lens up to 4 dioptres

€140 per single vision lens from 4.25 to 6 dioptres

€180 per single vision lens from 6.25 to 8 dioptres

€300 per single vision lens of 8.25 dioptres or above

€350 per lens for multifocal or progressive lenses.

The cost of an examination by an ophthalmic optician, in the absence of a prescription or examination by an ophthalmologist, is reimbursed at the rate of 85%, subject to a ceiling corresponding to that for a consultation or visit by a general practitioner.

Costs relating to tests of central vision or measurements using electronic equipment carried out by an optician or an optometrist are included in the ceiling for lenses.

In the case of loss or damage to the frame or lenses before the end of the minimum period for renewal, the cost of repair or replacement is reimbursed up to the value of any previously unused portion of the ceiling for that period.

d) Submission of invoices

The original, receipted invoice must specify:

- the type of vision to be corrected (distance – near – multifocal),
- a description of the lenses (strength of each corrective lens/dioptres),
- the price of the lenses and frame, indicated separately.

1.2. Contact lenses

a) General

- Reimbursement of the cost of corrective contact lenses does not rule out reimbursement of a pair of spectacles with single focus corrective lenses for near or distance vision or of a pair of spectacles with multifocal or progressive lenses.
- In the case of loss or tearing of the contact lenses before the end of the minimum period for renewal, the cost of replacement is reimbursed only up to the value of any previously unused portion of the ceiling for that period.
- The scheme will not reimburse the cost of non-corrective coloured contact lenses.

b) Reimbursement conditions

The cost of purchasing conventional and/or disposable corrective contact lenses, prescribed by an ophthalmologist or ophthalmic optician, and of products for use with them, is reimbursed at the rate of 85%, with a ceiling of €500 per period of 24 months.

Costs associated with adaptation and the supply of trial lenses by the ophthalmologist or ophthalmic optician are included in the ceiling for contact lenses.

The cost of an examination by an ophthalmic optician, in the absence of a prescription or examination by an ophthalmologist, is reimbursed at the rate of 85%, subject to a ceiling corresponding to that for a consultation or visit by a general practitioner.

c) Submission of invoices

The original, receipted invoice must specify:

- the type of vision to be corrected (distance – near – multifocal),
- a description of the contact lenses (strength of each corrective lens/dioptres),
- the type of lenses: disposable or conventional,
- the cost of the lenses.

1.3. Serious medical condition relating to vision

A derogation may be granted from the reimbursement conditions laid down for each category of lens or contact lens, subject to prior authorisation, in the case of recognised serious eye disease, supported by a medical report, or if the cost of purchasing lenses or contact lenses is greatly in excess of the maximum reimbursable amounts as a result of very limited sight or extreme dioptres.

1.4. Artificial eyes

The cost of purchasing artificial eyes is reimbursed at the rate of 85%, or 100% in the case of serious illness.

2. Hearing

2.1. The cost of purchase and repair of hearing aids prescribed by an oto-rhino-laryngologist or audiometrist is reimbursed at the rate of 85%, subject to a ceiling of €1500 per hearing aid.

2.2. The cost of maintenance and batteries is not reimbursed.

2.3. The renewal period for reimbursement in accordance with 2.1. is five years, except where there is a variation in the audiometric conditions and renewal has been prescribed by an oto-rhino-laryngologist.

2.4. A derogation may be granted from the ceilings and minimum renewal periods, subject to prior authorisation and after consultation of the Medical Officer, in the case of hearing aids for children up to the age of 18 or of serious hearing-related illness.

3. Orthopaedic appliances, bandages and other medical equipment

3.1. The cost of purchasing, hiring or repairing to the articles or equipment listed in the table in Annex II is reimbursed at the rate of 85%, or 100% in the case of serious illness.

3.2. In the case of appliances with an estimated cost of more than €2000, an application for prior authorisation, accompanied by a medical report and two detailed comparative estimates, must be submitted.

3.3. If a specific item of equipment is required in connection with a serious illness, prior authorisation derogating from the rules on maximum reimbursable amounts and minimum renewal periods may be obtained, after consultation of the Medical Officer.

3.4. Prior authorisation is required for the hire of orthopaedic appliances or equipment for periods of three consecutive months or more.

3.5. Costs incurred in relation to the purchase of appliances and/or equipment not provided for in these general implementing provisions may be reimbursed provided that prior authorisation has been obtained. Maximum reimbursable amounts may be laid down, based on market prices, after consultation of the Medical Officer.

Chapter 12 – Transport costs

1. **General provisions**

1.1. Prior authorisation must be obtained except in duly substantiated emergencies in which approval can be granted only after the event. The application must be accompanied by a certificate from the patient's doctor describing the nature of the transport and the medical grounds on which it was required.

1.2. If the transport has to be repeated on a regular basis, the medical prescription must set out the reasons and specify the number of essential journeys.

1.3. Prior authorisation is also required if the patient is to be accompanied by another person; the patient's doctor must have declared this to be a matter of absolute necessity, notably on grounds of the patient's age or because of the nature of his or her condition.

1.4. Prior authorisation is granted after consultation of the Medical Officer. The decision will take account, for example, of the fact that the treatment cannot be provided at the beneficiary's place of employment or residence and/or that the beneficiary is unable to use public or private transport.

2. **Reimbursement conditions**

2.1. Only reimbursement of the form of transport most appropriate to the beneficiary's condition to the closest medical establishment or practitioner able to treat his or her condition in an appropriate manner will be considered. Where the urgency of the case makes it impossible to obtain prior authorisation the Medical Officer will be consulted as to whether the costs incurred were justified.

2.2. The costs are reimbursed at the rate of 80%, or 100% in the case of serious illness, on presentation of the original supporting documents (receipted bills, tickets, etc.).

2.3. In the absence of the necessary supporting documents, reimbursement is fixed at 80% or 100% of the first-class rail fare. If there is no rail link, reimbursement is calculated on the basis of 80% or 100% of the €0.22 per kilometre ceiling, indexed by analogy with the European Commission's rules on mission expenses; the person insured must stipulate the distance covered (in kilometres) to the medical establishment or practitioner.

2.4. The transport costs of the person accompanying the patient are reimbursed at a rate of 80% on the same conditions as above, except where a private vehicle is used, in which case no costs are reimbursed.

2.5. The Scheme will not reimburse the following:

a) transport costs incurred for family or linguistic reasons, for personal convenience, for consultation of a general practitioner, for a thermal cure or convalescent care, for the patient to go to his place of work, or for any other reason not recognised by the Settlements Office,

b) repatriation in the event of illness or accident,

c) mountain search and rescue, air-sea rescue, etc.,

d) the cost of transport by private vehicle within the town or city of residence, except in the case of repetitive and arduous treatment, such as radiotherapy, chemotherapy, dialysis, etc. In such cases, transport costs – authorised in advance after consultation of the Medical Officer – are reimbursed under the conditions set out in 2.2 and 2.3.

3. **Staff serving outside the Union**

Transport costs for staff serving outside the European Union are reimbursed in accordance with the provisions of the Staff Regulations and the other rules and regulations applicable to such staff, in particular Annex X to the Staff Regulations.

Chapter 13 - Allowance towards funeral expenses

General provisions

The amount of the allowance towards funeral expenses payable under Article 25 of the joint rules is €2350.

This allowance is paid only on presentation of a copy of the death certificate.

In the case of a still birth, the allowance is granted provided that the foetus had reached at least 22 weeks.

In the case of the death of a person with top-up insurance, the allowance will be reduced by the amount of the allowance of the same type received from another source.

This allowance is separate from the reimbursement of the costs involved in transporting the body of an official in active employment, or of his or her spouse, dependent children or persons treated as dependent children, which by virtue of Article 75 of the Staff Regulations are borne by the institution to which the official belongs.

ANNEX I

LIST OF SURGICAL OPERATIONS
(by category)

N.B.: The purpose of the operations marked with an asterisk (*) is likely to be aesthetic and such operations always require prior authorisation.

CATEGORY A1	
General and plastic surgery	
1	Incision with drainage of an osseous paronychia or the surrounding tissues
2	Excision of one or more small tumours situated in or under the skin
3	Excision of an aponeurotic tumour without opening a cavity (ganglions, lipomas, etc.)
Orthopaedic surgery	
4	Reduction of a fracture of the clavicle
5	Reduction of a fracture of the scapula or sternum
6	Reduction of a dislocation of a finger or toe
Abdominal, urological and gynaecological surgery	
7	Removal of a foreign body from the rectum
8	Operation for a rectal polyp
9	Operation for a partial perineal rupture
10	Lumpectomy of the breast
11	Conisation of the cervix uteri
Vascular and thoracic surgery	
12	Ligature or resection of a varicose vein
Neurosurgery	
	/
ENT and stomatological surgery	

13	Excision of nasal polyps
14	Endoscopic excision of polyps or small tumours of the larynx
15	Operation for a salivary fistula
16	Simple reduction of a fracture of the nose
Eye surgery	
17	Enucleation of a chalazion
18	Laser treatment for a peripheral retinal lesion
19	Laser treatment for iridotomy

CATEGORY A2	
General and plastic surgery	
1	Incision of a deep abscess
2	Incision of an abscess in the pouch of Douglas
3	Incision of a purulent inflammation of soft parts or of a carbuncle
4	Sanguineous removal of a deeply embedded foreign body
5*	Simple skin grafting (less than 10 cm^2)
6	Opening of the ischiorectal fossa
7	Possible supplement for use of a surgical laser
8	Dermabrasion
Orthopaedic surgery	
9	Operation on a joint of the wrist or of the fingers, tarsus or toes
10	Reduction of a fracture of a bone of the forearm
11	Reduction of a fracture of a hand or foot
12	Reduction of a fracture of the patella
13	Reduction of a dislocation of the clavicle or the patella
14	Reduction of a dislocation of the elbow or the knee
15	Reduction of a dislocation of a hand or foot
16	Removal of screws or wires
17	Disarticulation of a finger or toe
18	Total or partial amputation of a finger or toe
19	Amputation of a metacarpal or metatarsal
20	Carpal tunnel operation
Abdominal, urological and gynaecological surgery	
21	Simple operation for an anal fissure

22	Correction of a rectal prolapse
23	Simple laparoscopy
24	Operation for a rectal prolapse by anal cerclage
25	Circumcision
26	Ligature of vasa deferentia
27	Percutaneous nephrostomy or pyelostomy
28	Operation on the external female genital organs
29	Puncture of the epididymus
Vascular and thoracic surgery	
30	Ligature or resection of varicose veins
31	Excision of the internal or external saphenous vein
Neurosurgery	
	/
ENT and stomatological surgery	
32	Reduction of a fracture of the nose using an immobilizing dressing
33	Removal of adenoids
34	Transtympanic drain
35	Extraction of impacted tooth in an operating theatre
36	Extraction of fewer than eight teeth under general anaesthetic
37	Excision of a submandibular gland
Eye surgery	
38	Excision of a non-invasive tumour of the conjunctiva, the cornea, the sclera or the eyelid
39	Simple operation on a lachrymal gland
40*	Canthoplasty (operation on the palpebral fissure)
41	Laser treatment for vasculopathy for secondary cataract

42	Operation on a pterygium

CATEGORY A3	
General and plastic surgery	
1*	Simple skin graft of 10-50 cm² or flap graft of less than 10 cm²
2	Operation on a cyst or a sacrococcygeal fistula
3	Full laser treatment for facial erythrosis
4	Insertion of penile implant
Orthopaedic surgery	
5	Osteotomy or trephination of a bone
6	Reduction of a fracture of the upper arm
7	Reduction of a fracture of both bones of the forearm
8	Reduction of a simple fracture of the pelvis
9	Reduction of a fracture of the leg
10	Stitching of a tendon
11	Plastic surgery of the tendon
12	Removal of nails or nail-plates
13	Resection of the coccyx
14	Resection of a joint of the hand or foot (except tibiotarsal joint)
15	Removal of a foreign body from a shoulder, elbow or knee joint
16	Osteotomy of a small bone with implantation of a tendon
17	Open reduction of a fractured clavicle
18	Open reduction of a fracture of the patella
19	Open reduction of a fractured ankle bone
20	Open reduction of a wrist or ankle fracture, except calcaneum
21	Disarticulation of the hand or foot
22	Simple amputation through a metatarsal

Abdominal, urological and gynaecological surgery	
23	Operation for an anal fissure with sphincterotomy
24	Endoscopic procedure on the bladder (resection of the neck, removal of calculi, etc)
25	Operation for varicocele or hydrocele
26	Epididymectomy
27	Orchidopexy
28	Suprapubic cystostomy
29	Endoscopic extraction of a uretral calculus
30	Destruction of urinary calculi by means of shock waves (per treatment)
31	Amputation of the cervix uteri
Vascular and thoracic surgery	
32	Resection of the arch of the internal saphenous vein + complete excision of the internal saphenous vein and/or ligature or resection of one or more varicose veins
33	Bronchoscopy or oesophagoscopy with extraction of a foreign body from the trachea, the bronchi or the oesophagus
Neurosurgery	
34	Microscopic suture of a nerve
ENT and stomatological surgery	
35	Tracheotomy
36	Operation for exostosis of the external auditory canal
37*	Operation for a simple harelip
38	Partial excision of the tongue
39	Surgical removal of a salivary calculus
40	Tonsillectomy
41*	Plastic surgery on the outer ear
42	External trephination of maxillary sinus
43	Endonasal operation on a sinus

44	Exeresis of the parotid without nerve dissection
45	Extraction or eight or more teeth under general anaesthetic
46	Disimpaction and extraction of impacted tooth by pericoronary bone resection and/or dental osteotomy
Eye surgery	
47	Removal of a lachrymal sac
48*	Operation for an ectropion or an entropion
49	Laser treatment of macular lesions for postvitrectomy whole-retina trabeculoplasty or iridoplasty because of adhesions of the vitreous body
50*	Plastic surgery on part of an eyelid
51	Excision of an invasive tumour of the conjunctiva, the cornea, the sclera or the eyelid
52	Removal of a foreign body from the front of the eye socket
53	Operation to correct strabismus by means of tenotomy
54	Operation to prevent detachment of the retina
55	Enucleation of the eyeball

CATEGORY B1	
General and plastic surgery	
1*	Simple graft of more than 50 cm² or tubulate graft
Orthopaedic surgery	
2	Radial surgery for Dupuytren's contracture
3	Resection of the tibiotarsal joint
4	Arthroplasty of a joint of the hand or foot
5	Meniscectomy
6	Reduction of a fractured vertebra
7	Open reduction of a site of fracture of the upper arm, forearm or the leg
8	Open reduction of a bimalleolar or trimalleolar fracture of the ankle
9	Open reduction of a fracture of the calcaneum
10	Reduction of a hip dislocation
11	Reduction of a dislocation of a vertebra
12	Disarticulation of the upper arm, the forearm or the lower leg
13	Amputation of the upper arm, the forearm, the thigh or the lower leg
14	Resection of the shoulder, elbow or knee joint
15	Operation for hallux valgus by the combined method
16	Suture of two or more tendons
17	Tendon graft
18	Plastic surgery on two tendons
19	Percutaneous discectomy for prolapsed intervertebral disc
20	Suture of the knee ligaments
21	Plastic surgery on the lateral knee ligaments
Abdominal, urological and gynaecological surgery	

22	Operation for a rectal fistula
23	Exploratory laparotomy
24	Appendectomy
25	Opening of an abscess in the abdomen
26	Operation for an inguinal or femoral hernia
27	Operation for an umbilical or epigastric hernia
28	Operation for a rectal prolapse by resection or plication of the levator ani muscles
29	Operation for haemorrhoids
30*	Eventration operation with plastic surgery
31	Pyelotomy
32	Exploratory lombotomy
33	Nephrostomy
34	Sanguineous extraction of a uretral calculus
35	Perineal urethrostomy
36	Endoscopic excision of a tumour of the bladder
37	Operation on the urethra
38	Correction of a retroverted uterus
39	Complete resection of the endometrium
40	Hysteropexy
41	Operation for complete rupture of the perineum
42	Colporraphy, with or without perineorraphy
43	Vaginal or abdominal excision of one or more uterine myomas
44	Unilateral or bilateral ovariosalpingectomy or other operation on the ovaries
45	Caesarean section
46	Operation for genital prolapse by anterior or posterior colporraphy
47	Vaginal or abdominal procedure to correct urinary incontinence

48	Treatment of the prostate using heat or laser therapy
49	Reanastomosis of vas deferens
Vascular and thoracic surgery	
50	Resection of the arch of the internal saphenous vein + excision of the internal and external saphenous veins
51	Opening of the pericardium
52	Implantation of a pacemaker
53	Stripping using radiofrequency energy
Neurosurgery	
54	Suture and grafting of a nerve or simple suture of several nerves, or intrafascicular neurolysis of a nerve
55	Operation for fractured skull with plastic surgery if necessary
56	Treatment for intracerebral haematoma by simple trepanation
ENT and stomatological surgery	
56*	Operation on a complicated harelip
57	External treatment of a sinus
58	Endonasal resection of an osseous choanal obstruction
59	Removal of a nasopharyngeal fibroma
60	Trephination of the mastoid
61	Eardrum graft
62	Submucous resection of the nasal septum
63	Simple thyroidectomy
64	Arthroplasty or other operation on a maxillary joint
65	Plastic surgery for incomplete cleft palate
66	Partial resection of a jawbone
Eye surgery	
67	Suture of a penetrating wound to the eyeball

68	Iridectomy
69	Anterior excision of a tumour of the eye socket
70*	Operation for ptosis
71*	Plastic surgery on an eyelid completely adhering to the eyeball or completely destroyed
72	Operation for strabismus using a method other than tenotomy
73	Radial or laser keratotomy to correct myopia
74	Enucleation of the eyeball with insertion of an optical implant for a prosthesis
75	Reconstruction of the lachrymal duct
76	Removal of a foreign body from the eye socket

CATEGORY B2	
General and plastic surgery	
1	Graft using pedicled flap with a side of more than 10 cm²
2*	Breast reduction surgery
3*	Breast reconstruction using a cutaneous or musculocutaneous flap
Orthopaedic surgery	
4	Operation for a recurrent dislocated shoulder or knee joint
5	Operation for a fracture of the femur or neck of the femur
6	Operation for a fracture of both bones of the forearm or a double fracture of the lower leg
7	Disarticulation of the thigh
8	Resection of the hip or removal of a prosthesis
9	Arthroplasty of the shoulder or elbow
10	Ligamentoplasty of cruciate ligament of the knee
11	Amputation of the shoulder girdle through the joint
12	Two-tendon graft
13	Tenontoplasty of three or more tendons
14	Operation for herniated dorsolumbar disc
Abdominal, urological and gynaecological surgery	
15	Abdominoperineal operation for a rectal prolapse
16	Operation for incompetence of the anal sphincter by means of myoplasty
17	Operation for a strangulated hernia with removal of part of the intestines
18	Low or abdominoperineal removal of the rectum
19	Cholecystectomy (normal or by laparoscopy)
20	Segmentary resection of the small intestine
21	Left-lobe hemipancreatectomy

22	Colonic reanastomosis
23	Unilateral removal of an adrenal gland
24	Endoscopic or suprapubic resection of the prostate
25	Treatment of hypospadias or epispadias by plastic surgery
26	Transdermal extraction of urinary calculus following fragmentation by ultrasound
27	Partial nephrectomy
28	Plastic surgery on the pelvis of a kidney
29	Partial cystectomy
30	Operation for incontinence of urine by prosthetic sphincter
31	Simple mastectomy or mastectomy with lymphectomy
32	Triple perineo-vaginal operation for genital prolapse
33	Vaginal and abdominal procedure to correct urinary incontinence
34	Vaginal or abdominal hysterectomy
35	Operation for a vesicovaginal or rectovaginal fistula
36	Creation of a neovagina
37	Extracorporeal shock wave lithotripsy
Vascular and thoracic surgery	
38	Arterial embolectomy
39	Lumbar sympathectomy
Neurosurgery	
40	Operation on the spinal cord
41	Suture and grafting of more than one nerve
ENT and stomatological surgery	
42*	Reconstruction of the nose
43	Laryngotomy
44	Operation for unilateral pansinusitis

45	Plastic surgery for complete cleft palate
46	Excision of the parotid gland with dissection of the facial nerve
47	Endoscopic surgery on the larynx
48	Petromastoid excavation
49	Complete resection of a jawbone
Eye surgery	
50	Removal of a magnetic foreign body from the back of the eye
51	Operation to correct strabismus by means of a muscle transplant
52	Cataract operation
53	Operation for glaucoma

CATEGORY C1	
General and plastic surgery	
	/
Orthopaedic surgery	
1	Arthroplasty of the acetabulum
2	Repair of more than one knee ligament
3	Graft of at least three tendons
Abdominal, urological and gynaecological surgery	
4	Subtotal gastrectomy
5	Hemicolectomy
6	Laparoscopic repair of hiatal hernia or bilateral inguinal hernia
7	Operation for a diaphragmatic hernia
8	Partial hepatectomy
9	Partial nephrectomy
Vascular and thoracic surgery	
10	Bypass of an artery of a limb
11	Transluminal dilatation of an artery other than the coronary artery
Neurosurgery	
	/
ENT and stomatological surgery	
12	Thyroidectomy with dissection of the recurrent nerves and/or parathyroid glands
13	Total laryngectomy
Eye surgery	
14	Removal of a non-magnetic foreign body from the back of the eye
15	Corneal graft

CATEGORY C2	
General and plastic surgery	
	/
Orthopaedic surgery	
1	Operation for lumbar canal stenosis
2	Operation for prolapsed cervical or dorsolumbar disc with arthrodesis
3	Total prosthesis of the hip
Abdominal, urological and gynaecological surgery	
4	Total gastrectomy with oesophagojejunal anastomosis
5	Total pancreatectomy or hemipancreatectomy with anastomosis
6	Bilateral adrenalectomy
7	Total colectomy
8	Total prostatectomy + removal of the seminal vesicles via the abdomen
9	Extraction of coral calculus by pyelotomy
10	Left hepatectomy
11	Radical hysterectomy with lymphectomy
12	Abdominoperineal amputation of the rectum
Vascular and thoracic surgery	
13	Revascularisation of a carotid artery
14	Revascularisation of an artery in a limb by internal saphenous vein graft
15	Revascularisation of the infrarenal aorta, including bifurcation
16	Revascularisation of a major thoracic vessel
17	Heart operation without extracorporeal circulation or hypothermia
18	Excision of a mediastinal tumour
Neurosurgery	

19	Intracranial haematoma repair through large trepanation
20	Placement of a drain for hydrocephalus
21	Removal of a tumour of the spinal canal
ENT and stomatological surgery	
22	Partial laryngectomy with reconstruction
23	Radical surgery for bilateral pansinusitis
24	Fenestration or operation on the ossicular chain
25	Resection of the jawbone and skull base
Eye surgery	
26	Operations for detachment of the retina

CATEGORY D1	
General and plastic surgery	
	/
Orthopaedic surgery	
	/
Abdominal, urological and gynaecological surgery	
1	Total gastrectomy + hemipancreatectomy
2	Duodenopancreatectomy
3	Portocaval shunt or similar
4	Total colectomy with ileal pouch reconstruction
5	Endothoracic operations on the oesophagus
6	Right hepatectomy
Vascular and thoracic surgery	
7	Operation on the heart or the great vessels with hypothermia
8	Operation on the heart or the great thoracic vessels with extracorporeal circulation
9	Pneumonectomy
Neurosurgery	
10	Treatment for intracerebral haematoma
11	Treatment for intracerebral tumour through large trepanation
12	Operation on the pituitary gland by trepanation or transnasal endoscopy
ENT and stomatological surgery	
	/
Eye surgery	
	/

CATEGORY D2	
General and plastic surgery	
	/
Orthopaedic surgery	
	/
Abdominal, urological and gynaecological surgery	
	/
Neurosurgery	
1	Operation for infratentorial brain tumour through large trepanation
2	Operation for intracerebral aneurysm
3	Operation for intramedullar tumour
4	Operation for a cerebellopontine angle tumour
ENT and stomatological surgery	
	/
Eye surgery	
	/
Transplants	
6	Kidney
7	bone marrow
8	Pancreas
9	heart and/or lungs
10	kidney and liver
11	liver

ANNEX II Cost of orthopaedic appliances, bandages and other medical equipment reimbursed at the rate of 85%, or 100% in the case of serious illness

	Products	MP: medical prescription	PA: prior authorisation (requiring detailed medical report and estimate)	Duration/ deadline	Normal rate of reimbursement	Maximum amount reimbursable at 85% (EUR)	Maximum amount reimbursable at 100% (EUR)	Comments	Equipment related to level of dependence
1	Compresses - elastic bandages - other, e.g. maternity belts, knee bandages, ankle supports and simple lumbar girdles	MP	None		85%				
	Elastic stockings for varicose veins	MP	None		85%			3 pairs a year	
2	Purchase or alteration of orthopaedic soles (per sole)	MP	None		85%	65	65	4 times a year	
	Repair of orthopaedic sole	Not reimbursed			0%				
3	Crutches and walking sticks								

	purchase	MP	None		85%				
	hire	MP	None		85%				
	repair	Not reimbursed							
4	External breast prostheses	MP	None		85%			2 per side per year	
	Prosthesis bras or swimming costumes	Not reimbursed			0%				
5	Simple manual wheelchair								*
	purchase	MP	PA	5 years	85%	650			
	hire < 3 months	MP	None		85%				
	hire > = 3 months	MP	PA	5 years	85%	650			
	repair	PA			85%				
	maintenance (tyres, etc.)	Not reimbursed			0%				
6	Walking frame with 2 wheels and seat								*
	purchase	MP	PA		85%	140	140	1 non-renewable agreement	
	hire < 3 months	MP	None		85%				
	hire > = 3 months	MP	PA		85%				
	repair	Not reimbursed			0%				
7	Commode, shower/bath seat (home use)								*

	purchase	MP	PA		85%	100	100	1 non-renewable agreement	
	hire < 3 months	MP	None		85%				
	hire > = 3 months	MP	PA		85%				
	repair	Not reimbursed			0%				
8	Hospital-type bed (for home use)								*
	purchase	MP	PA		85%	1.000	1.000	1 non-renewable agreement	
	hire < 3 months	MP	None		85%				
	hire > = 3 months	MP	PA		85%				
	repair or use in a nursing home, etc.	Not reimbursed			0%				
9	Pressure relief mattress, including compressor								*
	purchase	MP	PA	3 years	85%	500	500		
	hire < 3 months	MP	None		85%				
	hire > = 3 months	MP	PA		85%				
10	Sleep apnoeia equipment (CPAP), including humidifier								
	purchase	MP	PA	5 years	85%	1.700	1.700		
	hire < 3 months	MP	None		85%				
	hire > = 3 months	MP	PA		85%				

	CPAP accessories and maintenance excluding year of purchase	MP	PA	1 year	85%	350			
11	Blood pressure gauge	MP	PA	5 years	85%	125	125		
	repair	Not reimbursed			0%				
12	Aerosols, sprays and inhalers								
	purchase	MP	PA	5 years	85%	125	125		
	hire	MP	None		85%				
	hire > = 3 months	MP	PA		85%				
	repair	Not reimbursed			0%				
13	Equipment for monitoring and treating diabetes treated with insulin								
	glucometer	MP	PA	3 years	100%		75		
	test-strips, insulin syringes, lancets	MP	PA		100%			MP for first purchase only	
14	Equipment for monitoring and treating type-2 diabetes not requiring insulin, with glycated haemoglobin levels of more than 7%								
	glucometer	MP	PA	3 years	85%	75			
	test strips	MP	PA		85%	500		Maximum amount reimbursed per year	

15	Incontinence supplies	MP	PA	1 year	85%	600	600		*
16	Ostomy supplies	MP	None		85%				
17	Hair replacement - wig	MP	PA	1 year	85%	750	750		
18	Pair of corrective orthopaedic shoes made to measure								
	purchase in the case of a disorder of the foot not qualifying for 100% reimbursement	MP	PA		85%	720	NA	2 pairs a year	
	purchase in the case of a disorder of the foot qualifying for 100% reimbursement	MP	PA		100%	NA	1.440	2 pairs a year	
	purchase in the case of serious disease of the foot	MP	PA		100%	NA		2 pairs a year	
	repair, on presentation of the invoice	None	None		85%				
19	Artificial limbs and segments of limbs, articulated orthoses								
	purchase	MP	PA	to be decided on an individual basis, estimate required					
	repair, on presentation of the invoice	MP	PA	to be decided on an individual basis					
20	Other appliances with an estimated cost of more than €2000	MP	PA	to be decided on an individual basis, estimate required					
	specific, electric, electronic equipment and/or equipment made-to-measure in the case of serious illness (purchase)	MP	PA	to be decided on an individual basis, estimate required					*
21	Enemas and thermometers	Not reimbursed			0%				
22	Vacuum treatment for impotence	MP	PA			200	200		

23	Apparatus for measuring blood clotting time	MP	PA					criteria: in the case of anticoagulation for life	
24	Syringes	MP	PA					criteria: in the case of diabetes (cf.13) or other chronic illnesses requiring repeated injections	
25	Fixed costs of converting a residence or a vehicle, of home automation equipment, IT equipment, home monitoring (lifeline), furniture which is not strictly for medical use, such as reclining chairs and similar articles, are not covered by the scheme and are therefore not reimbursed.	Not reimbursed			0%				*

Title III – PROCEDURES

Chapter 1 – Claims for reimbursement and supporting documentation

1. **General provisions**

1.1. The treatment referred to in Title II of these general implementing provisions must be carried out by a legally authorised medical or paramedical practitioner, or by medical or paramedical establishments duly approved by the competent authorities.

1.2. The JSIS does not cover the cost of care provided by a practitioner (doctor, dentist, midwife, nurse, paramedic, etc.) to his or her spouse, recognised partner, relative in the descending line, relative in the ascending line, father-in-law, mother-in-law, brother, sister, brother- or sister-in-law, son- or daughter-in-law, uncle, aunt, niece or nephew. The cost of products or supplies used during such treatment may however be reimbursed according to the provisions of the joint rules.

2. **Claims for reimbursement**

Claims for reimbursement are to be made by members using the official claim forms duly completed and submitted, other than in cases of force majeure, no later than 18 months after the treatment was provided.

Members must indicate the type of reimbursement they are applying for, i.e.:

a) normal reimbursement;
b) reimbursement for an accident or occupational disease (giving the corresponding references);
c) reimbursement for serious illness (giving the corresponding references);
d) reimbursement for staff serving outside the European Union.

3. **Information to be included**

3.1 Original invoices and receipts (other than for top-up reimbursement) with the dates and fees paid for each medical treatment. Copies, duplicates and reminders are not acceptable, other than in duly documented cases of force majeure, such as loss, theft or destruction.

In the case of a surgical operation, the surgeon must state the nature of the operation. To maintain confidentiality, this information may be provided in a sealed envelope addressed to the Settlements Office Medical Officer.

3.2 The original of the medical prescription. A copy of the prescription or another official document showing the information contained in the prescription may be accepted if the healthcare provider needs to keep the original, or if the care or treatment is being repeated.

3.3 The reference number of the prior authorisation/estimate for dental treatment.

Members must sign claims for reimbursement, certifying that the documentation included is genuine and that the invoices have been paid.

Unsigned claims for reimbursement will not be accepted.

4. **Special provisions**

4.1. Claims for the special reimbursement referred to in Article 24 of the joint rules must be made within 12 months of the date on which the expenses last incurred in respect of treatment within the 12-month period in question were reimbursed.

4.2. For treatment not invoiced in euros, the conversion rate used for the rate of reimbursement and for the reimbursement is the one that applies in the month during which the claim for reimbursement was registered in the Settlements Office.

In the event, however, of a major devaluation of the currency, the Settlements Office may apply the monthly conversion rate that applied when the most recent medical treatment included in the claim for reimbursement was carried out. This exception applies only to medical treatment carried out in the three months preceding the devaluation.

4.3. Reimbursements are paid into the bank account into which the salary or pension is paid.

5. **Supporting documents**

5.1. Receipts and invoices must conform to local legislation in the country of issue, and must include the following information:

- the patient's full name
- the nature of the treatment
- the dates and fees paid for each medical treatment
- the name and official references of the healthcare provider.

5.2. Advances and prepayments will not be taken into consideration unless they are included with the final invoice.

6. **Pharmaceutical products**

Reimbursement for medicine is carried out on the basis of receipts or invoices from chemists containing the following information:

- the name of the prescribing practitioner
- the patient's full name
- the name of the prescribed medicine or, for generic medicinal products, the product supplied, or the composition of the preparation for magistral preparations (the preparation number will not suffice)

- the price of each product
- a mention of the full price and, for persons with top-up insurance, the price actually paid
- the date on which the medicines were supplied
- the chemist's stamp and signature.

These requirements also apply for repeat prescriptions.

Chapter 2 – Early diagnosis and health screening programmes

1. The Central Office, acting on a proposal from the Medical Council and after consulting the Sickness Insurance Management Committee, issues a list of medical tests that are included in the early diagnosis and health screening programmes. The composition of the programme and the regularity of the tests are determined on the basis of the age and sex of beneficiaries. All members of the Scheme are notified of this information.

The composition of the programmes may be amended to reflect medical advances in the area in question.

2. Members who wish to take screening tests must apply through their Settlements Office. After checking entitlement and the time elapsed since the previous tests, the Settlements Office issues an authorisation for the examination at an approved centre.

Only the costs of screening tests carried out at an approved centre, as part of a programme and at prescribed intervals, are reimbursed in full and paid directly by the JSIS without the member being invoiced.

The cost of any additional tests which prove necessary but are not included in the early diagnosis and screening programmes are reimbursed in accordance with the relevant provisions.

The costs of transport and subsistence aid of a person accompanying the patient are not eligible for reimbursement.

3. If, for reasons beyond his or her control, a beneficiary is unable to attend an approved centre, the Settlements Office may authorise the corresponding screening tests to be carried out at a medical or healthcare centre near the place of employment or residence. For such costs to be reimbursed in full, the member must submit a specific claim for reimbursement that includes all corresponding expenditure, accompanied by the originals of the supporting documentation.

Chapter 3 – Implementing rules for top-up reimbursement

1. Definition

Top-up cover is intended to ensure that persons who are covered by a national social security scheme receive the same level of reimbursement that they would have received if they had been primarily insured by the JSIS, without generating any unjustified expenditure for the Scheme.

Reimbursement may never be in excess of 100%, even when it is obtained under a private top-up insurance scheme, unless the exact amount cannot be calculated on account of the flat-rate nature of such a scheme.

2. Top-up beneficiaries

The following are eligible for top-up reimbursement:

2.1. Members, as defined in Article 2 of the joint rules, who voluntarily choose a different legal or statutory sickness insurance scheme as their primary cover.

2.2. The member's spouse or recognised partner who is not gainfully employed or in receipt of income deriving from previous gainful employment but is eligible for cover by another legal or statutory sickness insurance scheme and voluntarily chooses such a scheme.

2.3. A spouse or recognised partner who is in gainful employment or in receipt of income deriving from previous gainful employment, as defined in Article 13(2) of the joint rules, provided that his or her income before tax is less than the annual basic salary in grade AST2/1 multiplied by the correction coefficient for the country in which the income is received, and that he or she is covered by a sickness insurance scheme for all the treatment covered by the JSIS.

2.4. In order to maintain his or her spouse or partner's eligibility for top-up reimbursement, the member must send the Settlements Office official documentary evidence of their pre-tax income (such as a tax certificate or other document drawn up by the competent national authorities) each year.

Eligibility may then be extended on the basis of such documents from 1 July of the current year to 30 June of the following year.

If a spouse or partner enters gainful employment in the course of the year, eligibility for top-up cover is fixed on the basis of the actual amount earned (before tax) during the fraction of the year in question, starting from the date on which the first income was received. If the income from gainful employment of the spouse or partner changes in the course of the year, this is taken into account only for fixing entitlements the following year.

2.5. Member's children who are dependent within the meaning of Article 2 of Annex VII to the Staff Regulations, provided the scheme of the spouse or partner referred to above has agreed to provide them with primary cover without complementary contributions.

3. Procedures

Beneficiaries of top-up cover must begin by applying to their primary national social security scheme for reimbursement of medical expenses, as the JSIS acts only as a top-up scheme.

However, expenditure related to treatment that is not reimbursed by the primary scheme may be reimbursed by the JSIS provided it is covered by the Scheme. In such cases, the JSIS effectively acts as the primary insurer.

If, as a result of the freedom to choose the healthcare provider, especially for expenditure on healthcare received abroad, no reimbursement from the primary scheme is possible, the JSIS may also cover treatment which is reimbursable, provided the necessary documentation is provided, showing that the procedures and rules of the primary scheme have first been respected. In such cases the JSIS becomes the primary scheme for the treatment concerned.

Beneficiaries of top-up cover who depend on a national health service may only be reimbursed for expenditure incurred in the private sector for the healthcare treatments listed below if they can show that there are obvious failings in the public system (e.g. long waiting lists, or if the treatment is not available):

- hospitalisation and surgical operations
- treatment and examinations in hospitals
- convalescent and nursing homes
- home carers
- thermal cures and convalescence

Prior authorisation is required.

Other treatments not included in the list above may be reimbursed by the JSIS provided it covers such treatment.

Restrictions on freedom of choice do not apply either to the member or to dependent children with top-up cover.

4. Reimbursement

Claims for reimbursement must be sent to the Settlements Office according to the usual procedures.

If there has been partial reimbursement by the primary scheme, a copy of the invoices and the original statement of account from the primary scheme detailing the treatment that has been reimbursed must be included with the claim for reimbursement.

If the patient did not have to pay for all the treatment, but only certain parts (e.g. an additional contribution, or a supplement), the total cost of the treatment must still be included, as must the contribution paid by the primary scheme, and not simply the amount actually paid by the insured person.

As top-up reimbursement is calculated separately for each treatment, any reimbursement already received for a particular treatment should always be mentioned. Only the difference between the reimbursement obtained from the JSIS and the reimbursement obtained from the external scheme is eligible to be covered, subject to the percentages and ceilings that have been laid down.

If, however, it proves impossible to ascertain the full cost of the treatment, and provided such treatment is indeed eligible for reimbursement, the patient's contribution may be reimbursed at the rate provided for in the Scheme.

If the JSIS agrees to take the place of the primary scheme, the claim for reimbursement must include the original invoice that was paid and documentation showing the reasons for the primary scheme's refusal to pay.

Chapter 4 – Direct billing and advances

In line with Article 30 of the joint rules, members may be granted advances to help them cope with major items of expenditure. Direct billing is the primary form of assistance, although advances may be granted under exceptional circumstances.

Members who are only eligible for JSIS top-up cover will not be granted direct billing unless it can be established, by means of the necessary documentation, that the JSIS is to take the place of the primary scheme in accordance with the provisions of this Title on top-up cover.

1. Direct billing

Members must apply for direct billing in advance, except in an emergency or a case of force majeure.

Direct billing is granted in the following instances:

- In the event of hospitalisation, direct billing covers the main invoices and the surgeon's fees.

  If they are invoiced separately, invoices from the anaesthetist and the assistant may also be covered by direct billing.

  The maximum duration of direct billing of this type is 60 days. If the stay in hospital exceeds 60 days, an application for an extension should be submitted to the Medical Officer, together with a medical report explaining the need for the extension.

- Intensive out-patient care as part of a serious illness, such as radiotherapy, chemotherapy or dialysis.

- Expensive medicines that must be bought repeatedly, such as growth hormones, repeated use of a standard or light ambulance, or expensive tests, if the monthly cost of the tests exceeds 20% of the member's pension or basic salary.

In the event of direct billing, the proportion of the costs to be met by the member is, as a rule, deducted from later reimbursements, or from the salary, pension or other sums owing from the institution. At the request of the Settlements Office, the balance may be reimbursed by a transfer to the JSIS bank account.

2. Advances

At the request of a member who receives primary cover, a deferred debit card with a 60-day repayment period may be issued.

If it is not possible to issue a card of this type, on the basis of a reasoned request from the member who is insured on a primary basis, an advance on reimbursement may be granted in the form of a transfer to the member's bank account, if his or her pension or basic salary is equal to or less than the basic salary in grade AST2/1 and if the monthly medical costs to be paid by the member total more than 20% of such pension or basic salary.

The advance is automatically recovered if the member does not submit a claim for reimbursement of medical expenses within three months of receiving the advance, unless the treatment is for a longer period of time and it is not possible to obtain an interim invoice before the end of the treatment.

Chapter 5 – Recognition of the status of serious illness

1. **Definition**

Serious illnesses include tuberculosis, poliomyelitis, cancer, mental illness and other illnesses recognised by the appointing authority as of comparable seriousness.

Such illnesses typically involve, to varying degrees, the following four elements:

- a shortened life expectancy
- an illness which is likely to be drawn-out
- the need for aggressive diagnostic and/or therapeutic procedures
- the presence or risk of a serious handicap.

2. **What is covered**

The 100% reimbursement rate applies to:

- medical costs which appear, in the light of current scientific knowledge, to be directly linked to the diagnosis, treatment or monitoring of the development of the serious illness, or any complications or consequences it causes;

- costs eligible for reimbursement associated with a dependency caused by the serious illness.

3. **Procedures**

Applications for recognition of serious illness must be addressed to the Medical Officer and be accompanied by a detailed medical report which may be submitted in a sealed envelope. For an initial application, the report must include:

- the date of the diagnosis
- the exact diagnosis
- what stage the illness is at, and any complications
- the treatment required.

The 100% cover for expenditure related to serious illness is granted from a start date (the date of the medical certificate) to a date in the future, granting 100% cover for no more than 5 years. The Settlements Office will warn the member in due course when the cover is about to expire, in order to give him or her time to submit an application for the cover accompanied by a medical report that explains:

- how the illness has developed
- the treatment and/or care still required.

The decision granting 100% cover is reviewed regularly on the basis of up-to-date information on the person's state of health and scientific advances, to reassess, if necessary, the extent of the cover.

4. **Backdating**

As a rule, 100% cover is granted only from the date of the medical certificate supporting the application for recognition of serious illness.

However, on the basis of a reasoned request from the member indicating the treatment in question as entered on his or her account statements, the 100% cover may be backdated, after consulting the Medical Officer.

The backdating may not, however, extend beyond the time limit for reimbursement laid down in Article 32 of the joint rules.

Chapter 6 – Special reimbursement – Article 72(3) of the Staff Regulations

The conditions and arrangements for calculating the special reimbursement provided for in Article 72(3) of the Staff Regulations are set out in Article 24 of the joint rules. This top-up reimbursement applies when the expenditure incurred by the member is not excluded by these general implementing provisions from the scope of that Article, has not been reimbursed and, over a 12-month period, exceeds half the average basic monthly income received under the Staff Regulations over that same period.

The portion of the expenditure which has not been reimbursed and which exceeds half the average income is reimbursed at the rate of 90% to a member whose insurance covers no other person, and 100% in other cases.

1. Procedures

Special reimbursements are calculated on the basis of the date of the treatment and not the date of the account statements.

An information note established on the basis of non-reimbursed expenditure incurred during the previous 36 months will be sent automatically or on request to members likely to qualify for special reimbursement. The note takes account of the adjustment of remuneration provided for in Article 65 of the Staff Regulations.

The member must return the information note, duly signed, indicating the 12-month period he or she wishes to choose. If the member fails to specify such a choice, the period chosen for calculating the special reimbursement will be the one most advantageous to the member.

Expenditure submitted after the special reimbursement has been made cannot give rise to an additional special reimbursement.

2. Specific points

If the 12-month period includes fractions of months, the average basic monthly salary, pension or allowance will be calculated by taking into consideration the basic payments from the first month during which the period in question began, until the month during which the period ended.

If the family situation changed during the period in question, the situation used to determine the percentage to be reimbursed will be the one most advantageous to the member.

Chapter 7 – Calculating parity coefficients – Article 20(5)

Pursuant to Article 20(5) of the joint rules, parity coefficients are adopted at least once every two years in order to ensure equality of treatment for benefits paid out in any of the Member States of the European Union.

1. Reference Member State

The reimbursement ceilings provided for in these general implementing provisions are calculated on the basis of prices generally practised in Belgium for the treatment in question.

2. Period of observation

Only the previous two years are taken into account when calculating the price differentials for healthcare in the Member States of the European Union.

3. Calculation of the parity coefficients

3.1. On the basis of sufficiently representative statistical information on expenditure incurred by JSIS members during the period of observation in the Member State in question, the parity coefficient is set with a view to ensuring that for all treatment with a reimbursement ceiling the actual rate of reimbursement is the same as that observed in the reference Member State in at least 8 cases out of 10.

3.2. If sufficiently representative statistical data is not available, the parity coefficient is calculated by comparing health cost indices in the Member State in question and in the reference Member State.

The health cost indices are those established by Eurostat.

3.3 If the prices in a Member State are lower than those in the reference Member State, no parity coefficient is applied, and the treatment in question is reimbursed in line with the ceilings set for the reference Member State.

3.4 If the change in healthcare costs in a Member State is such that it is not possible to guarantee the same rate of reimbursement as in the reference Member State in 8 cases out of 10, the parity coefficient must be reviewed before the two-year deadline laid down in Article 20(5) of the joint rules.

Chapter 8 – Calculating reimbursement-level coefficients – Article 21(1)

Medical expenses incurred in a country outside the European Union where costs are particularly high are reduced by applying a reimbursement-level coefficient enabling the reimbursement rates provided for in the rules to be applied to a level of costs made comparable to the average in the European Union.

The reimbursement-level coefficient is only applied for third countries where health cost indices exceed the European Union average by 25% or more, and in the case of treatment that costs 25% or more than the average inside the Union. If the cost of treatment is comparable to the average inside the Union, the reimbursement-level coefficient is not applied to that particular treatment.

Reimbursement-level coefficients will not be applied in the case of serious illness, after consultation of the Medical Officer, if there is no equivalent medical treatment for that illness in the European Union.

The reimbursement-level coefficient is determined by comparing the health cost indices in the third country in question and the European Union average.

The health cost indices are those established by the OECD and Eurostat.

The coefficients are regularly reviewed as new up-dated indices become available, and members are informed accordingly.

Chapter 9 – Auditing of JSIS financial statements
Article 45(5)

1. Pursuant to Article 45(5) of the joint rules, the Commission's Accounting Officer appoints an auditor approved to carry out statutory audits of accounting documents in accordance with Directive 2006/43/EC of the European Parliament and of the Council.

2. To that end, after consulting the Management Committee, the Commission's Accounting Officer adopts the terms of reference for the designated auditor's audit engagement.

3. The designated auditor must be totally independent of the Accounting Officer and his department, and may not under any circumstances combine his JSIS statutory audit engagement with an advisory role as part of a commercial mandate.

4. Under the terms of his engagement, the designated auditor must deliver a specific opinion on the JSIS accounts that he has audited.

5. The auditor's opinion given in the report may be one of the following:

   - *Unqualified opinion*: the auditor certifies the regularity and bona fide nature of the JSIS annual accounts and that they give a true and fair view of the previous year's financial transactions and of the Scheme's financial position and assets at the end of the year.

   - *Qualified opinion*: in this case the auditor

     a) has noted errors, anomalies or irregularities in the application of accounting principles; the effect of these is significant, but does not warrant the rejection of the annual accounts as a whole;

     b) has been unable to scrutinise the accounts with the rigour he or she deemed necessary, although the imposed limitations have not been sufficient to warrant an adverse opinion.

     In either case, the auditor must clearly indicate in the report either the nature of the errors or the limitations that led to the qualification. Figures should be included whenever possible for any qualified opinion under (a) above. Such figures should show the effect on the entry in the annual accounts, on the profit

or loss for the financial year, and, if the error affects it, on the opening balance sheet.

If the qualification is entered under (b) above, the amounts in the annual accounts that might be affected by the limitations should be indicated.

- *Adverse opinion*: this means the auditor:
    a) has noted errors, anomalies or irregularities that are sufficient to compromise the validity and reliability of the annual accounts as a whole; and/or
    b) has worked under limitations or in circumstances such that he or she is unable to form an opinion on the annual accounts as a whole.

In the case of both (a) and (b), the auditor must supply the same information on the nature of the anomalies and their financial impact as is required for a qualified opinion