European Commission

Paymaster's Office

REIMBURSEMENT OF MEDICAL EXPENSES

PRACTICAL GUIDE

PMO

The purpose of this practical guide is to provide members of the Joint Sickness Insurance Scheme of the European Union institutions (the JSIS) with an easy-to-use summary of the rules for the reimbursement of medical expenses (General implementing provisions), which entered into force on 1 July 2007.

In the event of a discrepancy, it is the regulatory framework governing the JSIS (JSIS joint rules and the General implementing provisions) which prevails.

Contents

IN BRIEF

Who is covered by the JSIS?

- **Members:**
  - officials
  - temporary staff
  - contract staff
  - persons in receipt of a retirement pension or termination of service allowance
  - members of certain institutions.
- **Those covered by their insurance**:
  - dependent children
  - spouses
  - recognised partners.

  A number of restrictions apply to the last two categories (see Title I, Chapter 2 of the General implementing provisions).

→see *"For more information"*

How much will the rate of reimbursement be?

When calculating the amount to which you are entitled, a reimbursement rate is applied to each item of expenditure.

80%: basic rate for the following expenses:
- dental care and treatment
- miscellaneous therapeutic treatments
- medical auxiliaries and carers
- thermal cures
- transport costs.

85%: basic rate for the following expenses:
- medical consultations and visits
- surgical operations
- hospitalisation
- pharmaceutical products
- medical examinations
- laboratory tests
- glasses and contact lenses
- orthopaedic appliances and other medical equipment.

100%: reimbursement rate applied only to expenses incurred in relation to a recognised serious illness.
To be recognised as a serious illness, an illness must involve, to varying degrees, all of the following four criteria:

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

Under the Staff Regulations, illnesses such as tuberculosis, polio, cancer and mental illness are considered to be serious.

Cover at the rate of 100% is granted for the estimated duration of the treatment of the serious illness up to a maximum of five years. As a rule, cover starts from the date on which the recognised serious illness was diagnosed.

At the end of this period, you may submit a request for an extension, accompanied by a medical report. The report must indicate:

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

If, at this point, the illness no longer meets the four criteria, the 100% rate of cover cannot be extended.

If the situation subsequently changes, the decision can be reviewed if you make a new request.

N.B.:
Some treatment is subject to a ceiling for reimbursement, even in the case of a recognised serious illness.

Ceiling for reimbursement

The ceiling is defined as the maximum amount that may be reimbursed for a given treatment. Consequently, when the ceiling is applied the rate of reimbursement no longer corresponds to 80%, 85% or 100%, since the ceiling limits the amount reimbursed. For example, the ceiling for consulting a general practitioner is €35. Reimbursement is made at the rate of 85% up to €35.

Parity coefficients

The amounts given in the brochure relate to Belgium. To ensure equal treatment, a parity coefficient is applied to these amounts if the treatment is obtained in another Member State.

Excessive costs (Article 20(3))

If no reimbursement ceiling has been set (including in the case of a recognised serious illness), any part of the costs which exceeds the normal price charged in the country where the treatment was provided may not be reimbursed.
The portion of the costs deemed excessive will be determined on a case-by-case basis by the Settlements Office after consulting the Medical Officer.

Medical prescriptions: how to claim

All prescriptions must include the following information:

- the name and official details of the prescriber
- the patient's full name
- a description of the medical treatment (type of treatment, number of sessions, etc.)
- or the name of the medicine(s) prescribed and/or the active substance
- the date
- the prescriber’s signature.

N.B.: The date on the prescription must be less than six months before the date of the first treatment or the purchase of the medicines.

Supporting documents

Treatment can only be reimbursed if it is prescribed or carried out by a legally authorised medical or paramedical practitioner or in an establishment duly approved by the competent authorities.

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.

In Belgium, the certificate of treatment ('attestation de soins') showing the amount paid, or a receipt which is valid for tax purposes, is always compulsory. From 1 January 2015, if you do not have the official document you will not be reimbursed.

In the specific case of practitioners who are not authorised to issue certificates of treatment (psychologists, osteopaths, podiatrists and medical chiropodists in Belgium), receipts are taken from an official pad which follows a model laid down by the Finance Ministry; examples corresponding to the various categories of treatment are attached in annex. If you pay your practitioner by bank transfer, you can attach a bill, drawn up in accordance with the rules, together with proof of payment.

In Italy, your practitioner must provide you with an invoice (see annex).

> **N.B.:**
> Advances and prepayments will not be accepted for reimbursement.
> You must attach them to the final invoice, detailing the treatment, when you submit your claim for reimbursement.

Remember: the cost of medical care provided by a medical or paramedical practitioner to a member of his or her family who is covered by the JSIS will not be reimbursed.

Prior authorisation

This is a procedure required for certain reimbursements and must be carried out via your Settlements Office.

The request for prior authorisation must be submitted before the start of treatment. The request must have been approved for you to be able to submit a claim for reimbursement. However, there is no need to wait for the decision of the Head of the Settlements Office before you start the treatment. The decision will cover a certain period and either a given number of treatment sessions or a maximum amount to be reimbursed. Reimbursement will be made in accordance with the limits imposed by the decision.

A request for prior authorisation is made up of several documents:

- the prior authorisation application form or request via JSIS Online,
- a detailed medical prescription,
- a full medical report or estimate (depending on the nature of the treatment).

Send everything to your Settlements Office either by post or via JSIS Online.

A decision will be taken on the request after consulting the Medical Officer, who will assess the medical case for the treatment.

Direct billing and advances

Direct billing allows you to ask a hospital to send its invoice for hospitalisation straight to the sickness insurance scheme for direct payment. The hospital is not obliged to accept direct billing.

Members must apply in advance. Permission is granted in the following cases:

- hospitalisation: covers the main invoices and the surgeon's and anaesthetist's fees;
- intensive out-patient care: e.g. radiotherapy, chemotherapy or dialysis, in connection with a recognised serious illness;
- expensive medicines that must be bought repeatedly, such as growth hormones, repeated use of a standard or light ambulance, or certain expensive tests.

If there is no agreement, don't forget to specify in your request the date you expect to go into hospital, the daily rate for the room and/or an estimate of the overall cost.

Bear in mind that, following the calculation, a proportion of the costs (which may be substantial) will have to be met by you; if you are travelling to countries in which medical care is expensive you are advised to take out insurance cover against this risk.
If you opt for direct billing, the invoices in question will be paid by your Settlements Office once they have been received and initial checks have been carried out. If you would like copies of your invoices you can always contact the hospital. It is advisable to provide your Settlements Office – direct billing section – with all useful information regarding your stay/ invoice.

Under certain conditions, advances on reimbursement may also be granted to cover major items of expenditure (fill in the form 'Request for an advance on high medical costs' and send it to your Settlements Office).

N.B.:
Direct billing is a financial facility, not a guarantee of reimbursement. All the reimbursement procedures apply.

Claims for reimbursement

You can submit your claim for reimbursement electronically via JSIS Online https://webgate.ec.europa.eu/RCAM. The protection of your data is guaranteed thanks to the secure connection via ECAS (see also 'For more information' at the end of this document). You will then be required to keep your original documents for 18 months from the date on which you receive your statement.

Alternatively, members may submit their claims for reimbursement to their Settlements Office using a form and enclosing the original supporting documents.

In the case of claims for top-up reimbursement, you must attach a copy of the original invoice, with proof of payment, accompanied by a detailed statement of reimbursements received from another scheme.

REIMBURSEMENT RULES AND PROCEDURES

1. MEDICAL CONSULTATIONS AND VISITS

Consultation = at the doctor's surgery.
Visit = the doctor comes to the patient (e.g. at home or in hospital).

What does a consultation or visit normally involve?

- an interview with the patient
- a clinical examination
- a prescription, if necessary.

What else is included in the consultation or visit?

- diagnostic tests such as taking blood pressure, smear tests, etc.
- taking blood samples
- taking urine samples
- injections
- vaccinations
- applying dressings
- writing a medical certificate
- costs associated with the appointment and the doctor's travel costs.

Reimbursement of repetitive consultations may be refused, after consulting the Medical Officer, if it is felt that the reason given is inadequate or that they are unnecessary.

1.1. RATES AND AMOUNTS

Fees	Rate of reimbursement	Ceiling[1]	Rate in the case of a recognised serious illness
General practitioner	85 %	€35	100 %
Specialist	85 %	€50	100 %
Urgent visits, incl. night-time, weekend or public holidays	85 %	---	100 %
Consultation by phone, post or e-mail	85 %	€10	€10
Leading medical authority	85 %	€150	100 %

More information:
What is a **leading medical authority?** A leading medical authority is a specialist doctor with an international reputation in a particular field who heads a research team and is the author of publications. However, **reimbursement is limited to two visits a year for the same condition** and only if prior authorisation has been obtained.

1.2. THE FOLLOWING ARE NOT REIMBURSABLE:

- Internet consultations
- fees for appointments which the patient failed to attend
- the costs of sending medical reports that are invoiced separately
- consultations, examinations or procedures carried out for administrative or non-therapeutic reasons, such as:
  - expert report ordered by a court
  - examination for insurance purposes
  - examination to determine professional competence or to obtain a pilot's licence

1 Ceilings for Belgium. If necessary, a parity coefficient is applied if the treatment is obtained in another Member State.

→ See *in brief…*

- examinations carried out as part of occupational medicine (pre-recruitment medical or annual medical, which may be reimbursed by the Medical Service but not by the JSIS).

2. HOSPITALISATION AND SURGICAL OPERATIONS

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 in a day surgery unit or day hospital
- rehabilitation or functional re-education following a condition or operation resulting in invalidity
- undergoing treatment for psychiatric conditions
- receiving palliative care.

2.1. PRIOR AUTHORISATION

Prior authorisation (accompanied by a medical report) is needed for hospital stays:

- of more than six months
- in connection with plastic surgery (e.g. gastroplasty, correction of nasal septum, breast reconstruction)
- of more than 12 months in a psychiatric hospital
- for rehabilitation/re-education not following a period in hospital or lasting more than two months
- in a clinic specialising in screening and diagnosis
- for rehabilitation/re-education which does not follow a period in hospital
- for a person accompanying a patient.

2.2. LETTER OF DIRECT BILLING

Direct billing allows a hospital to send its invoice for hospitalisation straight to the sickness insurance scheme for direct payment.

The proportion of the costs to be met by you (which can be substantial, especially in countries where medical care is expensive, such as the USA, Canada, Switzerland and Norway) is normally deducted from later reimbursements or from your salary, pension or other sums owed to you by the institution.

N.B.:

- If you are covered by direct billing, the hospital cannot ask you to pay an advance.
- If you have top-up cover under the JSIS, you cannot obtain direct billing; you must ask your primary insurer in that case.
- If the Medical Officer has turned down a request for prior authorisation, you will not be granted direct billing and you will not be reimbursed.

Under certain conditions, **advances** on reimbursement may also be granted to cover major items of expenditure (fill in the form 'Request for an advance on high medical costs' and send it to your Settlements Office).

→ see Direct billing and advances under *In brief …*
→ see *"For more information"*
→ link to form / JSIS Online

If your hospitalisation is the result of an emergency …

In exceptional circumstances, you (or someone acting on your behalf) can apply for direct billing by leaving your name, personnel number and the name of the hospital concerned on the answering machine of the person responsible for direct billing at your Settlements Office; in the absence of an answering machine this can be done by e-mail.

In that case, the PMO will contact the hospital where you are staying and send it the necessary letter of direct billing.

After your stay in hospital …

If you were covered by direct billing:
your Settlements Office will send you a statement of expenses. The proportion of the costs to be met by you (approximately 15%) will in theory be deducted from your future reimbursements or from your salary, pension or other sums owed to you by the institution.

If you paid your hospital bill yourself:

- fill in a claim for reimbursement, enclosing:
  - the invoice setting out in detail the medical services provided (using the official national classification)
  - proof of payment of any advance payment you had to make on admission.
- Send everything to your Settlements Office.

2.3. RATES AND AMOUNTS

The rate of reimbursement is **85%** including the fees of the surgeon, the surgeon's assistants and the anaesthetist.

It is **100%**:

- in the case of a recognised serious illness
- for stays of three or more consecutive days in intensive care
- for stays in a palliative care unit
- for accommodation costs beyond 30 consecutive days (with the approval of the Medical Officer).

Where reimbursement is at the rate of **85%**, the ceilings can range from €535 to €10 000 depending on the category of operation. For the full list of surgical operations by category, please see Annex I to the General implementing provisions.

→see *"For more information"*

The costs of surgical operations that do not appear on this list but can be regarded as similar to operations of comparable importance will be reimbursed on the recommendation of the Medical Officer.

Accommodation costs:	reimbursement is limited to the price of the least expensive single room in the hospital and the length of the stay according to need. It will be made on the basis of a duly established invoice.
Costs of diagnosis and treatment:	the reimbursement rate is **85%** or **100%** (recognised serious illness) for the costs of the operating theatre and other costs of treatment relating to the surgical operation, as well as for medical fees, analyses, laboratory tests and other instruments directly related to the operation or hospitalisation.
Cost of stay for person accompanying the patient:	in exceptional circumstances, the accommodation costs of an accompanying family member may be reimbursed at the rate of **85%** (up to a ceiling of €40 per day) if the patient is under the age of 14 or requires special assistance from a family member on medical grounds, subject to a prescription from the patient's doctor and prior authorisation. This also applies to accommodation costs for a child who is being breastfed and has to accompany its mother.

2.4. THE FOLLOWING ARE NOT REIMBURSABLE:

Plastic surgery which is considered to be purely cosmetic.

3. SERVICES ASSOCIATED WITH DEPENDENCE

The reimbursement of services associated with dependence (stays in an institution and the costs of carers) excluding residential drug rehabilitation, depends on the degree of dependence.–– This is determined by the patient's doctor on the basis of two questionnaires. Only degrees of dependence from 1 to 4 qualify for reimbursement (see Chapter 3 of Title II of the General implementing provisions).

→see *'For more information'*

In all cases, applications 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,
- the two questionnaires on the degree of dependence completed by the patient's doctor.

Then forward these documents to your Settlements Office either by post or via JSIS Online.

3.1. CONTINUOUS OR LONG-TERM RESIDENCE

3.1.1. Convalescent and nursing homes

Authorisation is valid for twelve months and must be renewed.
The reimbursement rate for accommodation costs is **85%** or **100%** (recognised serious illness), with a ceiling of €36 per day.
If the items are aggregated on the invoice so that it is not possible to separate the costs of care from the accommodation costs, the ceiling will be €36 and the costs (care or accommodation) will be divided according to the degree of dependence.

3.1.2. Psychiatric home

Residence and care are reimbursable at the rate of **85%** or **100%** (recognised serious illness). Authorisations are renewable on presentation of a detailed report by the patient's doctor, for periods determined by the Settlements Office.

3.1.3. Rehabilitation or functional re-education establishment and psychiatric hospital

The reimbursement conditions are the same. However, in the case of an aggregated invoice, the costs will be divided according to the proportions for a level 1 degree of dependence.

3.1.4. Day centre

- Daytime attendance only at a convalescent or nursing home for the elderly or a neurological or psychiatric day centre: the costs of accommodation and care are reimbursed under the same conditions as permanent residence in a convalescent or nursing home, with a ceiling of €18 per day for accommodation costs.
- Attendance at a child guidance clinic: only care is reimbursable.

3.1.5. Non-hospital drug rehabilitation centre

Accommodation and treatment costs are reimbursed at the rate of **85%** only, with a ceiling of €36 per day for the accommodation costs.

In the case of an aggregated invoice, the costs will be divided according to the proportions for a level 1 degree of dependence and reimbursement will be limited to a stay of six months in a 12-month period.

3.2. CARERS

= nursing care in the patient's home for several hours a day or the whole day and/or night. Carers must be legally authorised to practise their profession.

An application for prior authorisation must be submitted, together with the two questionnaires evaluating the degree of dependence completed by your doctor, and a **medical report** stating the duration of the services and the nature and frequency of the treatment to be provided.
Proof of a contractual link with the carer must also be provided.

3.2.1. REIMBURSEMENT

To qualify for the reimbursement of care services, the following documents must be submitted: an invoice for the calendar month complying with national law, and, where appropriate, proof that social security contributions have been paid in accordance with national law.

Reimbursement is made at the rate of **80%** or **100%** (recognised serious illness).

- **Temporary home care (maximum 60 days):** reimbursed at the rate of **80%**, with a ceiling of €72 per day, or **100%** (recognised serious illness), with a ceiling of €90.
- **Long-term home care:** the rate of reimbursement depends on the degree of dependence.
- **Services of carers provided in hospital:** 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 the basis of a prescription issued by the patient's doctor are reimbursed at the rate of **80%**, with a ceiling of €60 per day, or **100%**, with a ceiling of €75 per day, subject to prior authorisation.

3.2.2. THE FOLLOWING ARE NOT REIMBURSABLE

- The carer's travel expenses, board and lodging, or any other ancillary costs,
- the services of adults who look after children who are ill at home while their parents are away (ask the social services about home help).

→see *'For more information'*

4. PHARMACEUTICAL PRODUCTS

To qualify for reimbursement, all pharmaceutical products (medicines, formulas prepared by a pharmacist or homeopathic preparations) must have been prescribed by a doctor in a way that is not excessive (i.e. not exceeding normal therapeutic guidelines).

4.1. HOW TO CLAIM

Reimbursement is made on presentation of **receipts** or **invoices** 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,
- 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.

Did you know?
A list of the main products that are and are not reimbursable is updated regularly. Products that do not appear on the list may be reimbursed with the approval of the Medical Officer.
→see *'For more information'*

You will need **prior authorisation** (accompanied by a medical report) to obtain reimbursement for the following products:

- slimming products
- anti-ageing hormonal treatment
- growth hormones
- products used to treat erectile disorders caused by a prostate operation, an accident or a recognised serious illness (up to a ceiling of €400 per year)
- narcotic drugs used during withdrawal treatment (100% for six months)
- pharmaceutical products used for a medical indication other than the recognised one
- dietary and hygiene products essential for survival.

4.2. RATES AND AMOUNTS

In most cases, the reimbursement rate is **85%** or **100%** (recognised serious illness). Other rates apply for:

- narcotic drugs used during withdrawal treatment (100% subject to certain conditions)
- dietary products (85% or 100% of 40% of the cost)
- products used for the treatment of nicotine dependency (€200, on one occasion only, whether or not the treatment is successful).

→see *'For more information'*

4.3. THE FOLLOWING ARE NOT REIMBURSABLE

- Products for cosmetic, hygienic, aesthetic or dietary purposes or for personal comfort, with certain exceptions
- tonic wines and beverages, organotherapy products and trace elements which have not been proved to be effective.

5. DENTAL CARE AND TREATMENT

5.1. HOW TO MAKE A CLAIM AND FOR WHAT AMOUNT

Preventive care and treatment
To obtain reimbursement, submit a claim for reimbursement of costs to your Settlements Office.
Reimbursement at 80% for preventive dental and oral hygiene care, x-rays, treatment and extractions (up to a ceiling of €750 per calendar year).
Reimbursement at 100% (up to a ceiling of €1 500) in the case of certain recognised serious illnesses.

Prior authorisation, granted by the Settlements Office after presentation of a detailed estimate and after consultation of the Dental Officer, is compulsory for the following treatment:

Periodontal treatment:	reimbursed at the rate of **80%** (with a ceiling of €350 per sextant, i.e. a maximum of €2 100 for the whole mouth, over a period of 16 years);
Orthodontic treatment:	reimbursed at the rate of **80%** (with a ceiling of €3 300). Treatment must begin before the patient's 18th birthday (except in the case of recognised serious illness). A second course of treatment is possible under certain conditions;
Dental occlusion:	reimbursed at the rate of **80%** (with a ceiling of €450). This type of treatment will be reimbursed only once;
Dental prostheses:	reimbursed at the rate of **80%** (with different ceilings for each type of treatment). The cost of replacing a prosthesis will be reimbursed only every six years (except in the event of trauma or recognised serious illness, and after consulting the Dental Officer and on presentation of detailed medical grounds and an estimate);
Implantology:	reimbursed at the rate of **80%** (with a ceiling of €550 per implant). 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.

In the case of a recognised serious illness affecting the buccal cavity, the rate of reimbursement for this type of treatment will be **100%** (up to twice the ceiling normally provided for each treatment) subject to the joint approval of the Medical Officer and the Dental Officer.

More information:
In the case of treatment requiring prior authorisation, the JSIS's official estimates should be used, except in emergencies or cases of force majeure.

5.2. THE FOLLOWING ARE NOT REIMBURSABLE

The costs of treatment for purely aesthetic purposes:

- tooth whitening
- systematic replacement of silver amalgam fillings
- veneers on intact incisors
- tooth jewellery, etc.

6. MEDICAL ANALYSES AND TESTS

= Medical imaging, analyses, laboratory tests and other forms of diagnosis.

6.1. HOW TO CLAIM

- Fill in a claim for reimbursement
- attach the invoice setting out in detail the medical services provided (using the official national classification)
- and send everything to your Settlements Office.

Some forms of diagnosis require **prior authorisation**, e.g.:

- analyses carried out in connection with:
  - anti-ageing treatment
  - multiple hormone treatment
  - allergies and food intolerance
  - genetic tests other than for investigating a specific condition
- new techniques for tests, analyses or medical imaging the costs of which do not qualify for reimbursement in at least one European Union Member State.

6.2. RATES AND AMOUNTS

The reimbursement rate is **85%** or **100%** (recognised serious illness).

More information:
The full list of all the diagnostic tests, both those that are reimbursed and those that are not, is updated regularly. →see *"For more information"*

6.3. 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 consultation of the Medical Officer.

7. PREGNANCY, CONFINEMENT AND INFERTILITY

7.1. PREGNANCY

= the period between fertilisation and confinement.

7.1.1. HOW TO MAKE A CLAIM AND FOR WHAT AMOUNT

Consultations, treatment and all other examinations and treatment 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.

The reimbursement rate is:

- **85%** for all medical consultations/visits
- **80%** for **individual** ante-natal sessions (ceiling of €25 per session) or **group** ante-natal sessions (ceiling of €15 per session) carried out by a physiotherapist or midwife on medical prescription. These sessions are not included in the maximum number of sessions of general physiotherapy allowed.

7.1.2. THE FOLLOWING ARE NOT REIMBURSABLE

- the cost of haptonomy sessions and antenatal aqua sessions
- charges for the availability of doctors/specialists.

7.2. CONFINEMENT

= any birth from the 22nd week of pregnancy onwards.

Since July 2013, excessive-fee thresholds have been imposed for eight Member States. As a result, maximum reimbursable amounts (for hospital stays, fees, etc.) are now €7 171 for Belgium, €9 591 for Italy, €5 446 for Germany, €6 203 for Spain, €6 616 for France, €7 246 for Luxembourg, €6 466 for the Netherlands and €16 713 for the United Kingdom.

7.2.1. HOW TO MAKE A CLAIM AND FOR WHAT AMOUNT

7.2.1.1. In hospital

The reimbursement rate is **100%** for:

- the fees of doctors who assist at the birth,
- 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. If the duration of the stay is more than ten days – and there are no complications – the rate is **85%**,
- the costs of neonatal accommodation and care for the baby.

> **N.B.**:
> When booking your stay in hospital, remember that reimbursement is limited to the price of the least expensive single room in the hospital.

After the birth…

If you paid your hospital bill or any additional bills yourself, fill in a claim for reimbursement and attach the invoice setting out in detail the medical services provided (using the official national classification), and send it to your Settlements Office.

7.2.1.2. At home

100% reimbursement of fees charged by the doctor, midwife and other medical auxiliaries (except home help) for a period of ten days.

7.2.1.3. At a "birthing centre" or approved non-hospital centre

Fill in a **claim for reimbursement**, attach the detailed invoice for the medical services provided and send them to your Settlements Office.

100% reimbursement of fees charged by the doctor, midwife and other medical auxiliaries (except home help) for a period of ten days.

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

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

Individual **post-natal physiotherapy** sessions carried out by a physiotherapist on the basis of a medical prescription are reimbursed at the rate of **80%** (ceiling of €25 per session) and are not included in the maximum number of sessions allowed.

7.3. INFERTILITY

The person affected may be male or female; the infertility must be the result of a pathological condition affecting the member of the scheme or the member's spouse or partner.

A request for prior authorisation is required, accompanied by a medical report.

The cost of infertility treatment will be reimbursed as follows:

- In vitro fertilisation:
  - maximum of five attempts per child,
  - treatment must begin before the mother's 45th birthday.
- Male infertility treatment: the infertility must not be the result of previous voluntary sterilisation.

> **In the case of in vitro fertilisation:**
> the costs of pre-implantation genetic diagnosis on the embryo and of egg donation are reimbursed – on certain conditions - subject to prior authorisation.

8. MISCELLANEOUS THERAPEUTIC TREATMENTS

These include: kinesitherapy, physiotherapy, osteopathy, infrared rays, ultrasound, aerosol therapy, acupuncture, speech therapy, psychotherapy, psychomotor therapy, speech / language pathology, medical chiropody, etc.

8.1. HOW TO CLAIM

The **medical treatments** must have been:

- prescribed by a doctor
- submitted for prior authorisation if necessary
- carried out by practitioners (psychologists, physiotherapists, osteopaths, acupuncturists, etc.) who are professionally qualified and legally recognised medical or paramedical practitioners, or by medical or paramedical establishments duly approved by the competent authorities.

In Belgium, only psychologists belonging to the Commission of Psychologists are recognised as being qualified to practise this profession. In other countries, however, psychotherapists, as well as psychologists, are qualified and legally recognised so their therapy sessions are also eligible for reimbursement.

Medical prescriptions must:

- have been written before the start of treatment
- be dated less than six months previously
- give the patient's name
- state the reason for the treatment
- state the type of treatment and the number of sessions.

Supporting documents must comply with the law of the country in which the treatment was provided.

8.2. RATES AND AMOUNTS

Medical treatments are reimbursed at the rate of **80%**, subject to the ceiling for each treatment, and at **100%** in the case of recognised serious illness, subject nonetheless to a ceiling for certain treatments. In fact, costs are reimbursed up to twice the normal ceiling when the treatment is provided in connection with a serious illness.

For all of these treatments there is a maximum number of sessions per calendar year for which reimbursement can be made. 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.

→ See point *8.4.* below. *Miscellaneous treatments table*

8.3. THE FOLLOWING ARE NOT REIMBURSABLE

- treatment for aesthetic purposes
- swimming pool subscriptions
- enrolment fees for sports or fitness centres.

8.4. MISCELLANEOUS TREATMENTS TABLE

MP = medical prescription
PA = prior authorisation

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**[2]	x		60	25	
A4	**Medical chiropody**	x		12	25	

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	

2 Similar treatments = 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.

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	 x	24 24	40	A higher number of sessions per year may be allowed but only with 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 or psychotherapist**	x 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 o Prescription by psychiatrist, neuropsychiatrist or neurologist o First 10 sessions may be prescribed by a general practitioner o 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 cases of recognised 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	**Orthoptics**	x	x	20 /12 months	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 normally renewable once	40	
D11	**Shock wave therapy (rheumatology)**	x	x	--	--	
D12	**Any other unspecified treatment**	x	x	--	--	NB: Whether or not costs are excessive is decided on a case-by-case basis

9. MEDICAL AUXILIARIES

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

Prior authorisation is required for additional treatment over and above the services provided by the carer.

THE FOLLOWING ARE NOT REIMBURSABLE

The practitioner's travel costs.

10. CONVALESCENT AND POST-OPERATIVE CURES

Two conditions must be met for a cure to be reimbursed (automatically subject to prior authorisation):

- it must be carried out under medical supervision in a convalescent centre with an appropriate medical and paramedical infrastructure;
- it must commence within three months of the operation or illness for which it was prescribed, except where there is a medical contra-indication duly justified in the report accompanying the medical prescription and accepted by the Medical Officer.

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

10.1. RATES AND AMOUNTS

Accommodation costs: reimbursed at the rate of **80%** (ceiling of €36 per day) for a maximum period of 28 days per annum, or at **100%** (ceiling of €45 per day).

Costs of care: reimbursed separately in accordance with the General implementing provisions.

Cost of stay for person accompanying the patient: reimbursed, in exceptional circumstances, at the rate of **85%** (ceiling of €40 per day), on presentation of a medical prescription and with prior authorisation, in the following cases:

- for a family member staying in the same room or within the establishment offering the cure, if the person following the cure is under the age of 14 or requires special 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.

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

10.2. THE FOLLOWING ARE NOT REIMBURSABLE

Travel expenses.

11. THERMAL CURES

= stay of between **10 and 21** days at a specialist establishment providing treatment under medical supervision using water taken from a spring before it has lost its specific properties, or at a specialist paramedical centre approved by the national health authorities.

The cure must include at least **two appropriate treatments per 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 recognised serious illness of a family member, etc.).

Authorisation for a cure is limited to:

- one cure per year, up to a maximum of eight cures in a lifetime, for the following conditions:
  - rheumatism and sequellae of trauma to bones or joints
  - phlebology and cardio-arterial diseases
  - neurological diseases
  - disorders of the digestive tract and related structures, and metabolic disorders
  - gynaecological disorders and disorders of the kidneys and urinary tract
  - dermatology and stomatology
  - diseases of the respiratory tract
- one cure per year provided that it is taken in connection with the treatment of a recognised serious illness or in the case of severe psoriasis which does not respond to conventional treatment.

N.B.:
Authorisation will not be granted unless:

- the thermal cure is considered necessary by the Medical Officer;
- you have followed the treatments prescribed in the course of the year and they have proved insufficient;
- the cure has proven therapeutic value.

11.1. HOW TO CLAIM

Before the cure …

At least six weeks before the start of the cure, you should submit a request for prior authorisation including the following documents:

- a medical prescription from a medical practitioner who has no links with a cure centre,
- a detailed medical report, drawn up within the previous three months, stating:
  - the patient's medical history and details of treatments undergone during the previous year for the medical condition for which the cure is necessary,
  - the duration of the cure, the nature of the thermal treatment to be followed and the type of approved cure centre in relation to the disorder in question,
- where necessary, a medical prescription explaining why the patient needs to be accompanied.

After the cure …

If prior authorisation has been **granted**:

- fill in a **claim for reimbursement**, enclosing:
  - the detailed invoice with proof of payment.
- Send everything to your Settlements Office.

Treatment costs may still be reimbursed, even if prior authorisation **has not been granted**:

- fill in a **claim for reimbursement**, enclosing:
  - 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, the number of sessions and the cost of the treatment.
- Send everything to your Settlements Office.

11.2. RATES AND AMOUNTS

Costs of treatment and medical supervision: **80%** (overall ceiling of €64 per day) or **100%** (overall ceiling of €80 per day) in the case of a recognised serious illness.
Cost of stay for person accompanying the patient: **85%** (ceiling of €40 per day), on presentation of a medical prescription and with prior authorisation, in the following cases:

- for a family member staying in the same room or within the establishment offering the cure, if the person following the cure is a child 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.

11.3. THE FOLLOWING ARE NOT REIMBURSABLE

- thalassotherapy and fitness cures,
- travel expenses,
- board, lodging and meals,
- costs ancillary to treatment,
- treatments such as:
  - sea, lake or sand baths,
  - sauna, solarium, etc.

12. SPECTACLES

Expenses are reimbursed:

- every year for young people up to the age of 18
- every two years for people over 18
- more often if there is a change in dioptre or axis of 0.50 or more, attested by an ophthalmologist or ophthalmic optician.

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 with single-vision lenses for correcting short or long sight.

12.1. HOW TO CLAIM

The **original invoice must show**:

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

12.2. RATES AND AMOUNTS

The **reimbursement rate** is **85%**:

- for the frames (ceiling of €120),
- for the lenses subject to the following ceilings:

	Ceiling per lens (in €)
Ordinary lenses	
up to 4 dioptres	110
from 4.25 to 6 dioptres	140
from 6.25 to 8 dioptres	180
8.25 dioptres and over	300
Multifocal/progressive lenses	350

12.3. THE FOLLOWING ARE NOT REIMBURSABLE

- spectacles with non-corrective lenses
- sunglasses
- spectacles for working on screen (reimbursed by the Medical Service, not the sickness insurance scheme)

13. CONTACT LENSES

13.1. HOW TO CLAIM

The **invoice** must indicate:

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

13.2. RATES AND AMOUNTS

The cost of purchasing conventional and/or disposable corrective contact lenses, and of products for use with them, is reimbursed at the rate of **85%** (overall ceiling of €500 per 24-month period).

If the contact lenses were purchased via the Internet, reimbursement can be made only on the basis of a duly established invoice (see 'Supporting documents').

14. HEARING AIDS

= purchase or repair of hearing aids prescribed by an ENT specialist or audiometrist.

14.1. HOW TO CLAIM

- Fill in a claim for reimbursement and attach the medical prescription from the ENT specialist or audiometrist and the receipted invoice.

14.2. RATES AND AMOUNTS

Reimbursed at the rate of **85%** (with a ceiling of €1 500 per ear).
Renewal is allowed every five years, except where there is a variation in the audiometric conditions.

14.3. THE FOLLOWING ARE NOT REIMBURSABLE

Maintenance and batteries.

More information:
In the case of a serious hearing-related illness or if the hearing aid is intended for a child under the age of 18, a derogation may be granted from the ceilings and minimum renewal periods, subject to prior authorisation.

15. ORTHOPAEDIC APPLIANCES AND OTHER MEDICAL EQUIPMENT.

More information:
There is a table setting out the various types of appliance, respective reimbursement rates and ceilings in Annex 2 to Title II of the General implementing provisions.
→see *"For more information"*

THE FOLLOWING ARE NOT REIMBURSABLE

- fixed costs of converting a residence or a vehicle, home automation equipment, IT equipment, home monitoring (lifeline), furniture which is not strictly for medical use, such as reclining chairs and other similar items.

16. TRANSPORT COSTS FOR PERSONS COVERED BY THE JSIS

16.1. HOW TO CLAIM

Before the journey …

Fill in a request for **prior authorisation** and attach a medical certificate explaining what kind of transport is needed and why. If the transport involves more than one return journey, the medical prescription must set out the reasons and specify the number of essential journeys.

As regards the conditions for reimbursement, 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.

After the journey …

Fill in a **claim for reimbursement**, enclosing:

- supporting documents in relation to the transport (e.g. receipted bills, tickets, etc.).

16.2. RATES AND AMOUNTS

Reimbursed at the rate of **80%** or **100%** (recognised serious illness).
In the absence of the necessary supporting documents, reimbursement is fixed at **80%** or **100%** of the first-class rail fare or the ceiling of €0.22/km, where appropriate.

Only reimbursement of the form of transport most appropriate to the beneficiary's condition to the closest medical establishment or practitioner able properly to treat his or her condition will be considered.

16.3. THE FOLLOWING ARE NOT REIMBURSABLE

Transport costs:

- for family or linguistic reasons or for personal convenience
- for consultation of a general practitioner
- for a thermal or convalescent cure
- to go to one's place of work or for any other reason not recognised by the Settlements Office
- for repatriation in the event of illness or accident
- for mountain search and rescue, air-sea rescue, etc.
- for 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 which case the costs will be reimbursed with the approval of the Medical Officer.

N.B.:
The cost of transport in a duly substantiated emergency (an accident, for example) can be reimbursed without prior authorisation. However, the Medical Officer may be called upon to give an opinion if necessary.

The fact that you are free to choose your medical practitioner or hospital does not necessarily mean that travel expenses will be reimbursed.

17. FUNERAL EXPENSES

A flat-rate allowance towards funeral expenses is paid:

- **to the member**: in the case of the death of a person covered by the member's insurance or a stillbirth (after 22 weeks or more of gestation),
- **to the spouse, recognised partner, children or, in the absence of these, to any other person who can show that they have paid the funeral costs**: in the case of the death of the member.

17.1. HOW TO CLAIM

If you are the member (in the case of the death of a person covered by your insurance or a stillbirth): send a copy of the death certificate to your Settlements Office.
If you are a person entitled under the member's insurance: send a copy of the death certificate to the member's Settlements Office.
If you are a third party: send proof of payment of funeral expenses to the member's Settlements Office.

17.2. RATES AND AMOUNTS

The amount of the allowance towards funeral expenses is €2 350.

18. HOLIDAYS

You are advised to:

- print out a certificate of cover under our medical insurance scheme for yourself and your family (via JSIS Online): https://webgate.ec.testa.eu/RCAM
- print out a request for direct billing http://myintracomm.ec.testa.eu/hr_admin/en/sickness_insurance/Pages/form.aspx#1d
- and an accident report form http://myintracomm.ec.testa.eu/hr_admin/en/sickness_insurance/Pages/form.aspx#4a

N.B.:
Some hospitals will not accept direct billing and demand immediate payment. We therefore recommend that you take out additional insurance with a private insurance company. This will also cover costs which are not reimbursed by our health insurance, such as transport and repatriation costs or amounts in excess of the reimbursement ceiling which would otherwise need to be borne by you (this is common in countries where healthcare is expensive).

FOR MORE INFORMATION

IF YOU HAVE ACCESS TO MYINTRACOMM ...

https://myintracomm.ec.europa.eu/hr_admin/en/sickness_insurance/Pages/index.aspx (for the Commission)
http://myintracomm.ec.testa.eu/hr_admin/en/sickness_insurance/Pages/index.aspx
(for other institutions and agencies)
https://myintracomm-ext.ec.europa.eu/retired
(for pensioners)

JSIS Online

Your ECAS password gives you easy access to JSIS Online. You can follow the progress of your JSIS file and, at this point, submit claims for reimbursement and requests for medical authorisation (dental estimates, serious illness, prior authorisation, etc.). Track your files via JSIS Online following an email notification or by going online occasionally to:

https://webgate.ec.europa.eu/RCAM/

The most recent versions of the paper forms are available here:
https://myintracomm.ec.europa.eu/hr_admin/en/sickness_insurance/Pages/form.aspx
(for the Commission)
http://myintracomm.ec.testa.eu/hr_admin/en/sickness_insurance/Pages/form.aspx
(for other institutions and agencies)
https://myintracomm-ext.ec.europa.eu/retired
(for pensioners)

- application form for prior authorisation
- claim for reimbursement of medical expenses
- application for recognition of a serious illness
- request for direct billing
- request for direct billing for convalescent/nursing home
- request for an advance on high medical costs
- bill for dental treatment
- dental treatment estimate for prior authorisation
- orthodontic treatment estimate for prior authorisation.

The simplest way to **contact the PMO**, find an answer to your questions or make a request is to go to:

https://ec.europa.eu/pmo/contact/

OR PHONE:

PMO Contact
☏ +(32)2-29.97777

Annexes

- example of a chiropodist's receipt
- example of a podiatrist's receipt
- example of an osteopath's receipt
- example of a psychologist's receipt

- example of an invoice from Italy