EUROCONTROL
European Organisation for the Safety of Air Navigation

RULE OF APPLICATION No. 10

concerning sickness insurance cover

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CONCERNING
SICKNESS INSURANCE COVER

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PART I

GENERAL PROVISIONS

TITLE I

SCOPE

Article 1

In pursuance of Article 72 of the Staff Regulations and Article 72 of the General Conditions of Employment (General Conditions of Employment), a Sickness Insurance Scheme is hereby set up within the Agency. Within the limits and on the conditions set forth in these Rules and under the general implementing provisions adopted on the basis of Article 48 of these Rules, the Scheme shall guarantee to the persons covered by it the reimbursement of expenses incurred as a result of illness, accident or confinement and the payment of an allowance towards funeral expenses.

The Scheme shall apply to its members and to persons covered under them.

TITLE II

MEMBERS

CHAPTER 1

COMMON PROVISIONS

Article 2
Membership

1. The following shall be members of this Scheme:

   - officials and servants at the Maastricht Centre,

   - contract staff, as provided for under the Conditions of Employment of Contract Staff at EUROCONTROL.

2. The following shall also be members of this Scheme:

   - former officials and servants at the Maastricht Centre in receipt of a retirement pension,

   - persons in receipt of an invalidity pension or disability allowance,

   - persons in receipt of an early or deferred retirement pension provided they are not in gainful employment,

   - officials, servants at the Maastricht Centre or contract staff on unpaid leave on personal grounds, at their request and provided they are not in gainful employment.

3. The following shall also be members of this Scheme:

   - surviving spouses [or surviving recognised partners] in receipt of a survivor's pension,

   - surviving divorced spouses in receipt of a survivor's pension,

   - persons in receipt of an orphan's pension at their request or at the request of their legal representative where they cannot be covered by a member's insurance.

Article 3 (10) (29) (52)
Contribution

1. The amount of the contribution to this Scheme shall be 6% of the basic salary, retirement pension, invalidity pension, disability allowance, survivor's or orphan's pension, or the allowances provided for in Articles 69b and 69c of the General Conditions of Employment, at the rate of one-third to be paid by members and two-thirds to be paid by the Agency.

   If a person is in receipt of a retirement or survivor's pension the contribution may not be less than that calculated by reference to the basic salary for a grade C5 [grade 1], step 1.

2. [In the case of full-time parental or family leave, the entire contribution shall be calculated by reference to the most recent basic salary and shall be borne by the Agency.]

   [In the case of half-time parental or family leave, the contribution borne by the Agency shall be calculated as the difference between the full basic salary and the basic salary reduced proportionately.]

   [In respect of the portion of the basic salary actually paid, members' contributions shall be calculated by applying the same percentages as if they were working full-time.]

3. In the case of part-time work, the contribution shall be calculated by reference to the full basic salary of the member according to the proportions provided for in paragraph 1.

4. In the case of unpaid leave on personal grounds, members may continue to be covered by this Scheme provided they pay half the contribution to the Scheme, calculated by reference to the most recent updated basic salary for their grade, in the first year and the full contribution from the second year on.

5. In the case of leave for military service, members shall not be covered by the Scheme. However, persons covered under them shall continue to be covered by the Scheme as provided below:

   - in the case referred to in the second subparagraph of Article 42 of the Staff Regulations and the General Conditions of Employment, without members having to pay contributions;

   - in the case referred to in the third subparagraph of Article 42 of the Staff Regulations and the General Conditions of Employment provided members pay their contribution calculated by reference to the most recent updated basic salary for their grade and step.

Article 4
Compulsory membership of another Sickness Insurance Scheme

Where officials, servants of the Maastricht Centre or contract staff are employed in a country in which they are required by the law of that country to join a compulsory scheme of sickness insurance, the contributions due under that scheme shall be paid in full from the budget of the Agency. In this event, Article 22 of these Rules shall apply.

CHAPTER 2

SPECIAL PROVISIONS APPLICABLE TO OFFICIALS AND SERVANTS AT THE MAASTRICHT CENTRE

Article 5
Unpaid secondment

Officials or servants on unpaid secondment under Article 39(f) of the Staff Regulations or the General Conditions of Employment may continue to be covered by the Scheme until they are required to resign, provided they pay all the contributions calculated by reference to the updated basic salary for their grade and step.

Article 6
Non-active status and retirement in the interests of the service

Officials, former officials and servants in receipt of an allowance provided for in Article 41 of the Staff Regulations or of the General Conditions of Employment, Article 50 of the Staff Regulations or Article 4 of Appendix IV to the General Conditions of Employment, may continue to be covered by this Scheme under the conditions set out in Annex II to the Staff Regulations or the General Conditions of Employment, or Appendix IV to the General Conditions of Employment.

Officials or servants may recommence cover under this Scheme on the basis of a duly justified written application in the month following the cessation of all gainful employment has ceased.

Article 7
Final termination of service

Officials or servants whose service has been terminated may continue to be covered by this Scheme for a maximum period of six months provided that they:

- are not gainfully employed, and

- pay one half of the contribution to this Scheme calculated by reference to the updated basic salary for their grade and step.

Application for cover must be made before the end of the first month following the date of final termination of employment.

The above conditions do not apply in the case of serious or protracted illness contracted before termination of employment and notified to the Director General before expiry of the six-month period provided for in the first paragraph, provided that the person concerned undergoes a medical examination arranged by the Agency.

Article 8
Forfeiture of remuneration

Officials or servants forfeiting the right to remuneration as a result of unauthorised absence or disciplinary measures may, at their written request in the month after the date of the decision, continue to be covered by this Scheme provided they pay one third of the contribution calculated by reference to their last basic salary, plus where appropriate the allowance provided for in Article 69b of the General Conditions of Employment, updated for their grade and step.

Article 9
Dismissal for incompetence

Officials or servants dismissed pursuant to Article 51 of the Staff Regulations or Article 52 of the General Conditions of Employment **[**who are in receipt of the allowance**]** may continue to be covered by this Scheme [during payment of the allowance] provided that they:

- are not gainfully employed, and

- pay one half of the contribution to this Scheme calculated by reference to the updated last basic salary for their grade and step.

CHAPTER 3

SPECIAL PROVISIONS APPLICABLE TO CONTRACT STAFF

Article 10
Resignation - End of contract

Contract staff who have resigned or reach the end of their contract may continue to be covered by this Scheme for a maximum period of six months provided that they:

- can prove that they cannot obtain reimbursement under another legal or statutory Sickness Insurance Scheme,

- pay one half of the contribution to this Scheme calculated by reference to the updated basic salary for their grade and step.

Application for cover must be made before the end of the first month following the date of resignation or of the end of the contract.

The above conditions do not apply in the case of serious or protracted illness contracted before termination of employment and notified to the Director General before expiry of the six-month period provided for in the first paragraph, provided that the person concerned undergoes a medical examination arranged by the Agency.

Article 11
Unemployment

Contract staff in receipt of unemployment benefit from EUROCONTROL shall be covered by this Scheme while that benefit is being paid.

This top-up cover does not require a contribution.

Contract staff may benefit from primary cover under this Scheme on duly justified written application if they cannot obtain cover under another legal or statutory Sickness Insurance Scheme.

TITLE III

PERSONS COVERED BY MEMBERS' INSURANCE

CHAPTER 1

SPOUSES [AND RECOGNISED PARTNERS]

Article 12
Insured persons

The following shall be covered by members' insurance under the conditions set out in Articles 13 and 14:

- spouses, unless they are already full members of the Scheme,

- [recognised partners of members of the Scheme even if they do not satisfy the last indent of Article 1(2)(c) of Rule of Application No.7,]

- spouses [or recognised partners] taking unpaid leave on personal grounds as provided for in the Staff Regulations or the General Conditions of Employment.

Article 13
Primary cover

Insured persons shall benefit from primary cover under this Scheme if they have no income of their own from gainful employment or if such income is so low that they cannot be covered by another compulsory legal or statutory Sickness Insurance Scheme.

Income from gainful employment shall be understood to mean any salaries, fees, emoluments, benefits, allowances or pensions arising from current or former gainful employment, excluding allowances towards costs.

Article 14
Top-up cover

1. If insured persons are in receipt of income from gainful employment they may benefit from top-up cover under this Scheme, provided:

   - their annual taxable income, before tax and after deduction of social welfare contributions and professional charges, does not exceed the basic annual salary of an official in the first step of grade C5 [grade 2] multiplied by the correction coefficient for the country in which the income is received, and

   - they are fully covered for the same risks under any other legal or statutory provisions.

2. In order for insured persons to continue to benefit from top-up cover under this Scheme members must provide, in the first half of each year, proof of income received by their spouse [or recognised partner] for the previous fiscal or calendar year.

3. Members are obliged to report any changes in the employment circumstances of their spouse [or recognised partner] which may give rise to changes in entitlements under this Scheme.

Article 15
Divorce - [dissolution of partnership]

1. Divorced spouses of members [or their recognised partners whose non-marital partnership status is dissolved] may be covered under this Scheme for a maximum of twelve months from the date of decree absolute of the divorce [or dissolution of the partnership] provided they are not in gainful employment.

2. [In the event of the member's death, if the recognised partner covered by the member's insurance is not entitled to a survivor's pension he/she shall continue to be covered by this Scheme under the conditions set out in paragraph 1.]

CHAPTER 2

DEPENDANTS

Article 16
Dependent children

1. Dependent children within the meaning of Article 2.2 of Rule of Application No. 7 shall be covered by this Scheme.

   If dependent children are eligible for reimbursement of medical care under another legal or statutory sickness insurance scheme, the Sickness Insurance Scheme shall provide top-up cover.

2. The age limit and exceptions to recognition of dependent children shall be as defined in Article 2.3 (b) and 2.5 of Rule of Application No. 7.

3. Dependent children shall not be covered by this Scheme during their civil or military service.

   Dependent-child cover may be granted after the age of 26 for a maximum period of one year provided that the child is not in gainful employment.

Article 17
Other dependent persons

Persons recognised as dependent on the member within the meaning of Article 2.4 of Rule of Application No. 7 may be covered by this Scheme provided they cannot be covered by another legal or statutory sickness insurance scheme.

Article 18
Extension

Provided they do not exercise any gainful employment, beneficiaries may continue to be covered by this Scheme for a maximum of twelve months from the date on which:

- they cease to be dependent children or persons treated as dependent children;

- they lose entitlement to an orphan's pension.

PART II

REIMBURSEMENT

TITLE I

BASIC PRINCIPLE

Article 19
Freedom of choice

1. Persons covered by this Scheme shall be free to choose their practitioners and hospitals or clinics.

2. The principle of freedom of choice does not automatically imply reimbursement of any resulting travel costs; the rules for reimbursing this type of cost are set out in the general implementing provisions.

3. Freedom of choice shall apply to beneficiaries of top-up cover only after the possibilities offered by the primary scheme have been exhausted.

TITLE II

RULES

Article 20
General reimbursement rules

1. For the purpose of protecting the financial equilibrium of the Sickness Insurance Scheme and respecting the principle of social security cover forming the basis for Article 72 of the Staff Regulations or the General Conditions of Employment, reimbursement ceilings for certain benefits may be set in the general implementing provisions.

   If the costs claimed by the member are lower than the ceiling, reimbursement shall be calculated on the basis of costs claimed.

2. In the case of benefits for which no reimbursement ceiling has been set, the proportion of the costs deemed excessive by comparison with normal costs in the country where the costs have been incurred shall not be reimbursed. The portion of the costs deemed excessive shall be determined on a case-by-case basis by the Settlements Office after consulting the Medical Officer and on the basis of the guidelines set up after consultation of the Management Committee foreseen in Article 38 of the present Rule of Application.

3. The cost of treatments deemed to be non-functional or unnecessary by the Settlements Office after consulting the Medical Adviser shall not be reimbursed.

4. The cost of benefits not provided for in the general provisions implementing these Rules may be covered up to a rate of 80% after the opinion of the Medical Adviser of the Settlements Office has been obtained. Members shall be regularly notified of such information.

5. In order to ensure equality of treatment for benefits paid for in any of the Member States, parity coefficients shall be adopted at least once every two years by the Director General, after consulting the Management Committee**,** based on the parity coefficients adopted by the European Communites. Members shall be notified of the coefficients.

6. In accordance with Article 72(1) of the Staff Regulations and the General Conditions of Employment, costs shall be reimbursed in full in the case of tuberculosis, poliomyelitis, cancer, mental illness and other illnesses recognised by the Director General as of comparable seriousness after consulting the Medical Adviser of the Settlements Office.

   The Medical Adviser's opinion shall be delivered on the basis of general criteria laid down in the general implementing provisions after consultation of the Medical Council.

   The costs linked to early detection screening provided for in the general implementing provisions and to confinement shall also be reimbursed in full.

   However, for the purpose of protecting the financial stability of the Scheme and respecting the principle of social security cover forming the basis for Article 72 of the Staff Regulations and the General Conditions of Employment, special ceilings for reimbursing certain benefits may in exceptional circumstances be set in the general implementing provisions.

7. Reimbursement in full shall not apply in cases of occupational disease or injury resulting in the application of Article 73 of the Staff Regulations or the General Conditions of Employment.

Article 21
Special reimbursement rules for benefits received outside the Member States

1. Expenses incurred in a non-Member State where costs are particularly high shall be reduced by applying a reimbursement-level coefficient enabling reimbursement rates to be applied to costs made comparable to the average in the Member States.

   The coefficients, in force at the European Communities and taken over by EUROCONTROL, shall be established on the basis of official health cost indices comparable among the various countries. They shall be reviewed periodically and notified to the members.

2. The reimbursement-level coefficient shall not be applied where the amount of the costs incurred to be reimbursed is lower than or equal to the reimbursement ceiling provided for in Article 20(1) and the fourth subparagraph of Article 20(6).

3. If there is no equivalent medical treatment in the Member States, in case of a medical emergency or for retired members living in such a country, a top-up reimbursement shall be paid so that the actual payment amounts to 50% of the total cost actually incurred if, after application of the reimbursement-level coefficient the portion of the costs not reimbursed by the Scheme results in a high financial burden to the beneficiary.

   The top-up reimbursement shall not apply to benefits which are subject to the reimbursement ceilings provided for in Article 20(1) and the fourth subparagraph of Article 20(6).

4. In the event of a serious illness as provided for in Article 20(6) where there is no equivalent medical treatment in the Member States, the reimbursement-level coefficient shall not be applied by the Settlements Office, after consultation of the Medical Adviser as required for prior authorisation.

Article 22
Reimbursements from another sickness insurance scheme

1. Where a member or a person covered by his insurance may claim reimbursement of expenses incurred under any other legal or statutory sickness insurance, the member shall:

   a) notify the office responsible for settling claims;

   b) in the first instance apply, or have the person concerned apply, for reimbursement under the other scheme.

      However, if obliged to pay into two schemes, members of this Scheme may choose the scheme to which they apply for reimbursement of the benefits they have received in the knowledge that the Scheme will be available as a top-up scheme in cases where it does not act as the primary scheme;

   c) attach to any application for reimbursement made under this Scheme a detailed original statement, together with supporting documents, of reimbursements which the member or the person covered by his insurance has obtained under the other scheme.

2. The Scheme shall act as a top-up scheme for reimbursement of benefits provided the other scheme has previously reimbursed the benefits covered by it.

   If a benefit is not covered by the primary scheme but is covered by the Scheme the latter shall act as the primary scheme.

3. If the total reimbursements received by members or by persons covered under him/her exceeds the reimbursement provided for in this Scheme, the difference shall be deducted from the amount to be reimbursed by the latter.

   Reimbursements obtained from a private top-up health insurance scheme intended to cover that portion of the costs not reimbursed by this Scheme shall not be included in this calculation.

Article 23
Exclusion of certain costs from reimbursement

1. Where, as a result of the medical examination on recruitment, it is decided in accordance with the second paragraph of Article 14 of the Conditions of Employment for Contract Staff that a contract staff member shall not be entitled to reimbursement of certain expenses, the result of the medical examination shall be forwarded to the Medical Adviser of the Settlements Office; the Medical Adviser shall inform the Office of any treatment in respect of which expenses incurred shall not be reimbursable.

2. Upon expiry of a period of two years from the date on which the contract staff member is recruited, the Director General may remove the restriction imposed if it is the opinion of the medical Adviser of the Agency that the sickness or invalidity has not reappeared or given rise to unusual sequelae in the course of the said period.

Article 24
Special reimbursement

1. Special reimbursements may be granted under Article 72(3) of the Staff Regulations or the General Conditions of Employment for that portion of the costs which is not reimbursed provided that those costs do not exceed:

   - 50% of the cost corresponding to 100% of the reimbursement ceilings provided for in Article 20(1) and the fourth subparagraph of Article 20(6);

   - and, in the case of benefits not subject to a ceiling, 50% of the amount corresponding to 100% of the costs actually reimbursed according to the rates in force, excluding the top-up reimbursement referred to in Article 21(3) and after application of Article 20(2) and/or Article 21(1).

   The 50% threshold shall be calculated after application, where appropriate, of the parity coefficient provided for in Article 20(5).

   Certain benefits subject to a reimbursement ceiling as laid down in Article 20(1) and the second subparagraph of Article 20(6) shall be ignored in the calculation of the special reimbursement. The list of these benefits shall be laid down in the general provisions implementing these Rules.

2. Where the non-reimbursable portion of costs not deemed to be excessive, covered by the scope of the general provisions implementing these Rules and incurred by members in respect of themselves or of those covered under them, exceeds half of the average monthly basic remuneration under the Staff Regulations received in any twelve-month period, the special reimbursement provided for in Article 72(3) of the Staff Regulations or the General Conditions of Employment shall be determined as follows:

   The non-reimbursed portion of the above-mentioned costs which exceeds half of the average monthly remuneration under the Staff Regulations shall be reimbursed at the rate of:

   - 90% in the case of a member whose insurance covers no other person;

   - 100% in other cases.

3. Where members are no longer entitled to a salary or allowance, the basis for the special reimbursement shall be calculated by reference to half the most recent monthly basic salary received, plus, where appropriate, the allowances provided for under Articles 69b and 69c of the General Conditions of Employment
4. Where two spouses [or recognised partners] are both members of this Scheme, they shall by common agreement be entitled to opt for aggregation of the non-reimbursable portions of their sickness costs provided that:

   - this is done in respect of the member spouse [or recognised partner] having the higher basic remuneration under the Staff Regulations;

   - the other spouse [or recognised partner] waives the right to submit a separate claim for a special reimbursement;

   - the twelve-month period is the same for both spouses [or recognised partners].

5. Decisions on requests for special reimbursement shall be taken by:

   - either the Director General, on the basis of an opinion delivered by the Settlements Office in accordance with general criteria adopted by the Management Committee after consulting the Medical Council for determining whether the expenses incurred are excessive;

   - or the Settlements Office, on the basis of the same criteria, where it has been empowered by the Director General to do so.

Article 25
Allowance towards funeral expenses

The following persons shall receive an allowance towards funeral expenses, the amount of which shall be set by the general provisions implementing these Rules:

a) in the event of the death of a person covered under him/her or of a still birth: the member;

b) in the event of the death of a member: the spouse, [recognised partner], children or, where there are no such persons, any other person who can prove that he/she has borne the funeral expenses.

TITLE III

PROCEDURES

Article 26
Registration

1. Persons covered by this Scheme shall be registered with the Central Office and with one of the Settlements Offices.

2. Persons covered by this Scheme who reside in a country in which a Settlements Office exists shall normally be registered with that office.

   Persons covered by this Scheme who reside in a country in which no Settlements Office exists shall be registered with an office designated by the Central Office.

Article 27
Prior authorisation

Where, pursuant to these Rules, reimbursement of expenses is subject to prior authorisation, the decision shall be taken by the Director General or by the Settlements Office designated by the Director General in accordance with the following procedure:

a) the application for prior authorisation, together with a prescription and/or an estimate made out by the attending dentist or doctor, shall be submitted by the member to the Settlements Office, which shall refer the matter to the Dental or Medical Adviser if need be. In the latter case, the Dental or Medical Adviser shall transmit his opinion to the Settlements Office within two weeks;

b) the Settlements Office shall take a decision on the application if it has been appointed to do so or shall transmit its decision and, where applicable, that of the Dental or Medical Adviser to the Director General for a decision. The member shall be informed of the decision forthwith;

c) applications for reimbursement of expenditure on treatment for which prior authorisation is required shall not be considered unless the authorisation is requested before the treatment begins. An exception may be made in medically justified emergencies deemed to be such by the Medical Adviser of the Settlements Office.

Article 28
Applications for reimbursement

Applications shall be made by members to the Settlements Office on standard forms accompanied by the originals of the supporting documents; in the case of applications for top-up reimbursement provided for in Article 22 of these Rules, a copy of the original paid invoice accompanied by a detailed statement of the reimbursements received from another scheme must also be attached.

Article 29
Divorce [and dissolution of partnership]

Provided that they are covered by this Scheme, divorced spouses [or recognised partners whose non-marital partner status has been dissolved] may submit applications for prior authorisation and reimbursement of costs directly for themselves and, where applicable, for children in their custody, under the same conditions as those in Articles 27 and 28.

Article 30
Advances

1. Advances may be granted to members in the case of hospitalisation to enable them to meet major items of expenditure. Such advances shall be allocated in the form of a request for direct billing.

2. Advances on medical expenses shall be recovered, either from any amount owed to the member under this Scheme or from the remuneration or pension or from any amount owed to the member by the Agency, or from the survivor's pension paid following the member's death.

Article 31
Subrogation of rights

Where an accident or illness is caused by a third party, the rights of action of the person concerned or of those entitled under him against the third party shall, within the limits of their obligations under this Rule, vest in the Agency in accordance with Article 87a of the Staff Regulations or Article 86a of the General Conditions of Employment.

Article 32
Loss of entitlement

1. Where members have not applied for reimbursement of expenses incurred by them or by persons covered under them during a period of eighteen months following the date of treatment, they shall cease to be entitled to reimbursement save where force majeure is duly established.

2. Application for the special reimbursement referred to in Article 24 shall 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 are reimbursed.

Article 33
Recovery of undue payment

Under Article 87 of the Staff Regulations or Article 86 of the General Conditions of Employment, any undue payment shall be recovered if the recipient was aware of the irregular nature of the payment or if this was so obvious that he/she could not fail to be aware of it.

Article 34
Fraud

Notwithstanding Article 33 of these Rules, a member or recipient who fraudulently obtains or attempts to obtain reimbursement of benefits for himself/herself or for a person covered under him/her shall automatically cease to be entitled to reimbursement of such benefits and shall be liable to disciplinary action.

Article 35
Appeals

1. Any person to whom this Rule apply shall be entitled to resort to the appeal procedure provided for in Articles 92 and 93 of the Staff Regulations or in Articles 91 and 92 of the General Conditions of Employment

2. Before taking a decision regarding a complaint submitted under Article 92.2 of the Staff Regulations or Article 91.2 of the General Conditions of Employment, the Director General shall request the opinion of the Management Committee.

   The Management Committee may instruct its Chairman to make further investigations. Where the point at issue is of a medical nature, the Management Committee may seek expert medical advice before giving its opinion. The cost of the expert opinion shall be borne by the Agency's Sickness Insurance Scheme.

   The Management Committee must give its opinion within two months of the request being received. The opinion shall be transmitted simultaneously to the Director General and to the person concerned.

   Should the Management Committee fail to deliver an opinion within the period prescribed above, the Director General may take his decision.

PART III

ORGANISATION OF THE SCHEME

TITLE I

PRINCIPLES

Article 36
Organs

The Scheme shall operate through a Management Committee, a Central Office, Settlements Offices and a Medical Council.

Article 37
Medical confidentiality

Staff working in the Settlements Offices and the Central Office, members of the Management Committee and anyone attending meetings of the Management Committee shall be bound by medical confidentiality with regard to information and/or documents to which they have access in the performance of their duties.

They shall continue to be so bound after termination of their employment in those offices or the Management Committee.

TITLE II

OPERATION OF THE ORGANS

Article 38
Management Committee

1. The Management Committee shall comprise the following full members:

   - four Agency representatives appointed by the Director General,

   - four representatives of the staff of the Agency, designated by its Staff Committees and the International Association of the Former Officials of EUROCONTROL.

2. Alternate members shall be appointed in the same manner as provided for in paragraph 1.

3. The term of office of the full and alternate members shall be two years. It shall be renewable.

4. Each member, or in his or her absence an alternate member, shall be entitled to vote.

5. The Management Committee shall adopt its rules of procedure by a two-thirds majority of the members who are entitled to vote.

   The rules of procedure shall include provisions concerning:

   - the election of the Chairman;

   - the organisation, convening and frequency of meetings;

   - the appointment, if need be, of a Committee to prepare its meetings;

   - the appointment of persons who may attend Committee meetings but may not vote;

   - the rules governing its deliberations and the delivery of opinions.

6. The Management Committee shall:

   a) ensure that these Rules are applied consistently and put to the Agency any relevant suggestion or recommendation;

   b) examine the financial position of this Scheme and put to the Agency any relevant suggestion or recommendation;

   c) make a detailed annual report on the financial position of this Scheme and forward it to the Director General and to the Staff Committees before 1 July;

d) where appropriate, propose or recommend to the Director General the adoption or amendment of the general provisions implementing these Rules and any measure required for the proper functioning of this Scheme and present proposals as to the amount of working capital required for the Scheme to operate;

e) deliver opinions as provided for in these Rules;

f) deliver its opinion, where appropriate, on any matter arising directly or indirectly from the application of the provisions of the Staff Regulations concerning sickness insurance;

g) deliver its opinion on the level of contributions and benefits, in particular where there is an appreciable change in the cost of medical treatment.

7. The work of the Management Committee shall be secret.

Article 39
Central Office

1. The Central Office shall be attached to the Human Resources Directorate.

2. It shall:

a) coordinate and monitor the work of the Settlements Offices;

b) ensure that the rules concerning the payment of benefits are consistently applied

c) provide the secretariat for the Management Committee

d) carry out any statistical survey or analysis required for the satisfactory operation of this Scheme so as to give the Management Committee an accurate view of the extent, distribution and trend of the risks insured against and enable it to deliver opinions as provided for in Article 38(6)(g) of these Rules.

e) in liaison with the Settlements Offices, endeavour to negotiate, wherever possible, with the representatives of the medical profession and/or the competent authorities, associations and establishments, agreements specifying the rates for both medical treatment and hospitalisation applicable to persons covered by this Scheme, account being taken of local conditions and, where appropriate, the scales already in force.

f) negotiate, as far as possible, with the Member States' primary schemes, general agreements aimed at simplifying the procedures applicable to beneficiaries of this Scheme.

Article 40
Offices responsible for settling claims

1. Settlements Offices shall be opened or closed down by the Director General wherever he considers this to be necessary, taking into account, in particular, the places where the officials and servants at the Maastricht Centre are employed.

2. A Settlements Office may be opened or closed down only with the consent of that Director General and after the Management Committee has been consulted.

3. Staff of the Settlements Offices shall perform the tasks provided for in these Rules in accordance with the instructions and under the supervision of the Central Office.

4. Medical and Dental Advisers shall be attached to each Settlements Office and perform the tasks specified in this Rule.

   The function of the Medical Adviser attached to a Settlements Office is incompatible with that of the Medical Adviser of the Agency.

5. Each Settlements Office shall:

   a) accept and process applications for reimbursement of expenses submitted by members registered with it and make the relevant payments;

   b) as provided for in these Rules and where matters of a medical nature connected with the payment of benefits are raised by the Management Committee or by the Central Office, consult the medical officer;

   c) examine applications for prior authorisation and take the necessary action;

   d) deliver opinions as provided for in this Rule;

   e) provide secretarial services for the Medical Advisers.

Article 41
Medical Council

The Management Committee shall be assisted by a Medical Council composed of the Medical Advisers attached to each Settlements Office.

The Medical Council may be consulted by the Management Committee or the Central Office concerning any matter of a medical nature which arises in connection with this Scheme. It shall meet at the request of the Management Committee, of the Central Office or of the Medical Adviser of the Settlements Offices and shall deliver its opinion within such time as may be specified.

PART FOUR

FINANCIAL PROVISIONS

TITLE I

MANAGEMENT

Article 42
Contributions

The Agency shall each month, not later than eight days after the payment of remunerations and pensions, or allowances in the case of members referred to in Article 2, point 2, pay its own contributions and those of the members.

Article 43
Autorisation and checking

Payments to be made by the offices responsible for settling claims shall be authorised and checked in accordance with the Financial Regulations of the Agency.

TITLE II

ACCOUNTS

Article 44

The Agency shall record all receipts and expenditure of the Insurance Scheme in a separate Part of the Agency's Budget:

- the amount of contributions paid;

- the amount of payments made.

TITLE III

FINANCIAL BALANCE OF THE SCHEME

Article 45
Financial balance

The cost of benefits provided under this Scheme must be balanced by contributions from the Agency and from members over a three-year period.

Article 46
Deficit

1. Where the accounting position shows a deficit which leaves the Scheme out of balance financially, it shall be covered out of the surpluses referred to in Article 47 of this Rule.

2. Should the surpluses be insufficient to cover the deficit, the Management Committee shall immediately refer the matter to the Director General who shall determine what measures are to be taken to balance the accounts.

Article 47
Reserves

1. Where the accounting position of the Sickness Insurance Scheme shows a surplus, the Agency may enter the surplus in an account entitled "Surpluses of the Sickness Insurance Scheme".

   The surpluses shall be available to cover any increase in the risks covered.

2. After consulting the Management Committee, the Agency shall invest the surpluses on the best terms available, subject to the cash requirements of the Scheme for settling claims.

3. Where the surpluses reach the level of the total expenditure for one year, the Agency shall, after consulting the Management Committee launch an actuarial study which should be the basis for the consideration whether its contribution and the contributions of members should be reduced.

PART V

FINAL PROVISIONS

Article 48
Determining and updating the rules governing the reimbursement of costs

1. Under the third subparagraph of Article 72(1) of the Staff Regulations and the General Conditions of Employment, the Director General shall be competent to lay down, by general implementing provisions, the rules governing the reimbursement of costs with a view to protecting the financial balance of the Scheme and respecting the principle of social security cover forming the basis for the first subparagraph of Article 72(1) of the Staff Regulations and the General Conditions of Employment.

2. The general implementing provisions shall be drawn up after consultation of the Management Committee.

Article 49
Amendment

1. This Rule may be amended in accordance with Article 100 of the Staff Regulations and Article 95 of the General Conditions of Employment

2. The Management Committee shall deliver an opinion on any proposal to amend the Rules.

Article 50
Repeal

The Rules on sickness insurance cover for officials and servants at the Maastricht Centre, as last amended on 1 October 1994, are hereby repealed.

Article 51
Entry into force

With the exception of the provisions shown in square brackets, which shall enter into force with the Administrative Reform, this Rule of Application shall enter into force on 1 January 2008.

GENERAL IMPLEMENTING PROVISIONS FOR THE REIMBURSEMENT OF MEDICAL EXPENSES

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GENERAL IMPLEMENTING PROVISIONS RELATING TO THE REIMBURSEMENT OF MEDICAL EXPENSES

GENERAL DEFINITIONS

Under Article 72 of the Staff Regulations and the General Conditions of Employment, and Rule of Application No. 10, the Agency's Sickness Insurance Scheme (hereafter the "Scheme") covers the medical expenses of its beneficiaries resulting from illness, accidents and confinement and contributes to funeral expenses.

Persons covered by the Scheme

The Scheme's beneficiaries are the members - i.e. officials, servants at the Maastricht Centre, contract staff and persons in receipt of a retirement pension or termination of service allowance - and those covered by their insurance, subject to the conditions and limits laid down by Rule of Application No. 10 (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 Director General 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 and of the General Conditions of Employment 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 General Conditions of Employment 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 Adviser, who will assess the medical case for the treatment.

The Medical Adviser 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 Director General after consulting the Medical Adviser 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 Rule of Application No. 10 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 Rule of Application No. 10, 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 Adviser. The Medical Adviser 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 Adviser

The opinion of the Medical or Dental Adviser is a medical opinion delivered on the basis of the medical data relating to the patient in that Adviser'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 Advisers 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 Advisers will issue opinions only in situations specifically provided for in Rule of Application No. 10 and in these general implementing provisions, and within the limits provided for therein.

Opinion of the Medical Council

The duties of the Medical Council of the Sickness Insurance Scheme are performed by the Medical Council of the Sickness Insurance Scheme of the European Communities as provided for in the legislation applicable to the Communities.

TITLE I

ENTITLEMENT

CHAPTER 1

PROVISIONS RELATING TO MEMBERS

1. Contract staff - third indent of Article 2(1)

1.1 On their entry into service, contract staff must inform the Director General whether they wish to maintain their sickness insurance under their previous national social security scheme or to join the SIS. 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 Sickness Insurance Scheme on the first day of the month following that in which the Agency ceased to pay a contribution to their previous national social security scheme.

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 may be readmitted to the Sickness Insurance Scheme 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 Rule of Application No. 10, 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 C5/1 [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 Sickness Insurance Scheme 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 AST1/1, 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 Rule of Application No. 10.

3. Cover while on leave on personal grounds - seventh indent of Article 2(3)

3.1 Members who wish to remain covered by the Sickness Insurance Scheme while on leave on personal grounds must apply to do so to the Director General 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 Sickness Insurance Scheme must inform the Director General 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 the Director General to be covered once again by the Sickness Insurance Scheme.

3.4 Members who remain covered by the Sickness Insurance Scheme 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 Sickness Insurance Scheme.

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. 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 Agency 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. 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

PROVISIONS RELATING TO 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 C5/1 [AST2/1] may benefit from primary cover under the Sickness Insurance Scheme 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 Sickness Insurance Scheme 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 Sickness Insurance Scheme 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 Rule of Application No. 10.

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 Director General.

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 Scheme in countries where no correction coefficient exists, the coefficient for Belgium will be used.

b) The Scheme 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 Sickness Insurance Scheme 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)].

The Sickness Insurance Scheme 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 Sickness Insurance Scheme 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 [and 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 Sickness Insurance Scheme 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 Sickness Insurance Scheme.

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 Sickness Insurance Scheme.

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 Sickness Insurance Scheme.

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 period of extension provided for in Article 18 of Rule of Application No. 10, the beneficiary enters gainful employment within the meaning of Article 2 of Rule of Application No. 10, cover under the Scheme 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 Scheme will continue to cover the beneficiary during this period, until the end of the 12-month extension.

Members who which 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.

CHAPITER 3

COMMON PROVISIONS FOR MEMBERS AND PERSONS COVERED BY MEMBERS' INSURANCE

1. Extension of cover for members 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 this Scheme calculated by reference to the 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 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 or the former member of contract staff cannot be covered by another legal or regulatory sickness insurance for the medical expenses associated with their 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 Agency 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 Rule of Application No. 7 of the Staff Regulations.

TITLE II

RULES ON REIMBURSEMENT

CHAPTER 1

MEDICAL CONSULTATIONS AND VISITS

1. General points and definitions

Consultations and visits consist, in principle, of an interview with the patient, a clinical examination and, if necessary, the prescription of certain treatment.

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.

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 Adviser, if no reason is given for them or if the need for them is not recognised.

2. Reimbursement conditions

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 € 42, 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 € 64, 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 Adviser, 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 Adviser.

Reimbursement conditions:

In order to qualify for reimbursement, the hospitalisation must be the subject of a medical report to the Medical Adviser 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 test, 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 a 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	85% reimbursement Ceiling (€)
A1	535
A2	735
A3	1350
B1	2000
B2	2600
C1	4250
C2	5350
D1	10000
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 Adviser.

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 Adviser.

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 Adviser. Plastic surgery which is considered to be purely cosmetic will not be reimbursed.

CHAPTER 3

TREATMENT ASSOCIATED WITH DEPENDENCE ON CARE

The reimbursement of treatment associated with dependence on care (stays in establishments and costs of nursing care), with the exception of stays at substance abuse rehabilitation centres, shall depend on the degree of dependence of the person covered by the scheme.

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) a convalescent establishment or hospital/clinic which is approved by the competent authorities and possesses the medical and/or paramedical infrastructure to assist the elderly and/or disabled;

b) a psychiatric hospital/clinic which is approved by the competent authorities and possesses the medical and paramedical infrastructure, for a continuous permanent stay;

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 of the general implementing provisions);

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 of the general implementing provisions);

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

f) Prior authorisation

1.2 Prior authorisation

In order to be reimbursable, the costs of stays and care at establishments as enumerated in 1.1 above shall be subject to prior authorisation on the basis of a medical report submitted to the Medical Adviser, as specified in 1.3 below.

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

1.3 Reimbursement conditions

The portion of the costs payable by scheme members shall not be subject to special reimbursement as provided for in Article 24 of Rule of Application No. 10.

a) Convalescent establishments or hospitals/clinics

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.

Authorisation shall be granted for a period not exceeding 12 months. It shall be 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 relating to care	Costs relating to the stay
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) A stay and the care provided at a psychiatric hospital/clinic shall be reimbursable at 85%, or 100% in the case of serious illness, subject to the same conditions as applicable to convalescent establishments and hospitals/clinics.

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

c) A continuous stay at a functional therapy or rehabilitation establishment or psychiatric hospital/clinic and the care provided there shall be reimbursable at 85%, or 100% in the case of serious illness, subject to the same conditions as applicable to convalescent establishments and hospitals/clinics.

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.

d) A stay at a day centre and the care provided there shall be reimbursable in accordance with the following conditions:

- Visits during the daytime only to a convalescent home or hospital/clinic for the elderly or to 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) A stay at a substance abuse rehabilitation centre or the like which is not a hospital and the care provided there shall be reimbursed at 85% only, subject to a maximum reimbursable amount of € 36 per day for the costs of the stay.

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

Home care shall mainly involve caring for a patient in his/her own home for several hours a day, or for the entire day and/or night.

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

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) Required conditions

- 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 Adviser 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.

  The bills must comply with the legislation in the countries 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.

Non-reimbursed costs shall not be subject to special reimbursement as provided for in Article 24 of Rule of Application No. 10.

- 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

  As from 60 days, the cost of home care shall be reimbursed at 80%, or 100% in the case of serious illness, in accordance with the maximum reimbursements set out in the table below, subject to a reduction equal to 10% of the basic income of the scheme member (salary, retirement pension, invalidity pension or allowance, or other allowance provided for in the Staff Regulations).

Degree of dependence	Ceiling for reimbursement
4 and 3	50% of the basic salary of a grade C5/1 [AST2/1] official
2 and 1	100% of the basic salary of a grade C5/1 [AST2/1] official

  Authorisation may be granted for a period not exceeding 12 months. It shall be 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 Adviser, 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.

Subject: Mr/Ms ……. Payroll No. ……..

I. ASSESSMENT OF FUNCTIONAL AUTONOMY

ITEM	DESCRIPTION	SCORE
EATING	Independent, capable of using cutlery, eats in a reasonable time. Needs help, for example to cut up food. Incapable of feeding himself/herself.	 10 ☐ 5 ☐ 0 ☐
BATHING	Takes a bath without assistance. Incapable of taking a bath.	5 ☐ 0 ☐
GROOMING	Washes face, combs hair, cleans teeth, shaves (plugs in electric razor). Incapable of doing any of this.	 5 ☐ 0 ☐
DRESSING	Independent. Ties shoelaces, attaches clothes fasteners, puts on braces/straps. Needs help, but does at least half the work in a reasonable time. Incapable of doing any of this.	 10 ☐ 5 ☐ 0 ☐
BOWEL CONTROL	No problem. Capable of using enemas/suppositories if necessary. Occasional problems. Needs help with enemas/suppositories. Incapable of using enemas or suppositories.	 10 ☐ 5 ☐ 0 ☐
BLADDER CONTROL	No problem. Capable of taking care of urine collection equipment, where applicable. Occasional problems and needs help using urine collection equipment. - Incapable of using this equipment.	 10 ☐ 5 ☐ 0 ☐
TOILET USE	Goes to the toilet or uses the bedpan independently. Holds clothes, uses toilet paper, flushes or cleans the bedpan. Needs help balancing, holding clothes or using toilet paper. Incapable of doing any of this.	 10 ☐ 5 ☐ 0 ☐
TRANSFERS TO BED, TO ARMCHAIR AND TO CHAIR	Independent, including applying the brake on the wheelchair and lowering the footrest. Needs minimal assistance or mere supervision. Capable of sitting down but needs maximum assistance for transfers. Totally dependent.	15 ☐ 10 ☐ 5 ☐ 0 ☐
WALKING	Can walk 50 metres independently. May use walking sticks but does not use wheelchair. Can walk 50 metres with assistance. - Independent in a wheelchair over 50 metres, only where incapable of walking. - Cannot walk.	15 ☐ 10 ☐ 5 ☐ 0 ☐
CLIMBING STAIRS	Independent. May use walking sticks. Needs assistance or mere supervision. Incapable of climbing stairs.	10 ☐ 5 ☐ 0 ☐
TOTAL FOR ALL ITEMS:	……/100	

The practitioner must **tick one box** for each item.

II. SPATIO-TEMPORAL ASSESSMENT

ITEM	ASSESSMENT OF DIFFICULTIES OBSERVED		SCORE
1. DIFFICULTY EXPRESSING HIMSELF/HERSELF Making himself/herself understood by word and/or gesture.	- continually - from time to time, rarely - never		**0** ☐ **5** ☐ **10** ☐
2. VOCALLY DISRUPTIVE BEHAVIOUR Shouting without reason and/or disturbing others by shouting and/or screaming.	- continually - from time to time, rarely - never		**0** ☐ **5** ☐ **10** ☐
3. LOSS OF CONCEPT OF DECORUM Inappropriate behaviour with cutlery and food, untimely undressing, urinating in places other than the toilet, spitting, etc.	- continually - from time to time, rarely - never		**0** ☐ **5** ☐ **10** ☐
4. TEMPORAL ORIENTATION	- completely disoriented - disoriented from time to time - no disorientation		**0** ☐ **5** ☐ **10** ☐
5. AGITATION Relational and emotional problems and/or autoaggressive behaviour and/or psychomotor agitation (wandering, running away, etc.)	- continually - from time to time, rarely - never		**0** ☐ **5** ☐ **10** ☐
6. NIGHT-TIME BEHAVIOUR Wandering, disturbing others, confusing day with night.	- continually - from time to time, rarely - never		**0** ☐ **5** ☐ **10** ☐
7. SPATIAL ORIENTATION	- completely disoriented - disoriented from time to time - no disorientation		**0** ☐ **5** ☐ **10** ☐
8. DESTRUCTIVE BEHAVIOUR Violent towards equipment or objects in his/her surroundings, such as clothing, furniture, magazines, etc., and/or aggressive towards others.	- continually - from time to time, rarely - never		**0** ☐ **5** ☐ **10** ☐
9. LOSS OF MEMORY …	**a)** - short-term memory:	YES NO	**0** ☐ **5** ☐
	b) - long-term memory:	YES NO	**0** ☐ **5** ☐
10. RECOGNITION OF SURROUNDINGS Loss of ability to recognise:	a) close family (children, spouse):	YES NO	**0** ☐ **5** ☐
	b) friends, acquaintances, others:	YES NO	**0** ☐ **5** ☐
TOTAL FOR ALL ITEMS:	...../100		

The practitioner must **tick one box** for each item.

…… .....……...
Date: Signature and stamp of practitioner

CHAPTER 4

PHARMACEUTICAL PRODUCTS

1. Definition

For the purpose of the Sickness Insurance Scheme 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, etc.) 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 Adviser.

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 six 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.

These are as follows:

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

One list 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 Adviser.

CHAPTER 5

DENTAL CARE, TREATMENT AND DENTAL 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 Adviser and the Dental Adviser, up to a ceiling of € 1500. 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 Adviser, 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 Adviser will be reimbursed at the rate of 80%, with a ceiling of € 350 per sextant, i.e. € 2100 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 € 3300 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 Adviser. 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; autorisation 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 Adviser.

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 Adviser 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	350
Cast crown, telescopic crown, ceramo-metallic crown or element, ceramic facet	350
Attachment (Dolder bar: by pillar)	350
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 Adviser, 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 Adviser.

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 Adviser and the Dental Adviser, up to an amount of twice the ceiling provided for each treatment.

8. Special provisions

In the case of treatment requiring prior authorisation, the Sickness Insurance Scheme'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 Adviser 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 Adviser.

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

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 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 Adviser.
     Non-functional analyses and tests are considered to be those that have not been scientifically validated as effective and safe.

CHAPTER 7

PREGNANCY, CONFINEMENT AND FERTILITY TREATMENTS (INCLUDING MEDICALLY ASSISTED REPRODUCTION)

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 Special provisions

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 Rule of Application No. 10 will be determined according to the relevant invoicing rules applicable in the country where the confinement took place, after consultation of the Medical Adviser.

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 Adviser. 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 Adviser. 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 Rule of Application No. 10 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 and services relating to fertility treatments (including medically assisted reproduction)

The treatments and services in relation to fertility and medically assisted reproduction, whether related to a pathology or outside of the context of pathology, can be reimbursed under the conditions as laid down in this section and insofar as they are not linked to a voluntary sterilisation procedure which either of the prospective parents may have undergone in the past.

The following treatments carried out on beneficiaries shall be reimbursed at the rate of 85 %:

3.1 Pharmaceutical fertility treatments:

a) Ovulation induction agents from the list of pharmaceutical products validated for reimbursement by the Medical Council, when the use of such agents is medically indicated;

b) Agents to improve sperm quality from the list of pharmaceutical products validated for reimbursement by the Medical Council, when the use of such agents is medically indicated.

3.2 Surgical fertility treatment

a) Surgical interventions on the female reproductive organs, when medically indicated:

- Laparoscopic surgery (laparoscopic ovarian drilling by diathermy or laser) to induce ovulation;
- Procedures to improve tubal patency;
- Salpingectomy;
- Surgical resection of endometriosis lesions;
- Hysteroscopic resection of a uterine septum or lysis of adhesions or endometrial polypectomy;
- Myomectomy;
- Uterine operations in case of malformation.

No reimbursement can be granted for interventions which have as objective the reversal of a voluntary sterilisation.

b) Surgical interventions on the male reproductive organs when medically indicated:

- vaso-vasostomy, subject to a ceiling corresponding to category B1 surgical operation;
- epididymo-deferential anastomosis, subject to a ceiling corresponding to category B1 surgical operations;
- ejaculatory duct resection, subject to a ceiling corresponding to category B1 surgical operations;
- varicocele repair (surgical removal or embolism), subject to a ceiling corresponding to category A2 surgical operations.

No reimbursement can be granted for interventions which have as objective the reversal of voluntary vasectomy.

The reimbursement of penile implants is covered in the chapter on prostheses.

3.3 The following treatments of medically assisted reproduction can be reimbursed subject to the conditions and within the age limits as specified in this section, where medical assistance is required:

a) intra-uterine insemination with patient or donor sperm, up to a maximum of six attempts per child;

b) the selection of sperm samples (deferential, epididymal or testicular) and their preparation for intra-cytoplasmic sperm injection (hereinafter “ICSI”), subject to a ceiling corresponding to category A2 surgical operations;

c) in vitro fertilisation (hereinafter “IVF”) including ICSI, subject to a ceiling corresponding to category B1 surgical operations.

The maximum number of attempts of IVF that can be reimbursed is 8 for life.

Up to the age of 40, the reimbursement of the costs of the first IVF can only be granted after exhaustion of the six attempts of intra-uterine insemination. Exceptions to this rule can be granted subject to prior authorisation when there are medical reasons justifying that intra-uterine sperm insemination has no or very limited chance of success.

At least the first IVF attempt must take place before the beneficiary's 45th birthday. This condition shall not apply to persons who will reach their 45th birthday within 18 months of the date of taking effect of this point 3.

IVF attempts between the 45th and 48th birthdays may be reimbursed subject to prior authorisation.

The reimbursable costs cover the following interventions:

- retrieval of spermatocytes, including the costs of analyses and tests, and of short-term conservation of selected spermatocytes, pending their use for fertilisation;
- stimulation and retrieval of oocytes, including the costs of analyses and tests, and of short-term conservation of selected oocytes, pending their use for fertilisation;

- stimulation and retrieval of oocytes from a donor, excluding any other costs;
- with prior authorisation, purchase of sperm via a fertility centre;
- fertilisation using the selected oocytes and spermatocytes, including the costs of culturing, analyses and tests, and of short-term conservation of selected embryos;
- transfer of the selected embryos into the uterus.

d) Outside IVF, even where there is no medical indication:

- retrieval of spermatocytes, including the costs of analyses and tests, and long-term conservation of selected spermatocytes subject to a ceiling corresponding to category B1 surgical operations;

- stimulation and retrieval of oocytes, including the costs of analyses and tests, and long-term conservation of selected oocytes subject to a ceiling corresponding to category B1 surgical operations. The reimbursement is subject to the condition that the collection takes place before the 36th birthday.

e) In case of a proven disease or genetic abnormality identified in a family member related to either prospective parent in the first or second degree, reimbursable costs can cover the following additional interventions:

i. Pre-conceptual genetic examinations of oocytes and spermatocytes;
ii. Preimplantation Genetic Diagnosis on the embryos.

f) Treatments under point 3.3 which meet the conditions for reimbursement, and which invoice remains within the reimbursement period on the date of entry into force of this Decision shall be eligible for reimbursement.

3.4 Medical treatments related to fertility and reproduction not mentioned in this Chapter may be subject to exceptional reimbursement upon request for prior authorisation.

3.5 Medical treatments related to fertility and reproduction shall not be reimbursed under the scheme beyond the age of 48.

3.6 Where the beneficiaries are covered under another sickness insurance scheme provided for by law or regulation, they must first request reimbursement under that scheme before submitting a claim for reimbursement under the Sickness Insurance Scheme. The (part of the) treatments and services in relation to fertility and medically assisted reproduction which concern a prospective parent who is not a scheme beneficiary in primary or top up cover, are not reimbursed under the scheme.

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
A1	Aerosol therapy	x		30	--	
A2	Consulting a dietician	x		10	25	
A3	Kinesitherapy, physiotherapy and similar treatments*	x		60	25	
A4	Medical chiropody	x		12	25	

* 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
B1	Acupuncture	x		30	25	Carried out by a practitioner legally authorised to perform this kind of treatment.
B2	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
B3	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
C1	Full psychological examination/assessment by a single practitioner	x			150	
C2	Chiropractic/osteopathy - People aged 12 or over - Children aged under 12	 x x	 24 x	24	40	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.
C3	Speech therapy (medical report drawn up by ENT doctor or neurologist) - Children aged up to 12 - Children aged between 13 and 18 - People aged over 18 Logopaedic assessment	 x x x	 x x	 180 over one or more years 30 for the entire treatment	35 40	 Serious neurological disorders: more than 180 sessions subject to prior authorisation This concerns: - children suffering from serious deafness or neurological disease - adults suffering from neurological or laryngeal disease

C4	Psychomotor therapy, graphomotor therapy	x		60	35	
C5	Psychotherapy Carried out by - doctor specialising in psychiatry, neuropsychiatry or neurology - psychologist	 x	 x	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. - 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 sessions per year / (12 months)	Ceiling 80 % (€)	Comments
D1	Multidisciplinary neuropsychological assessment	x	x		600	On the basis of a medical report by a neuropaediatrician or psychiatrist.
D2	Hyperbaric chamber	x	x		--	

D3	Lymphatic drainage	x	x	20/12 months	25	In case of serious illness, no limit on number of sessions and no ceiling.
D4	Endermology not for aesthetic purposes	x	x	5/12 months	--	Treatment of deforming scars
D5	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
D6	Ergotherapy	x	x	--	--	
D7	Laser: Laser or dynamic phototherapy (dermatology)	x	x	20	--	
D8	Orthoptic	x	x	20/12 month	35	Prescription by doctor specialising in ophthalmology, naming the orthoptist
D9	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 Adviser.

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 Adviser 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:

  o 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,

  o 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 Adviser 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 Adviser 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 Adviser 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 Rule of Application No. 10.

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 Rule of Application No. 10, 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 reimbursement 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 € 1800 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 Adviser, 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 Adviser.

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 Adviser.

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 Adviser. 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 Adviser 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; 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 Adviser - are reimbursed under the conditions set out in 2.2 and 2.3.

CHAPTER 13

ALLOWANCE TOWARDS FUNERAL EXPENSES

General provisions

The amount of the allowance towards funeral expenses payable under Article 25 of Rule of Application No. 10 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 by virtue of Article 75 of the Staff Regulations.

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.

CATÉGORIE 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 cm²)
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

CATEGORY A2	
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 and 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

CATEGORY A3	
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

CATEGORY B1	
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

CATEGORY B2	
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	Pneumectomie
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	
	/
Transplantations	
6	Kidney
7	bone marrow
8	Pancreas
9	heart and/or lungs
10	kidney and liver
11	Liver

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%				

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 (cf. Title II, Chapter 11, Section 3)

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			

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 (cf. Title II, Chapter 11, Section 3)

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%	1320	1320		*
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					

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 (cf. Title II, Chapter 11, Section 3)

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 lige	
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%				*

ANNEX II - Cost of orthopaedic appliances, bandages and other medical equipment reimbursed at the rate of 85% or 100% at the rate of 85% or 100% in the case of serious illness (cf. Title II, Chapter 11, Section 3)

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 Sickness Insurance Scheme 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. However, the cost of products and supplies used in the course of such treatment is reimbursable in accordance with this Rule.

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);

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 Adviser.

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 Application for the special reimbursement referred to in Article 24 of Rule of Application No. 10 shall 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 are 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, shall issue 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 Sickness Insurance Scheme 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 Sickness Insurance Scheme, 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 Rule of Application No. 10, 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 Rule of Application No. 10, provided that his or her income before tax is less than the annual basic salary in grade C5/1 [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 Sickness Insurance Scheme.

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 Rule of Application No. 7 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 Sickness Insurance Scheme 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 Sickness Insurance Scheme provided it is covered by the Scheme. In such cases, the Sickness Insurance Scheme 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 Sickness Insurance Scheme 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 Sickness Insurance Scheme 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 Sickness Insurance Scheme 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 Sickness Insurance Scheme 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 Sickness Insurance Scheme 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

In line with Article 30 of Rule of Application No. 10, members may be granted advances to help them cope with major items of expenditure. Direct billing is the primary form of assistance.

Members who are only eligible for Sickness Insurance Scheme top-up cover will not be granted direct billing unless it can be established, by means of the necessary documentation, that the Sickness Insurance Scheme 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.

     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 Adviser, 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.

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 Agency. At the request of the Settlements Office, the balance may be reimbursed by a transfer to the Sickness Insurance Scheme bank account.

2. "Reserved"

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 Director General as of comparable seriousness.

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

- 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
- a shortened life expectancy.

These cumulative criteria must be subject to an overall assessment of the seriousness of the consequences of the illness in question. Given the way in which they may be interlinked, the assessment of one of the criteria is likely to influence the assessment of the other criteria, particularly as regards cases of serious disability. The examination of one criterion in the light of the assessment of the other criteria may lead to the conclusion that the criterion in question, in particular the criterion relating to shortened life expectancy, has been fulfilled.

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;

- costs relating to follow-up examinations of serious illnesses.

3. Procedures

Applications for recognition of a serious illness must be addressed confidentially to the Medical Adviser and be accompanied by a detailed medical report. 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 (date of the diagnosis as stated on the medical certificate) to a date in the future, granting 100% cover for no more than 5 years excluding the costs for the medical monitoring of the serious illness which may be reimbursed after that period.

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 to be extended, 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 diagnosis as stated on the medical certificate supporting the application for recognition of the 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 Adviser.

The backdating may not, however, extend beyond the time limit for reimbursement laid down in Article 32 of Rule of Application No. 10.

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 or the General Conditions of Employment are set out in Article 24 of Rule of Application No. 10. This top-up reimbursement applies when the expenditure incurred by the member is not excluded by these general implementing rules 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. "Reserved"

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 Rule of Application No. 10, parity coefficients are adopted at least once every two years (based on parity coefficients adopted by the European Communities) in order to ensure equality of treatment for benefits paid out in any of the Member States.

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.

3. Calculation of the parity coefficients

   3.1 On the basis of sufficiently representative statistical information on expenditure incurred by Sickness Insurance Scheme 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 Rule of Application No. 10.

CHAPTER 8

CALCULATING REIMBURSEMENT-LEVEL COEFFICIENTS - ARTICLE 21(1)

Medical expenses incurred in a country outside the Member States where costs are particularly high are reduced by applying a reimbursement-level coefficient (in force at the European Communities and taken over by EUROCONTROL) enabling the reimbursement rates provided for in the rules to be applied to a level of costs made comparable to the average in the Member States.

The reimbursement-level coefficient is only applied for third countries where health cost indices exceed the average in the Member States by 25% or more, and in the case of treatment that costs 25% or more than the average in the Member States. If the cost of treatment is comparable to the average in the Member States, 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 Adviser, if there is no equivalent medical treatment for that illness in the Member States.

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

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.