

European Central Bank

Staff Rules

Annex III

European Central Bank health insurance rules

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Section I – General provisions**Article 1: Definitions**

For the purposes of this Annex the following definitions apply:

- 1.1 “administrator” means an external service provider selected in accordance with the procedures laid down by the European Central Bank’s (ECB’s) procurement framework and entrusted with the administration of the ECB health insurance[, including the settlement of claims for reimbursement], in accordance with these Rules;
- 1.2 “basic reimbursement” means the amounts reimbursed as set out in Appendix I (Schedule of benefits).
- 1.3 “calendar year” means the period between 1 January and 31 December;
- 1.4 “contribution basis” means the amounts referred to in Article 12;
- 1.5 “costs of the ECB health insurance” means the costs of the ECB health insurance pursuant to Article 11.1;
- 1.6 “cover”, when used without any further qualification, includes both primary cover and top-up cover ;
- 1.7 “primary cover” means an entitlement to reimbursement of eligible expenditure from the ECB health insurance where the insured person is not entitled to claim under, or benefit from, another health insurance or social security scheme;
- 1.8 “top-up cover” means an entitlement to reimbursement of eligible expenditure from the ECB health insurance where the insured person is entitled to claim under, or benefit from, another health insurance or social security scheme;
- 1.9 “deductible” means that part of an insurance claim that must be paid by insured persons when filing a claim with another health insurance or social security scheme and which is not subject to reimbursement from such other health insurance or social security scheme;
- 1.10 “dental practitioner” means a dentist or dental surgeon registered with the appropriate governing body of the dental profession in the country where the dental service is provided;
- 1.11 “dependent child” has the same meaning as provided in Article 16 of the Conditions of Employment and Article 3.6.1 of the Staff Rules;
- 1.12 “ECB’s medical adviser” means a medically qualified person or a dental practitioner with whom the ECB signed a service contract to receive medical advisory services;
- 1.13 “eligible expenditure” means the portion of expenditure incurred that is eligible for basic reimbursement;
- 1.14 “excessive expenditure” means the portion of expenditure incurred that significantly exceeds the amounts normally charged for a treatment in the country where the treatment was provided;
- 1.15 “expenditure incurred” means the expenditure incurred or to be incurred in respect of medical or dental treatment as confirmed by the corresponding invoice or receipt issued either by or on behalf of the respective medically qualified person, or by the respective pharmacy;

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- 1.16 “full contribution” means the total contribution payable in respect of an insured person pursuant to these rules, which shall be established by multiplying the contribution basis by the uniform premium rate;
- 1.17 “income” means the “gross annual income” as defined in Article 3.5.1 of the Staff Rules;
- 1.18 “insured person” means an insured member or an insured dependant as specified in Articles 2 to 4 who is covered by the ECB health insurance;
- 1.19 “insured dependant” means a spouse, recognised partner, former spouse or recognised partner, or child who is insured in accordance with Articles 3 or 4 of this Annex;
- 1.20 “insured member” means a person who is insured in accordance with Article 2 of this Annex;
- 1.21 “risk carrier” means an external service provider, selected in accordance with the procedures laid down by the ECB’s procurement framework, with whom the ECB has signed an agreement limiting the ECB’s financial risks in respect of the ECB health insurance;
- 1.22 “leading specialist” means a medically qualified person who is considered by the administrator to have an outstanding reputation in a particular medical field. The outstanding nature of the medically qualified person’s reputation could be based, for example, on the development or application of a new surgical method, therapy, protocol or treatment or state-of-the-art prostheses and orthopaedic appliances, heading a research team or holding a university chair;
- 1.23 “medical or dental officer” means a medically qualified person or dental practitioner designated by the administrator or the risk carrier to provide it with expert advice on medical or dental questions, the identity of whom shall be made available to all insured persons;
- 1.24 “medical prescription” means a document containing the name and official details of the medically qualified person issuing the prescription, the name of the patient, the medical treatment (type and number of sessions) or the name of the medication(s) being prescribed. It must be dated and signed by a medically qualified person. The prescription must pre-date the start of the treatment;
- 1.25 “medically qualified person” means a person who graduated from a medical or dental school listed in the World Health Organisation’s Directory of Medical Schools and who is licensed to practise medicine or dentistry in the country where the treatment is received.
- A medically qualified person shall also include:
- (a) for the purpose of providing physiotherapy services, persons possessing a qualification in physiotherapy and a licence to practise as a physiotherapist in the country where the physiotherapy services are provided;
 - (b) for the purpose of providing nursing care, persons possessing a qualification in nursing care and a licence to practise as a nurse in the country where the nursing care is provided;
 - (c) a ‘Heilpraktiker’ or equivalent possessing a licence to practise as such in the country where the treatment is provided;
- 1.26 “non-eligible expenditure” means the portion of expenditure incurred that is not eligible expenditure;

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- 1.27 “out of pocket expenditure” means the part of eligible expenditure incurred that is not reimbursed under the rules for basic reimbursement. Non-eligible expenditure does not constitute out of pocket expenditure;
- 1.28 “relevant calendar year” means the calendar year preceding the year for which the eligibility or contribution is assessed, or for which reporting is required;
- 1.29 “serious illness” means:
- (a) a medical condition included in Appendix II (list of serious illnesses); or
 - (b) a medical condition that is comparable in seriousness to those included in Appendix II, and which fulfils at least two of the following criteria:
 - (i) unfavourable vital forecast;
 - (ii) chronic evolution;
 - (iii) need for onerous diagnostic and/or therapeutic measures;
 - (iv) presence of risk of serious handicap.

When deciding whether a medical condition is of a comparably serious nature under this point, the following aspects shall be taken into account:

- the age of the person suffering from the medical condition;
 - the need for the person suffering from the medical condition to receive treatment; and
 - the severity and intensity of the medical condition, bearing in mind that the same condition may manifest itself differently, ranging from mild to severe forms;
- 1.30 “spouse or recognised partner” means the spouse or recognised partner (as defined in Article 3.4 of the Staff Rules) of an insured member;
- 1.31 “former spouse or recognised partner” means the former spouse or former recognised partner of an insured member in respect of whom the latter is under a legal obligation to provide health insurance by virtue of the terms of a divorce or of a separation agreement. Such legal obligation must have arisen during the employment of the insured member with the ECB;
- 1.32 “ECB health insurance” means the insurance cover provided as set out in this Annex;
- 1.33 “treatment” means treatment of a medical or dental nature, including any kind of medical or dental consultation or intervention, which satisfies the following cumulative conditions:
- (a) it must be founded on evidence-based medicine and must be designed to cure or alleviate symptoms of the underlying medical condition. Alternatively, it may include treatments and medical products that have proven to be equally effective in practice or that are used because conventional medical methods or medication are not available;
 - (b) it must be necessary and not excessive;
 - (c) it must be provided by a medically qualified person;
- 1.34 “uniform premium rate” means the percentage established by the Director General Human Resources pursuant to Article 11.2.

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Section II – Insured persons**Article 2: Insured members**

- 2.1 Members of staff with an ECB employment contract for a definite or an indefinite period are insured on a compulsory basis from the date of appointment in respect of treatment obtained on or after that date, unless they have opted out of the health insurance in accordance with Article 33 of the ECB Conditions of Employment or Article 5 of this Annex.
- 2.2 Members of staff who may no longer continue to opt out pursuant to Article 33 of the ECB Conditions of Employment or Article 5 of this Annex are compulsorily insured from the date following the cessation of the opt-out in respect of treatment obtained on or after that date.
- 2.3 Cover for insured members ceases on the date on which their employment with the ECB ends. Notwithstanding this, the following persons may elect to extend health insurance cover on a voluntary basis and are considered insured members if they decide to do so:
- (a) former members of staff whose employment contract with the ECB ended, and who are entitled to insurance cover pursuant to Articles 36 or 36a of the ECB Conditions of Employment;
 - (b) when point (a) does not apply, former members of staff who decide to continue to be insured for a maximum period of six months, starting on the day following the date on which their employment with the ECB ends;
 - (c) former members of staff whose employment contract with the ECB ended, and who are entitled to insurance cover pursuant to Article 37a of the ECB Conditions of Employment;
 - (d) the spouse, recognised partner or dependent child of an insured member referred to in Article 2.1 or points (a) or (c) who, following the death of the insured member, are entitled to receive a spouse's pension or a children's pension in accordance with the pension arrangements referred to in Article 38 of the ECB Conditions of Employment, provided they are not themselves already insured as an insured member in accordance with Article 2.1.
- 2.4 Insured members benefit from primary cover under the ECB health insurance subject to the payment of regular contributions, calculated pursuant to Articles 12 and 13.

Article 3: Conditions of insurance cover for spouses or recognised partners and former spouses or recognised partners**3.1 *Primary cover for spouses or recognised partners***

- 3.1.1 Upon application by an insured member, spouses or recognised partners are eligible for primary cover under the ECB health insurance, provided that:
- (a) they are not insured in any other social security scheme or private health insurance; and
 - (b) they are not themselves insured members.
- 3.1.2 Notwithstanding the provisions of Article 3.1.1, where a spouse or recognised partner receives a pension or other retirement benefits from another social security system, they are eligible to continue with primary cover under the ECB health insurance only if they were benefiting from

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primary cover under the ECB health insurance for at least five years prior to the date of their retirement.

3.2 Without prejudice to Article 3.1.1 or Article 3.1.2 the following conditions apply with regard to the income of, and contributions in respect of, spouses or recognised partners.

- (a) Spouses or recognised partners whose income does not exceed the income threshold referred to in Article 3.6.1(c)(iii) of the Staff Rules in the relevant calendar year shall be insured without payment of an additional monthly contribution.
- (b) Where the income of spouses or recognised partners exceeds the income threshold referred to in Article 3.6.1(c)(iii) of the Staff Rules but does not exceed the income threshold referred to in Article 15 of the Conditions of Employment during the relevant calendar year, such spouses or recognised partners shall be covered if:
 - (i) the actual cost of alternative health insurance that is generally comparable to the ECB health insurance would exceed 25% of the income of such spouses or recognised partners in the relevant calendar year; and
 - (ii) the insured member pays an additional monthly contribution calculated pursuant to Articles 12 and 13.
- (c) Where the income of spouses or recognised partners exceeds the income threshold referred to in Article 15 of the Conditions of Employment in the relevant calendar year, such spouses or recognised partners shall not be eligible for primary cover as from 1 April of the year in which eligibility is assessed and the provisions of Article 3.5(b) shall apply.
- (d) In cases where a spouse or recognised partner's income exceeds the income threshold referred to in Article 15 of the Conditions of Employment in the relevant calendar year, and the insured member provides evidence that they ceased to receive any income and have no access to alternative health insurance at a cost not exceeding the additional monthly contribution referred to in Article 3.4, entitlement to insurance cover under this Article is assessed by reference to the new situation of the spouse or recognised partner concerned.

3.3 *Top-up cover for spouses or recognised partners*

- (a) Spouses or recognised partners who are not eligible for primary cover are entitled to top-up cover, provided that:

they are primarily insured with, or covered by, another health insurance or social security scheme which provides for either:

 - (i) reimbursement of reasonable and customary medical expenditure, providing for a general reimbursement rate for in-patient treatments of at least 80%; or
 - (ii) access to reasonable and customary medical treatment (benefits in kind) which covers, as a minimum, treatment received in the country of residence of the spouse or recognised partner.

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- (b) If their income exceeds the income threshold referred to in Article 15 of the Conditions of Employment in the relevant calendar year, they are insured subject to the payment of an additional monthly contribution, calculated pursuant to Articles 12 and 13.

3.4 Cover for former spouses or recognised partners

- (a) Former spouses or recognised partners are eligible for primary cover if the insured member pays an additional monthly contribution, calculated pursuant to Articles 12 and 13.
- (b) Former spouses or recognised partners are not eligible for top-up cover.

3.5 Reporting obligations in respect of spouses or recognised partners

- (a) For spouses or recognised partners to continue to benefit from cover under the ECB health insurance, insured members must, by 31 March of each year at the latest, provide to the ECB proof of income received by such spouse or recognised partner in the relevant calendar year. Failure to provide the necessary information by this date results in the cessation of insurance cover with effect from 1 April of the current year. Where the necessary evidence is provided at a later date, cover is resumed with effect from the first day of the month following the date on which the insured member provides the necessary evidence.
- (b) If the insured member submits to the ECB proof of income received by a spouse or recognised partner with respect to the relevant calendar year, which requires adjustment at a later point, the insured member shall submit the updated information to the ECB as soon as it becomes available to them. In such cases:
 - (i) the additional monthly contribution due for the relevant period of insurance coverage is adjusted accordingly;
 - (ii) the insurance cover initially granted is not revoked retroactively when the threshold referred to in Article 3.2(c) is exceeded.

- 3.6 The insurance cover of insured spouses or recognised partners or insured former spouses or recognised partners is conditional on the insurance cover of the insured member for any given time period. However, the insurance cover of insured spouses or recognised partners or of insured former spouses or recognised partners is not affected by the suspension of the cover of the insured member concerned during the insured member's periods of military or alternative service.

Article 4: Conditions of insurance cover for children**4.1 Dependent children**

Upon application by an insured member, dependent children benefit from primary cover under the ECB health insurance, provided that they do not benefit from another primary insurance, in which case they only benefit from the ECB's top-up cover.

Coverage under this Article is provided without the payment of any additional contributions by the insured member.

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4.2 Limited extension of primary cover for non-dependent children

Insured members may request to extend the ECB's primary cover with regard to their children beyond the date on which such children cease to qualify as dependent children. Such extension is possible for a period or several periods of up to one year per request, as long as the following conditions are met:

- (a) their children have not yet reached the age of 30;
- (b) their children are not eligible for cover under a national health insurance scheme at their place of residence;
- (c) their children's income in the year for which eligibility is assessed does not exceed the threshold referred to in Article 3.6.1 of the ECB Staff Rules; and
- (d) the insured member pays an additional monthly contribution in respect of such child, calculated pursuant to in Articles 12 and 13.

4.3 Non-compliance with reporting obligations

Insured members are obliged to immediately report any changes in the situation of their insured children that may result in changes in entitlements under the ECB's health insurance. Without prejudice to any payment due under Article 4.2(d), where changes in the situation of an insured child are not reported in a timely manner, and the insured child continues to benefit from cover even though they no longer fulfil the relevant conditions, the insured member must pay a penalty, equivalent to 50% of the additional monthly contribution provided for in Article 4.2(d) for the period during which the child unduly benefited from coverage.

4.4 The insurance cover of insured children is conditional on the insurance cover of the insured member for any given time period. However, the insurance cover of insured children is not affected by the suspension of cover of the insured member concerned during periods of military or alternative service.

Article 5: Opting out

5.1 Members of staff on a fixed-term, short-term or a permanent contract working part-time may be authorised to opt out of the ECB health insurance on production of evidence that their medical expenditure is covered by another insurance or social security scheme. In such cases, such members of staff are still covered against medical and dental expenditure incurred because of accidents at work and occupational diseases. The member of staff must request authorisation within one month of taking up appointment or part time work. The decision to opt out is irrevocable, unless the members of staff concerned prove that they are no longer covered by an insurance plan or social security system for reasons that are beyond their control.

5.2 Members of staff on parental leave may opt out of the health insurance during periods of such leave.

Article 6: Cover during periods of unpaid leave

6.1 Days of unpaid leave to take care of sick children or relatives

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- (a) Unpaid leave taken pursuant to Article 5.10.2 (care for a sick child) or Article 5.10.3 (care for a sick relative) of the Staff Rules does not interrupt coverage under the ECB health insurance.
- (b) Unpaid leave taken pursuant to Article 5.9.2 (care for a sick child) or Article 5.9.3 (care for a sick relative) of the ECB Rules for Short Term Employment does not interrupt coverage under the ECB health insurance.

6.2 Cover during periods of unpaid leave under Article 5.12 of the ECB Staff Rules

- (a) No later than two weeks prior to the commencement of unpaid leave taken pursuant to Article 5.12 of the Staff Rules, insured members may apply to remain covered under the ECB health insurance for the entire duration of their unpaid leave. Notwithstanding this, such cover is not available with respect to insured members when their unpaid leave is granted for compulsory military or alternative service, or if their risk profile will significantly increase as a consequence of the activities to be performed during the period of unpaid leave.
- (b) Notwithstanding the provisions of Article 3.1, insured members who, during periods of unpaid leave taken pursuant to Article 5.12 of the Staff Rules, have no income of their own and whose spouse or recognised partner is an insured member, remain eligible for primary insurance coverage during such leave as if they were insured dependants.

6.3 Cover during periods of parental leave under Article 5.11 of the Staff Rules

Notwithstanding the provisions of Article 3.1, insured members who take parental leave pursuant to Article 5.11 of the Staff Rules and whose spouse or recognised partner is an insured member, remain eligible for primary insurance coverage during such leave as if they were insured dependants.

6.4 Cover during periods of unpaid leave under a scheme supporting transition to a career outside the ECB

Insured members who apply for unpaid leave under a scheme supporting transition to a career outside the ECB may apply to remain covered under the ECB health insurance in accordance with the rules of such a scheme.

Article 7: Individual subsequent health insurance

- 7.1 Upon ceasing to be covered by the ECB health insurance those who were insured members prior to such cessation have the right to receive an insurance proposal for individual subsequent health insurance from the risk carrier or an affiliated company, provided that they submit such a request to the risk carrier before the cessation of their ECB health insurance cover. Insured members may request an insurance proposal for themselves as well as their insured dependants. The ECB shall provide the insured members with the necessary contact information of the risk carrier.
- 7.2 Such individual subsequent health insurance is independent from the ECB health insurance and cannot give rise to any liability on the part of the ECB. The insured member making a request pursuant to this Article is solely and fully responsible for the costs associated with such a request and with any such subsequent health insurance.

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7.3 The risk carrier may decide to impose a waiting period for the individual subsequent health insurance or require a prior medical examination for access to such health insurance.

Article 8: Waiting periods and prior medical examination

8.1 Appendix I (Schedule of benefits) provides for waiting periods for the ECB health insurance in certain circumstances. In the event of cessation of insurance cover for one year or less, such waiting period shall be suspended. In the event of cessation of insurance cover for more than one year, a new waiting period shall commence.

8.2 There is no requirement for a prior medical examination for access to the ECB health insurance.

Article 9: Coordination of benefits

9.1 Insured persons under the ECB's primary cover may take out additional private health insurance, in which case they may claim first under the ECB health insurance and subsequently claim under their private health insurance any additional amounts not reimbursed under the ECB primary cover. The combined amount of reimbursements from the ECB health insurance and the other health insurance shall not exceed the actual costs incurred.

9.2 Persons insured under the ECB's top-up cover shall first claim reimbursement of expenses or benefits under their other health insurance or social security scheme. This is not obligatory in cases where treatment is obtained outside the country of residence of the insured dependant. The combined amount of reimbursements from the ECB health insurance and the other health insurance shall not exceed the actual costs incurred.

9.3 The following is not eligible for reimbursement under the ECB's top-up cover for spouses and recognised partners:

- (a) dental expenditure, where such coverage was specifically excluded under their other health insurance;
- (b) medical expenditure for out-patient treatments, where such coverage was specifically excluded under their other health insurance;
- (c) the amount of deductible agreed with their other health insurance, to the extent it exceeds EUR 500 per calendar year.

The treatments mentioned in points (a) and (b) are eligible for reimbursement where such exclusions are provided for by national legislation on statutory health insurance schemes or social security.

Article 10: Membership administration

10.1 The ECB shall report in writing to the administrator relevant data relating to insured persons and any changes relating thereto at a minimum once a month. This reporting may include the following data relating to insured persons:

- (a) a unique identifier per insured person;
- (b) their name;
- (c) their gender;

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- (d) their date of birth;
- (e) start and end dates of coverage;
- (f) start and end dates of any suspension from coverage;
- (g) the nature of the employment relationship of the respective insured member;
- (h) the relationship of the insured person to the respective insured member;
- (i) the place of employment of the respective insured member;
- (j) the date of death.

10.2 The ECB retains the right to correct such reported data, including any retroactive changes in data regarding insured persons.

Section III – Contributions**Article 11: Costs of the ECB health insurance**

11.1 Insofar as costs of the ECB health insurance are concerned, Article 33 of the Conditions of Employment is implemented as follows:

The costs of the ECB health insurance comprise the total amount required to fund:

- (a) the reimbursement of eligible expenditure;
- (b) the fees of the administrator; and
- (c) the fees of the risk carrier.

11.2 On the basis of the costs of the ECB health insurance, the Director General Human Resources establishes a uniform premium rate, which is used for the purpose of calculating:

- (a) the regular monthly contribution referred to in Article 2.4;
- (b) the additional monthly contributions referred to in Article 3.2(b)(ii), Article 3.3(b), Article 4.2(d) and Article 3.4(a).

The uniform premium rate is adjusted regularly as required.

Article 12: The contribution basis

12.1 When a contribution is payable pursuant to these rules, the contribution basis is the full time basic salary of the insured person concerned or, where relevant, the basic salary they would have received for normal full time work, except in the following cases:

- (a) during periods of unemployment and cooling off under Articles 36 and 36a of the Conditions of Employment, the contribution basis is the monthly unemployment allowance or the special monthly allowance;
- (b) for former members of staff entitled to benefits under Article 37a of the Conditions of Employment, the contribution basis is an amount corresponding to 60% of the revalued earnings;

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- (c) for persons in receipt of a spouse's pension under Article 38 of the Conditions of Employment, the contribution basis is an amount corresponding to 36% of the revalued earnings of the former member of staff concerned;
- (d) for persons in receipt of a children's pension under Article 38 of the Conditions of Employment, the contribution basis is an amount corresponding to 24% of the revalued earnings of the former member of staff concerned;
- (e) for members of staff participating in a scheme supporting transition to a career outside the ECB, the contribution basis is defined as provided in the rules of such a scheme.
- (f) for non-dependent children referred to in Article 4.2, the contribution basis is 50% of the full-time basic salary of band A step 1;
- (g) for spouses or recognised partners referred to in Article 3.2(b)(ii) and Article 3.3(b), the contribution basis of the additional monthly contribution referred to in those Articles is their own income in the relevant calendar year, as defined in Article 1;
- (h) for former spouses or recognised partners under Article 3.4, the contribution basis of the additional monthly contribution referred to in this Article is 140% of the full-time basic salary of band A step 1.

12.2 The revalued earnings referred to in points (b) to (d) of Article 12.1 are calculated in accordance with Article 1 of Annex IIIa to the Conditions of Employment. In the case of former members of staff with no entitlement to a pension under Annex IIIa to the Conditions of Employment, but who are entitled to a pension under Annex III to the Conditions of Employment, the revalued earnings are calculated in accordance with Article 1.1 of Annex III to the Conditions of Employment. Revalued earnings are adjusted every year in line with pension adjustments resulting from the application of the provisions governing pension adjustments.

Article 13: Cost sharing of contributions

13.1 In accordance with Article 33(b)(iii) of the Conditions of Employment, insured persons pay one third of the full contribution, except in the cases listed below.

- (a) During periods of unpaid leave under Article 30 of the Conditions of Employment and Article 5.12 of the Staff Rules, insured members pay the full contribution.
- (b) During periods of unemployment and cooling off under Articles 36 and 36a of the Conditions of Employment, former members of staff pay half of the full contribution.
- (c) Members of staff participating in a scheme supporting transition to a career outside the ECB pay their contributions as provided in the rules of such a scheme.
- (d) During a period of up to six months, as provided for in Article 2.3(b), former members of staff opting for such an extension of coverage pay the full contribution.
- (e) Children in receipt of a children's pension are not required to pay contributions if they have a surviving parent that is already paying contributions.

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- (f) For non-dependent children referred to in Article 4.2, insured members pay the full contribution.
- (g) For spouses or recognised partners under Article 3.2(b)(ii), insured members pay an additional contribution equal to 150% of the full contribution.
- (h) For spouses or recognised partners under Article 3.3(b), insured members pay an additional contribution equal to half of the full contribution.
- (i) For former spouses or recognised partners under Article 3.4, insured members pay the full contribution.

13.2 When the amounts referred to in this Article must be paid by a person in receipt of an ECB salary or pension, they are deducted directly from such a salary or pension.

Section IV – Schedule of benefits**Article 14: Scope of cover**

- 14.1 Eligible expenditure incurred is reimbursed in line with Appendix I (Schedule of benefits).
- 14.2 Expenditure is reimbursed in euro, irrespective of the currency in which the expenditure is incurred. Any conversion is carried out on the basis of the euro foreign exchange reference rates published by the ECB on its own website, with reference to the date on which the relevant invoice was issued.

Section V – Reimbursement principles and rules**Article 15: Freedom of choice and conditions of access**

- 15.1 Insured persons who are insured under the ECB's primary cover have freedom as to the choice of the medically qualified person, pharmacist or hospital. Insured persons shall not be obliged to consult a general practitioner before seeking the advice of, or treatment from, a specialist.
- 15.2 Insured persons who are insured under the ECB's top-up cover only have access to the ECB health insurance after having exhausted the possibilities of claiming under or benefiting from their primary insurance or social security scheme as specified hereunder.
 - (a) If their primary insurance or social security scheme grants them benefits in kind or restricts access to certain medical service providers, the possibilities offered are considered exhausted if the insured person would not be eligible to receive treatment with the allowed service providers:
 - (i) within one month for non-urgent medical issues;
 - (ii) within 24 hours for urgent medical issues.
 - (b) Without prejudice to Article 9.3, if their primary insurance or social security scheme excludes certain treatment, insured persons have immediate access, including freedom of choice, in respect of such treatment.

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The administrator shall take a decision, on the basis of the documentation and information provided, on whether insured persons have exhausted the possibilities of claiming under or benefiting from their primary insurance or social security scheme.

- 15.3 The principle of freedom of choice, and the possibility of immediate access in accordance with point (b) of Article 15.2, does not automatically imply:
- (a) a right to reimbursement of expenditure under this insurance;
 - (b) reimbursement of any resulting travel costs, including repatriation.
- 15.4 Without prejudice to the principle of freedom of choice, the administrator shall make available a list of medically qualified persons and other providers of medical services, such as hospitals, pharmacies, and opticians, with whom price and/or settlement arrangements have been negotiated by the administrator. Medical service providers, with whom the administrator has agreed on discounts, are indicated separately in this list together with the nature of the discount. These arrangements and the communication of this list to the insured persons do not constitute a recommendation or warranty by the ECB, the administrator or risk carrier, of the medically qualified persons or other providers of medical services or of the medical services provided.
- 15.5 Subject to the provisions in Article 18, the ECB health insurance has worldwide coverage.

Article 16: Prior authorisation

- 16.1 Where Appendix I (Schedule of benefits) provides that prior authorisation is required before the start of a treatment for the reimbursement of the related expenditure, the insured person shall send any request for prior authorisation in writing directly to the medical or dental officer of the administrator.
- 16.2 Before deciding on a request for prior authorisation, the administrator may, where appropriate, contact the prescribing medically qualified person or dental practitioner and/or the insured person, to obtain further details concerning the request.
- 16.3 If the medical or dental officer of the administrator is of the opinion that the request for prior authorisation should be accepted, the administrator shall take a decision authorising such prior authorisation on the basis of this opinion. The administrator shall notify the insured person of such a decision without delay.
- 16.4 If the medical or dental officer of the administrator is of the opinion that the request for prior authorisation should be rejected, they shall submit their considerations including their medical reasoning to the ECB's medical adviser. The ECB's medical adviser shall review the medical documentation submitted, examine the insured person if necessary, and form an opinion. On the basis of this opinion the administrator shall take a decision granting or rejecting prior authorisation. The administrator shall inform the insured person about any such decision without delay.
- 16.5 Prior authorisation is not required for urgent medical treatment.

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Article 17: Reimbursement – general provisions

17.1 There is no exclusion from coverage for pre-existing medical conditions of insured persons.

17.2 Any claim for reimbursement shall be limited to expenditure incurred.

17.3 *Reimbursement of non-conventional treatments*

Where an insured person incurs expenses for non-conventional medical methods or medication, the administrator may limit reimbursement to the costs that would have been incurred if available conventional medical methods or medication had been used.

17.4 *Pro-rated reimbursement limits*

(a) In the case of commencement or cessation of insurance cover over the course of a calendar year, the limits specified in Appendix I (Schedule of benefits) concerning the number of treatments for the respective calendar year are pro-rated in accordance with the following formula:

$$A = \frac{B * C}{12}$$

(i) A = maximum number of treatments to which the insured person is entitled after prorating, which is rounded up to the nearest full number;

(ii) B = maximum number of treatments to which any insured person is entitled per calendar year;

(iii) C = number of months of insurance coverage in the respective calendar year.

(b) The limit for the reimbursement of dental expenditure is pro-rated as provided for in Appendix I (Schedule of benefits).

(c) In no case may the administrator, in the application of the pro-rating, be entitled to reclaim money already paid to the insured member.

17.5 *Internet purchases*

Without prejudice to any other conditions under the ECB health insurance, including the obligation to obtain a medical prescription from a medically qualified person, internet purchases for medical products may only be accepted for reimbursement if the online provider has a registered and official/regular point of sale that is authorised to sell those products in the country of registration. Purchases via auction websites are excluded from reimbursement.

17.6 *Proof of payment*

Within six months from the date of the settlement, the administrator may request proof of payment from the insured person, where they presented only an invoice or request for payment for the purposes of reimbursement. Within one month of such a request, the insured person shall provide the administrator with a bank transfer statement, credit card receipt, cashier's receipt or any other valid proof of payment. Failure to provide the requested proof of payment within the given

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timeframe shall result in the corresponding reimbursement being considered an undue payment, which is recoverable pursuant to Article 24. The reimbursement shall not be considered an undue payment if the insured person is prevented from presenting any valid proof of payment due to force majeure.

17.7. Validity of medical prescription

Where Appendix I (Schedule of benefits) requires a medical prescription as a condition for reimbursement, such a prescription must not be dated earlier than six months before the date of the first treatment or the purchase of the medicine, as the case may be, and must not be issued prior to the start of insurance cover.

Article 18: Eligible expenditure**18.1 Expenditure incurred in Germany**

18.1.1 Expenditure relating to treatment incurred in Germany is eligible for reimbursement insofar as it is based on the relevant scales of fees for medical and dental practitioners or 'Heilpraktiker' (*Gebührenordnung für Ärzte (GOÄ)*, *Gebührenordnung für Zahnärzte (GOZ)* and *Gebührenordnung für Heilpraktiker (GebüH)*) applicable at the time of treatment (hereinafter the 'relevant scales').

18.1.2 Reimbursement may be claimed up to factor 2.3 of the relevant scales or up to factor 3.5, if a justification for exceeding factor 2.3 is provided. Expenditure exceeding factor 3.5 is eligible for reimbursement only when the services are provided by a leading specialist and prior authorisation has been granted.

18.1.3 If Appendix I (Schedule of benefits) limits the reimbursement of eligible expenditure to a maximum amount, expenditure not covered by the relevant scales is considered eligible expenditure only insofar as it does not exceed 150% of such maximum amounts.

18.2. Expenditure incurred outside Germany but within the European Economic Area (EEA) or within the countries specified in Article 18.2.2.

18.2.1 Expenditure relating to treatment incurred outside Germany but within the EEA or within the countries specified in Article 18.2.2 is eligible for reimbursement insofar as it is based on the national relevant scales applicable at the time of treatment, if any, or if it is otherwise reasonable and customary.

18.2.2 The other countries specified in this paragraph are: Albania, Andorra, Belarus, Bosnia-Herzegovina, Kosovo, North Macedonia, Moldova, Monaco, Montenegro, San Marino, Serbia, Switzerland, Ukraine, United Kingdom and Vatican City.

18.2.3 If Appendix I (Schedule of benefits) limits the reimbursement of eligible expenditure to a maximum amount, expenditure not covered by the relevant scales is considered eligible expenditure only insofar as it does not exceed 150% of such maximum amounts.

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18.3 *Expenditure incurred in the rest of the world*

18.3.1 Expenditure incurred for the treatment of medical or dental emergencies during private travel in the rest of the world is eligible for reimbursement under the same conditions provided in Article 18.2.1 and 18.2.3.

18.3.2 Other expenditure relating to treatment in the rest of the world is limited to the costs that would have been incurred had the expenditure been incurred in Germany pursuant to Article 18.1.

18.4 *Expenditure incurred by insured persons working in ECB representative offices or on external secondment outside the EEA or outside the countries referred to in Article 18.2.2*

The reimbursement limits set out in Appendix I (Schedule of benefits) are multiplied by a factor of 5 and Article 18.3 does not apply to:

- insured members working in an ECB representative office outside the EEA or outside the countries referred to in Article 18.2.2 and their insured dependants, with respect to treatment received in the country where the representative office is located,
- insured members on external secondment pursuant to Annex VI, outside the EEA or outside the countries referred to in Article 18.2.2 and their insured dependants, with respect to treatment received in the country where the host organisation is located.

Article 19: Procedure for the qualification of treatment

19.1 Before deciding whether medical or dental treatment qualifies as “treatment” as defined in Article 1, the administrator may, where necessary, contact the prescribing medically qualified person and/or the insured person.

19.2 If the medical or dental officer of the administrator considers that the medical or dental treatment does not qualify as “treatment” as defined in Article 1, they shall submit their considerations, including their medical reasoning, to the medical or dental officer of the risk carrier. If the latter shares this opinion, they shall submit their considerations, including their medical reasoning to the ECB’s medical adviser. The ECB’s medical adviser shall review the medical documentation submitted and form an opinion. On the basis of this opinion the administrator shall take a decision under this Article. The administrator shall inform the insured person of any such decision without delay.

Article 20: Reimbursement of items not mentioned in the Schedule of benefits

20.1 Expenditure incurred in respect of items not mentioned in Appendix I (Schedule of benefits) may be reimbursed at the rate of 80% after approval by the medical or dental officer of the administrator. This approval may be subject to a maximum amount for reimbursement.

20.2 Before deciding on the reimbursement or maximum limits, the administrator may, where necessary, contact the prescribing medically qualified person and/or the insured person to obtain any information necessary for the assessment.

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20.3 If the medical or dental officer of the administrator considers that the expenditure qualifies for reimbursement and/or should be subject to maximum reimbursement limits, they shall submit their considerations to the medical or dental officer of the risk carrier. The latter shall submit the considerations of the administrator together with their opinion, including an impact assessment on the funds of the ECB health insurance, to the ECB's medical adviser. The ECB's medical adviser shall review the documentation submitted and form an opinion. On the basis of this opinion the administrator shall take a decision under this Article.

20.4 The administrator must inform the insured person of any such decision without delay.

Article 21: Subrogation of rights

21.1 The administrator shall reimburse medical and dental expenditure in accordance with the ECB health insurance even when a third party may be liable for reimbursement of the related expenditure. In such cases:

- (a) when submitting a claim under the ECB health insurance, the insured person is deemed to have automatically assigned their right of recourse against any liable third parties to the administrator so that the insured person's rights are subrogated to the administrator to the extent of the reimbursement made by the administrator;
- (b) the insured member shall disclose to the administrator the relevant information concerning the possible claim against one or more third parties, including, where applicable and known, a description of the incident, a police report and the contact details or insurance details of the third parties;
- (c) the insured member shall cooperate with the administrator to the extent necessary so that the latter may enforce its rights resulting from this subrogation.

21.2 Notwithstanding the provisions of Article 21.1, rights are not subrogated to the administrator in respect of claims for non-material damages, such as moral damages, damages for pain and suffering or moral compensation for disfigurement and loss of amenity, which are not covered by the ECB health insurance.

21.3 Insured persons are not considered as third parties amongst themselves.

Article 22: Claims for serious illness

22.1 The assessment of whether a medical condition is comparably serious as defined in Article 1 is made by the administrator, who shall seek the agreement of the ECB's medical adviser.

22.2 Applications for the recognition that an insured person suffers from a serious illness shall be made by the insured member to the administrator. The application shall include the following information:

- (a) date of the diagnosis;
- (b) exact diagnosis;
- (c) stage of the illness and any occurring complications; and
- (d) treatments required or received.

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If the medical or dental officer of the administrator is of the opinion that the application should be accepted, they shall inform the insured member without delay.

If the medical or dental officer of the administrator is of the opinion that the application should be rejected, they shall submit their considerations, including their medical reasoning, to the ECB's medical adviser. The ECB's medical adviser shall review the medical documentation submitted, examine the insured person if necessary, and form an opinion. On the basis of this opinion the administrator shall take a decision under this Article.

22.3 Medical and dental expenditure relating to a serious illness is reimbursed to the extent it is incurred:

- (a) after the date of the application referred to in Article 22.2, for as long as the serious illness persists; and
- (b) up to 12 months prior to the date of application referred to in Article 22.2.

Article 23: Full reimbursement

23.1 Notwithstanding anything else contained in these rules, during every calendar year insured members benefit from full reimbursement of all eligible expenditure from the moment that their total out-of-pocket expenditure during that calendar year exceeds a threshold of EUR 1 000. Out-of-pocket expenditure of, or relating to, insured dependants is added to that of their insured member for the purposes of this threshold.

23.2 The benefit referred to in Article 23.1 is granted by the administrator without any specific request from the insured members. The administrator shall keep insured members informed about the balance in respect of this threshold.

23.3 The following expenditure is not considered out-of-pocket expenditure and does not benefit from full reimbursement:

- (a) the part that is not covered under basic reimbursement for accommodation in hospitals;
- (b) the part that is not covered under basic reimbursement for treatments listed in Articles 15 to 18 of Appendix I (Schedule of benefits), which covers physiotherapy, kinesiotherapy and similar treatments, psychological care, speech therapy and graphomotor and psychomotor therapy, insofar as they exceed the number of reimbursable sessions or frequency, unless an exception was granted as described in the respective chapters;
- (c) the part that is not covered under basic reimbursement for treatments listed in Article 13 of Appendix I (Schedule of Benefits) (in vitro fertilisation);
- (d) the part that is not covered under basic reimbursement for laser eye surgery;
- (e) the part that is not covered under basic reimbursement for frames;
- (f) expenses incurred for treatments listed in Article 19 of Appendix I (Schedule of benefits), which covers alternative therapeutic treatments and medicine, which exceed the corresponding maximum eligible amount for reimbursement;

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- (g) the part that is not covered under basic reimbursement for dental treatment because it exceeds the limits mentioned in Article 9 of Appendix I (Schedule of benefits).

Section VI – Undue or irregular reimbursement**Article 24: Recovery of undue reimbursement**

- 24.1 Acting on behalf of the ECB, the administrator shall endeavour to recover from any person, any sums that have been
- (a) overpaid;
 - (b) unduly paid; or
 - (c) paid as a result of fraud, misrepresentation or omission of facts.
- 24.2 The recovery by the administrator of sums overpaid or unduly paid must be initiated no later than five years from the date on which the sum was unduly paid. The recovery of sums paid as a result of fraud, misrepresentation or omission of facts must be initiated no later than ten years from the date on which the sum was paid.
- 24.3 Where the administrator fails to recover the sums referred to in Article 24.1 within six months from the first recovery attempt, the ECB shall recover these sums in accordance with Article 21a of the Conditions of Employment.

Article 25: Irregular or otherwise unwarranted requests for reimbursement

The administrator may reject requests for reimbursement if it has knowledge or a well-founded suspicion that the reimbursement would be irregular or otherwise unwarranted. The administrator shall inform the insured person of such decision without delay.

Article 26: Irregularities and breach of professional obligations

- 26.1 The Executive Board shall appoint a person (hereinafter the “coordinator”) who shall receive the information referred to in this Article from the administrator or risk carrier. The coordinator is subject to the obligation of professional secrecy pursuant to Article 10(3) of Regulation (EC) No 45/2001 of the European Parliament and of the Council¹, or the equivalent provision in the data protection legal framework applicable to Union institutions at the relevant time.
- 26.2 The administrator and the risk carrier shall, without delay, provide to the coordinator any evidence they may become aware of which may give rise to a suspicion of any irregularities or breaches of professional obligations in relation to the ECB health insurance, subject to the following constraints:
- (a) the administrator and the risk carrier shall only provide the evidence that is directly relevant to the suspicions referred to in Article 26.2;
 - (b) evidence must not contain data concerning health unless the administrator or risk carrier considers that the data concerning health constitutes evidence of the suspicions referred to

¹ Regulation (EC) No 45/2001 of the European Parliament and of the Council of 18 December 2000 on the protection of individuals with regard to the processing of personal data by the Community institutions and bodies and on the free movement of such data (OJ L 8, 12.1.2001, p. 1).

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in Article 26.2. In such a case, they shall provide such evidence in a manner that does not allow the insured person to be identified.

This Article also applies to requests submitted to the administrator by the ECB following a request by public authorities in charge of investigating criminal offences.

- 26.3 (a) The coordinator shall assess the information, prepare a written report on the merits of the case and send it to any of the persons referred to in Article 3 of Decision (EU) 2016/456 of the European Central Bank (ECB/2016/3)² for a decision on how to follow up.
- (b) Should any of the persons referred to in point (a) require further information or evidence, the coordinator shall request such information, including the disclosure of the identity of the insured person, from the administrator or risk carrier, as applicable, and submit it to the persons investigating the case.
- 26.4 Any transfer of information pursuant to this Article must take place via the secure means defined in the contract between the administrator and the ECB.

Section VII – Claims and settlements**Article 27: Time limits for claims**

The administrator shall pay a claim only if it is submitted (a) within 12 months following the date of the treatment; or (b) within three months following the date of receipt of the invoice, whichever comes later.

Article 28: Claims for direct settlement

- 28.1 The administrator shall directly settle hospital bills, if the insured member so requests, provided the insured member has agreed, in writing, to reimburse the administrator for any amounts that are not covered by the ECB health insurance (hereinafter the “non-insured expenditure”).
- 28.2 The administrator shall recover any non-insured expenditure from the insured member by:
- (a) setting it off from future reimbursements that may be due to the insured member or their insured dependants; and/or
- (b) requesting in writing the insured member to transfer the outstanding amount to the administrator’s bank account within one month from the date of the request. Such a request shall be made within six months after the date when the hospital bill is settled or the date when the insurance cover of the insured member ceases, whichever is earlier.

Article 29: Guarantee of payments

Where required by medical service providers, national legislation or standard medical practice, the administrator shall issue a guarantee of payment to the relevant medical service provider.

² Decision (EU) 2016/456 of the European Central Bank of 4 March 2016 concerning the terms and conditions for European Anti-Fraud Office investigations of the European Central Bank, in relation to the prevention of fraud, corruption and any other illegal activities affecting the financial interests of the Union (ECB/2016/3) (OJ L 79, 30.3.2016, p. 34).

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Article 30: Claims for reimbursement

- 30.1 Without prejudice to Article 24, the administrator shall only reimburse claims after verifying that the conditions mentioned in this Article have been complied with. The administrator may request from the insured member any supplementary information which may be necessary for such verification.
- 30.2 All claims for reimbursement of eligible expenditure shall be made by the insured members, in respect of themselves or their insured dependants, to the administrator in electronic format accompanied by scans of invoices and supporting documents or in hard copy accompanied by originals of invoices and supporting documents. If insured members submit claims in electronic format, they must keep the original documents for six months for the purposes of audit by the administrator.
- 30.3 Insured members claiming reimbursement under the ECB's top-up cover must add the following to their claim for reimbursement:
- (a) the name of the other health insurance and the amounts received;
 - (b) the settlement note provided by the other health insurance.
- 30.4 The administrator shall refuse a claim for reimbursement under the ECB's top-up cover if an insured person has not claimed under their primary insurance prior to submitting their claim under the ECB health insurance.
- 30.5 The administrator must provide via a secure internet-based service, an overview of each settlement, including information on reimbursement and payment details, as well as any additional information. Every time a claim has been processed, the administrator must send an email to the insured member announcing that new settlement information is available online.

Section VIII – Complaints and appeals procedures**Article 31: Complaints procedure***Complaints to the administrator*

- 31.1 Insured members may complain to the medical or dental officer of the administrator within six months about its decisions, action or lack of action by providing full details of their complaint.
- 31.2 The medical or dental officer of the administrator shall confirm receipt of the complaint in writing to the insured member and indicate a reference number identifying the complaint.
- 31.3 If the medical or dental officer of the administrator requires further information, it may contact the insured member using their preferred method of contact. Any such request suspends the time period referred to in Article 31.5.
- 31.4 If the medical or dental officer of the administrator considers that the substance of the complaint may impact the functioning of the ECB health insurance, they must consult the ECB without giving any information that would make the complainant identifiable and follow the opinion of the ECB on the matter. Any such consultation suspends the time period referred to in Article 31.5.

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- 31.5 The medical or dental officer of the administrator must provide a written response to the insured member within 10 working days.
- 31.6 If the complaint is rejected, the medical or dental officer of the administrator shall provide the insured member within, the deadline referred to in Article 31.5, with a written explanation of the decision, including information on the interpretation of the ECB health insurance rules or the settlement process and on the assessment of the medical facts.

Escalation to the risk carrier

- 31.7 If insured members are dissatisfied with the decision of the medical or dental officer of the administrator, they may ask the administrator to escalate their complaint to the medical or dental officer of the risk carrier within two months from the date of refusal of the complaint. The medical or dental officer of the risk carrier shall re-examine the complaint in an impartial manner and provide the insured member with a final written response within two months explaining the decision, including information on the interpretation of the ECB health insurance rules, on the settlement process and on the assessment of the medical facts.
- 31.8 The medical or dental officer of the risk carrier is entitled to request all necessary documentation from the administrator and the insured member. If the medical or dental officer of the risk carrier determines that the complaint affects the functioning of the ECB health insurance, it must consult the ECB without giving any information that would make the complainant identifiable and follow the opinion of the ECB on the matter. Any such consultation suspends the time period referred to in Article 31.7.
- 31.9 If a complaint concerns the question of whether medical or dental treatment qualifies as “treatment” as defined in Article 1, an opinion from the medical expert referred to in Article 34 must be obtained by the medical or dental officer of the risk carrier, which is binding on all parties. Any such consultation suspends the time period referred to in Article 31.7.
- 31.10 The decision of the medical or dental officer of the risk carrier is binding on the administrator and is deemed to constitute the final decision on the case.

Data protection

- 31.11 All persons involved in the complaints procedure are subject to the obligation of professional secrecy pursuant to Article 10(3) of Regulation (EC) No 45/2001 or Article 9(2)(h) of Regulation (EU) No 2016/679 of the European Parliament and of the Council³, whichever may be applicable at the relevant time.

Article 32: ECB internal appeals

- 32.1 Insured members may utilise the procedures referred to in Article 41 of the Conditions of Employment to challenge decisions taken by the ECB with respect to the ECB health insurance,

³ Regulation (EU) 2016/679 of the European Parliament and of the Council of 27 April 2016 on the protection of natural persons with regard to the processing of personal data and on the free movement of such data, and repealing Directive 95/46/EC (General Data Protection Regulation) (OJ L 119, 4.5.2016, p. 1).

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excluding any decisions taken pursuant to these rules on behalf of the ECB that are subject to the complaints procedure under Article 31.

32.2 If the competent decision maker referred to in Article 41 of the Conditions of Employment considers that medical expertise is necessary to come to a decision, the ECB's medical adviser shall deliver an opinion. The request for such opinion suspends the timeframe for delivering a decision taken pursuant to Article 41 of the Conditions of Employment.

Article 33: Jurisdiction of the Court of Justice

Pursuant to Article 42 of the Conditions of Employment, after all available internal appeals procedures referred to in Articles 31 or 32 have been exhausted, the Court of Justice of the European Union shall have jurisdiction.

Article 34: Opinion of the medical expert as to whether medical or dental treatment qualifies as “treatment”

34.1 The medical expert referred to in Article 31.9 is chosen by agreement between the medical or dental officer of the administrator and the insured person.

34.2 The medical or dental officer of the risk carrier shall request the insured person to propose a medical expert to the medical or dental officer of the administrator. Such medical expert shall:

- (a) possess the relevant medical expertise required to produce an expert opinion related to the medical dispute;
- (b) not have been consulted in any way by the insured person or their family in the three years prior to the request.

34.3 If the insured person does not propose within one month a medical expert whom the medical or dental officer of the administrator considers to meet the criteria referred to in Article 34.2, the medical or dental officer of the administrator shall ask the medical or dental officer of the risk carrier to designate the medical expert.

34.4 The medical expert shall:

- (a) independently review all relevant documentation;
- (b) examine the insured person, if necessary;
- (c) provide their opinion to the medical or dental officer of the risk carrier within 60 working days.

34.5 The costs incurred in relation to the medical expert shall be fully borne by the administrator in all cases.

Section IX – Transitional provisions**Article 35: Transitional provisions**

35.1 Notwithstanding anything to the contrary in this Annex, spouses or recognised partners whose only health insurance on 1 January 2018 was the ECB medical and dental plan shall be entitled to primary cover until 31 December 2022, subject to the following conditions:

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- (a) if their income during the calendar year preceding that for which their eligibility is assessed does not exceed EUR 22 800 they shall be insured without payment of additional monthly contributions;
 - (b) if their income during the calendar year preceding that for which their eligibility is assessed exceeds EUR 22 800 but does not exceed the threshold referred to in Article 15 of the Conditions of Employment, they shall be insured subject to the payment of an additional monthly contribution which shall be established by multiplying the premium with the “contribution basis”, where:
 - (i) the “contribution basis” referred to in this point shall be their own income in the calendar year preceding that for which their eligibility is assessed;
 - (ii) the “premium” referred to in this point shall be equal to the regular monthly contribution referred to in Article 13.1(g).
 - (c) The additional monthly contribution under point (b) shall be shared as follows:
 - (i) one third of the full contribution shall be paid by the insured member and two thirds by the ECB, from 1 January 2018 until 31 December 2019;
 - (ii) two thirds of the full contribution shall be paid by the insured member and one third by the ECB, from 1 January 2020 until 31 December 2021;
 - (iii) the full contribution shall be paid by the insured member from 1 January 2022 until 31 December 2022.
 - (d) If their income during the calendar year preceding that for which their eligibility is assessed exceeds the threshold referred to in Article 15 of the Conditions of Employment, they shall lose entitlement to insurance pursuant to paragraph 1 as from 1 April of the year in which eligibility is assessed and the provisions of Article 3.5(b) shall apply.
- 35.2 In all cases referred to in Article 35.1, insured persons shall comply with the reporting obligations referred to in Article 3.5.
- 35.3 Notwithstanding Article 3.3(a), spouses or recognised partners who, on 1 January 2018 were insured under the ECB medical and dental plan, while also having alternative health insurance, shall be entitled to top-up cover under the ECB health insurance until 31 December 2022, irrespective of the compliance of such alternative health insurance with the requirements of Article 3.3(a). If their income during the calendar year preceding that for which their eligibility is assessed exceeds the threshold referred to in Article 15 of the Conditions of Employment, they shall pay an additional monthly contribution calculated pursuant to Articles 12.1(g) and 13.1(h).
- 35.4 For the purposes of Article 9.5 of Appendix I (Schedule of benefits), all persons insured on 1 January 2018 under the ECB medical and dental plan shall be considered as if they had been insured for three years under the ECB health insurance laid down in this Annex. They shall not be entitled to carry over any unused portion of the limit for reimbursement of dental costs from the ECB medical and dental plan.

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- 35.5 All persons insured on 1 January 2018 under the ECB medical and dental plan shall be deemed to have fulfilled all waiting periods mentioned in Appendix I (Schedule of benefits).
- 35.6 By way of derogation from Article 12.1(b) to (d), where the persons referred to in those provisions opt out of the ECB long-term care insurance within one month of its introduction, their contribution to the ECB health insurance shall remain based on the pension to which the former member of staff was entitled on retirement pursuant to: (i) Article 11.2 of Annex III of the Conditions of Employment, before any part of such pension was converted to a lump sum under Article 11.4 of the same Annex; and/or (ii) Appendix 1 to Annex IIIa to the Conditions of Employment; or on the spouse's pension or on the children's pension as the case may be. The contribution may be increased in line with changes to such pensions and to the cost of insurance.
- 35.7 Where the persons referred to in Article 12.1(b) to (d) do not opt out of the ECB long-term care insurance, their contribution shall remain based on the pension determined in accordance with Article 35.6 for a period of six months following the date of entry into force of this Decision.

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Appendix I**European Central Bank health insurance rules (Annex III to the Staff Rules)****Schedule of benefits****Content**

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Schedule of benefits – European Central Bank (ECB) health insurance**1. Consultation of doctors**

Expenditure incurred for consultations, medical examinations and treatments performed by medically qualified persons, excluding dental practitioners, is reimbursed at the rate of 85%.

2. Out-patient surgical procedures**2.1 Surgeon's fees, costs of diagnosis, treatment and use of operating theatre**

Expenditure incurred for the following out-patient medical services is reimbursed at the rate of 100%:

- (a) consultations, medical examinations and treatments performed by surgeons or attending physicians relating to a surgical procedure;
- (b) anaesthesia;
- (c) use of the operating theatre or plaster room;
- (d) dressings; and
- (e) other expenditure in respect of any general care pertaining to surgical procedures.

2.2 Plastic surgery

The provisions of Article 2.1 shall apply to plastic surgery subject to the following restrictions:

- (a) The reimbursement of expenditure incurred for plastic surgery relating to an accident or illness is subject to prior authorisation, as provided for in Article 16 of Annex III to the Staff Rules.
- (b) Expenditure incurred for plastic surgery that is considered to be purely of cosmetic nature is not eligible for reimbursement.

2.3 Pre/post-operative treatment

Expenditure incurred for any pre/post-operative consultations, medical examinations and treatments linked to an out-patient surgical procedure conducted in out-patient care immediately preceding or following the out-patient surgical procedure is reimbursed at the rate of 100%, provided that the respective invoice indicates that these services are related to the surgical procedure.

In all cases, expenditure incurred for consultations, medical examinations and treatments with the surgeon or attending physician(s) 10 days prior to or 10 days after the out-patient surgical procedure is reimbursed at the rate of 100%.

2.4 Laser eye surgery

- (a) Expenditure incurred for laser eye surgery solely for the purpose of correcting myopia or hypermetropia is reimbursed at the rate of 100%, limited to EUR 1 750 per eye once every ten years. These reimbursements are only granted where the insured person has been insured under the ECB health insurance for more than one year. Reimbursement of expenditure under this Article excludes reimbursement of expenses under Article 3.9(a) during the period referred to in this paragraph.

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- (b) If laser eye surgery is necessitated for medical reasons other than correcting myopia, hypermetropia or astigmatism, or if it is performed due to severe ametropia, reimbursement is made at the rate of 100% without the application of a reimbursement limit and a waiting period.

3. In-patient surgical procedures, hospitalisations and hospice care**3.1. Hospitalisations**

Expenditure incurred for consultations, medical examinations and treatments and surgical procedures, which require at least one overnight stay in a hospital (including clinics, convalescent establishments, long-time hospitalisations and stays in hospices) is reimbursed in accordance with Articles 3.2 to 3.9.

Expenditure incurred in respect of accommodation, subsistence or non-medical care during a stay in a home for elderly persons or comparable facilities is not eligible for reimbursement.

3.2. Accommodation costs

- (a) Expenditure incurred for accommodation is reimbursed as follows:
- (i) for a stay in a hospital in a double room, at the rate of 100%;
 - (ii) for a stay in a hospital in a single room, at the rate of 80%, capped at 150% of the price charged by the same hospital for a double room;
 - (iii) for a stay in a single room, where the hospital is built to offer only single room accommodation, at the rate of 100%.
 - (iv) for a stay in a hospital for treatment of a contagious disease or treatment due to contact with a contagious and contaminating substance, where the medically qualified person in charge of the treatment prescribes a stay in quarantine or isolation, at the rate of 100%;
 - (v) for a stay in an intensive care unit, at the rate of 100%;
 - (vi) for a stay in a hospice, at the rate of 100%. Any benefits received from the ECB long-term care insurance are deducted from such reimbursements.
- (b) Accommodation costs comprise the costs of subsistence (including meals and other similar necessary costs) and medical treatment, including taxes. Expenditure related to personal comfort (e.g. newspapers, television, telephone, a bigger room) is not eligible for reimbursement.
- (c) For each stay in a hospital, an amount of EUR 20 per night is deducted from the total reimbursement related to the insured person's hospitalisation for the first five nights. The total amount deducted must not exceed EUR 200 in any calendar year.

No such deduction is made in respect of:

- (i) insured dependants up to the age of 18;
- (ii) a stay in a hospice.

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3.3 Surgeon's fees and costs of diagnosis, treatment and use of operating theatre for in-patient care

Expenditure incurred for the following in-patient medical services is reimbursed at the rate of 100%:

- (a) consultations, medical examinations and treatments performed by surgeons or attending physicians relating to a surgical procedure;
- (b) anaesthesia;
- (c) use of the operating theatre or plaster room;
- (d) dressings; and
- (e) other expenditure in respect of any general care pertaining to a surgical procedure, medical fees for visits and calls, laboratory analysis and tests, X-rays, medication and other diagnostic or therapeutic services.

3.4. All-inclusive prices in hospitals

If a hospital charges an all-inclusive price per day in hospital, which comprises the cost of the stay as set out in Article 3.2, and all or part of the expenses set out in Article 3.3, reimbursement is at the rate of 100%.

3.5. Cost of stay for a person accompanying an insured person

Where, in view of their age and the nature of their illness, insured persons need to be accompanied in hospital by a member of their family or other carer, and when a medically qualified person has affirmed that necessity in a prescription, the expenditure relating to the stay of the person accompanying the insured person is, by way of exception and on prior authorisation, as provided for in Article 16 of Annex III to the Staff Rules, reimbursed at the rate of 85%, subject to a maximum limit of EUR 45 per day.

Notwithstanding this, no prescription and prior authorisation is required for accompanying insured dependants below the age of 12.

3.6. Robotic surgery

Robotic surgery and robot-assisted surgery is subject to prior authorisation, as provided for in Article 16 of Annex III to the Staff Rules.

3.7. Plastic surgery

The provisions of Article 3 shall apply to plastic surgery subject to the following restrictions:

- (a) the reimbursement of expenditure incurred for plastic surgery relating to an accident or illness is subject to prior authorisation, as provided for in Article 16 of Annex III to the Staff Rules; and
- (b) expenditure incurred for plastic surgery that is considered to be purely of cosmetic nature is not eligible for reimbursement.

3.8. Pre/post-operative treatment

Expenditure incurred for any pre/post-operative consultations, medical examinations and treatments linked to an in-patient surgical procedure conducted in out-patient care immediately preceding or following the in-patient surgical procedure is reimbursed at the rate of 100%, provided that the respective invoice indicates that these services are related to the surgical procedure.

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In all cases, expenditure incurred for consultations, medical examinations and treatments with the surgeon or attending physician(s) 10 days prior to or 10 days after the in-patient surgical procedure is reimbursed at the rate of 100%.

3.9 Laser eye surgery

- (a) Expenditure incurred for laser eye surgery solely for the purpose of correcting myopia or hypermetropia is reimbursed at the rate of 100%, limited to EUR 1 750 per eye once every ten years. These reimbursements are only granted where the insured person has been insured under the ECB health insurance for more than one year. Reimbursement of expenditure under this Article excludes reimbursement of expenses under Article 2.4(a) during the period referred to in this paragraph.
- (b) If laser eye surgery is necessitated for medical reasons other than correcting myopia, hypermetropia or astigmatism, or if it is performed due to severe ametropia, reimbursement is made at the rate of 100% without the application of a reimbursement limit and a waiting period.

4. Organ or tissue transplantation

- 4.1** Expenditure incurred by an organ or tissue recipient for undergoing transplantation is reimbursed at the rate of 100%.
- 4.2** Expenditure incurred by an organ or tissue donor for the extraction or removal of the respective organ or tissue and any necessary aftercare is reimbursed at the rate of 100%. Any reimbursement that the organ or tissue donor receives from any third party in respect of such expenditure is deducted from the reimbursement.
- 4.3** Reimbursement under this Article also covers any compensation that the organ or tissue recipient may be obliged to pay to the organ or tissue donor pursuant to national legislation in the respective country where the transplantation services are provided, but shall not cover any other kind of remuneration to the donor.

5. Palliative care

Expenditure incurred for out-patient or in-patient palliative care is reimbursed at the rate of 100%.

6. Serious illnesses

- 6.1** Reimbursement of expenditure incurred relating to a serious illness as defined in Annex III to the Staff Rules is made at the rate of 100%. The limits for reimbursement contained in this schedule of benefits do not apply, except in the cases referred to in Articles 6.2 and 6.3.
- 6.2** The reimbursement for the following treatments may not exceed an amount equal to twice the maximum amount provided under basic reimbursement:
 - psychological care (Article 16);
 - medical stays at a facility for the preservation or recovery of health (Article 22);
 - hearing aids (Article 23);
 - medical aids and equipment (Article 24).

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6.3 The reimbursement for the following benefits or treatments may not exceed the maximum amounts mentioned in the following articles:

- family or carer assistance in case of hospitalisation (Article 3.5);
- in vitro fertilisation (Article 13);
- alternative therapeutic treatments and medicine (Article 19);
- nursing care (Article 21);
- vision (Article 25).

7. Prevention and early detection screening programmes

7.1 Early detection screening tests

Expenditure incurred for early detection screening tests and paediatric early detection examinations is reimbursed at the rate of 100%. Expenses for cancer tests, including medical examinations when they are part of such tests, are also reimbursed at this rate, provided that they are labelled as such on the invoice or on the claims form.

7.2 Gynaecological visits

Expenditure incurred for gynaecological visits for prevention and early detection screening programmes is reimbursed at the rate of 100%. This reimbursement is limited to two visits per calendar year.

7.3 Dental controls and professional teeth cleaning

Expenditure incurred for two dental control visits and two professional teeth cleanings per calendar year is reimbursed at the rate of 100%. These reimbursements are fully taken into account with regard to the overall limit for dental care provided for in Article 9.

7.4 Annual medical check-up

- (a) Expenditure incurred for one annual medical check-up per calendar year is reimbursed at the rate of 100% up to an amount of EUR 750. Expenditure incurred in excess of this amount is not eligible for reimbursement.
- (b) An insured person is entitled to the reimbursement referred to in point (a) after having been insured for more than one year under the ECB health insurance. Insured persons under the age of 26 are not entitled to a medical check-up.
- (c) The annual medical check-up may include the following tests or examinations:

Blood analysis	Haematology Sedimentation rate Blood sugar Creatinine, urea SGPT, SGOT, Gamma – GT, Bilirubin Total cholesterol, LDL – cholesterol, HDL – cholesterol, Triglyceride
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	Ferritin PSA (only for male insured persons over the age of 50)
Urine analysis	Microscopic evaluation Glucose Albumin
Spirometry	Pulmonary function test
Faeces analysis	Occult blood
Static and exercise ECG	Once every two years Every year for insured persons over the age of 45

- (d) The medically qualified person conducting the annual medical check-up may decide to include tests or examinations which are not mentioned in point (c) on the basis of an individual health risk assessment. The expenditure incurred for such additional tests or examinations is reimbursed subject to the provisions of point (a).

7.5 Vaccinations

All vaccinations are reimbursed at the rate of 100%.

8. Medication**8.1 Medication**

- (a) “Medication” means a product prescribed by a medically qualified person or midwife that is generally recognised by and used in conventional medicine for the treatment of illnesses and disorders.
- (b) Branded (non-generic) medication is reimbursed at the rate of 85%.
- (c) Generic medication is reimbursed at the rate of 100%.
- (d) Personalised medication and genetic therapies are reimbursed subject to prior authorisation as provided for in Article 16 of Annex III to the Staff Rules.
- (e) Expenditure for routinely prescribed contraception is reimbursed in accordance with the rates provided for in points (b) or (c) respectively.
- (f) Medication that has proven to be equally as effective in practice as conventional medical methods or medication, or that is used because conventional medical methods or medication are not available, shall also be reimbursed in line with points (b), (c) and (d). However, the administrator shall limit reimbursement to the cost that would have been incurred if available conventional medical methods or medication had been used.

8.2 Items excluded from coverage

The following items are excluded from coverage:

- (a) Mineral waters, tonic wines and beverages, infant foods, haircare products, cosmetics, special diet foods, anti-ageing products, hygiene products, irrigators, thermometers, tisanes,

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aromatherapeutic products and similar products and instruments shall not be considered as medication and are therefore excluded from the basic and additional reimbursement.

- (b) Regardless of point (a), if the pathological condition of an insured person under the age of six requires special dietary measures entailing additional expenses, such expenditure is reimbursed at the rate of 85% if the special dietary measures are considered medically necessary and prescribed by the medically qualified person treating such insured person. Such special dietary measures are subject to prior authorisation as provided for in Article 16 of Annex III to the Staff Rules.

8.3 Sexual performance products

Expenditure incurred for sexual performance products is reimbursed if they are prescribed by a medically qualified person for the treatment of the underlying medical condition.

8.4 Food supplements and vitamins

Expenditure incurred for food supplements (i.e. concentrated sources of nutrients or other substances with a nutritional or physiological effect) or vitamins is reimbursed at the rate of 80% only when used for any of the following:

- cancer;
- acute Crohn's disease;
- renal insufficiency;
- serious (inherited/congenital) metabolic disorders;
- for female insured persons, during pregnancy and one year thereafter;
- for insured persons under the age of six.

9. Dental benefits**9.1 Dental treatment**

Expenditure incurred for dental treatment is reimbursed at the rate of 80%.

9.2 Periodontal treatment

Expenditure incurred for periodontal treatment is reimbursed at the rate of 80%.

9.3 Dental prostheses

Expenditure incurred for dental prostheses is reimbursed at the rate of 80% where the insured person has been insured under the ECB health insurance for more than one year. No such waiting period shall apply for insured persons up to the age of 26.

9.4 Orthodontic treatment

- (a) Expenditure incurred for orthodontic treatment is reimbursed at the rate of 80%, provided that the insured person has obtained prior authorisation, as provided for in Article 16 of Annex III to the Staff Rules, on the basis of an initial cost estimate prepared by the dental practitioner. The amount mentioned in the cost estimate shall cover all treatments to be provided to an insured person. Additional treatments not mentioned in the initial cost estimate are

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reimbursed upon approval by the dental officer of the administrator, following receipt of a reasoned explanation by the dental practitioner in charge of the treatment referring to the necessity of such additional treatment.

- (b) Expenditure incurred for a repetition and/or second course of treatment is only reimbursed following the procedure referred to in point (a).
- (c) Expenditure incurred for orthodontic treatment for purely cosmetic reasons is not eligible for reimbursement.
- (d) Prior authorisation for orthodontic treatments of adults is granted on the basis of treatment needs as provided for by the index of orthodontic treatment need (IOTN) rating system. Orthodontic treatments do not qualify for reimbursement when the dental health component is below four and the aesthetic component is below seven. However, individual cases not rated in this way shall be assessed by the administrator's medical and dental officer who may exceptionally authorise the treatment, taking into consideration factors such as the following:
 - enclosed canine teeth;
 - agenesis;
 - overjet;
 - reversed overjet;
 - crossbite;
 - open bite;
 - overbite with trauma of the gingiva; and
 - superfluous elements.

Expenditure incurred for orthodontic treatments for insured persons as of age 19 is only reimbursed where the insured person has been insured under the ECB health insurance for more than one year.

- (e) Prior authorisation for orthodontic treatments of insured persons up to the age of 18 is granted even if there is no need for treatment according to the IOTN rating system.

9.5 Maximum reimbursement limits

- (a) The reimbursement of dental expenditure incurred pursuant to Articles 9.1 to 9.4 is subject to the following maximum eligible amount for reimbursement per calendar year, increased over time as follows:

Duration of insurance coverage	Maximum eligible amount for reimbursement per calendar year
First year	EUR 2 000
Second year	EUR 3 500
Thereafter	EUR 5 000

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- (b) When insurance cover commences or ceases in the course of a calendar year, the applicable maximum eligible amounts for reimbursement, in accordance with point (a), are pro-rated accordingly for the year in which the insurance commences or ceases.
- (c) Without prejudice to point (b), when insurance cover commences on or after 1 July, the calendar year following commencement of insurance coverage shall be deemed to be the first year of insurance coverage for the purpose of calculating the maximum yearly eligible amount set out in point (a).
- (d) Expenditure incurred pursuant to Articles 9.1 to 9.4 exceeding the maximum eligible amounts set out in point (a) for reimbursement is not eligible for reimbursement.
- (e) Carry over

Where an insured person has not exhausted the maximum eligible amounts for reimbursement of dental costs, an amount equivalent to 50% of the unused portion shall be carried over to the following calendar year, to be used exclusively in that year.

When effecting reimbursements pursuant to Articles 9.1 to 9.4, the administrator shall first have recourse to the funds available in accordance with the regular maximum eligible amounts for reimbursement referred to in point (a). Only once this fund is exhausted may the administrator may have recourse to the funds carried over.

9.6 Dental surgical procedures

- (a) Expenditure incurred for in-patient dental surgical procedures is reimbursed under the rules of in-patient surgical procedures contained in Article 3, if the dental surgical procedure requires at least one overnight stay in hospital. Such reimbursement is not taken into account for the annual limit of reimbursable dental costs.
- (b) Expenditure incurred for out-patient dental surgical procedures is fully taken into account for the purpose of the annual limit of reimbursable dental costs.

9.7 Extraction of teeth and root canal treatment

Expenditure incurred for the extraction of teeth and root canal treatment shall be reimbursed at the rate of 100% and not taken into account for the annual limit of reimbursable dental costs.

9.8 Dental coverage in the case of accidents

Where dental treatments, out-patient dental surgical procedures, dental prostheses or orthodontic treatments are necessary due to a non-work related accident that fulfils the criteria for an accident, as provided for in Article 6.3 of the Staff Rules, expenditure for such treatments is reimbursed at the rate of 80%, up to a total amount of EUR 10 000.

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10. Radiology, analyses, laboratory tests and other forms of diagnosis

10.1 Expenditure incurred for radiology, analyses, laboratory tests and other forms of diagnosis is reimbursed at the rate of 85%, including administrative costs, e.g. postage or forwarding costs.

10.2 Expenditure incurred for radiology, analyses, laboratory tests and other forms of diagnosis performed as part of an early detection screening test is reimbursed at the rate of 100%.

11. Pregnancy

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

11.2 Medical consultations and all other prenatal examinations, treatment and monitoring relating to pregnancy carried out by medically qualified persons and midwives are reimbursed in accordance with the general reimbursement provisions laid down in these rules.

11.3 Expenditure incurred for retaining medically qualified persons or midwives on call during the period of pregnancy is reimbursed at the rate of 85% in the case of risk pregnancies. Risk pregnancies are to be determined by a medically qualified person.

In the case of home confinements, expenditure incurred for retaining medically qualified persons or midwives on call are covered for a period starting four weeks prior to the expected date of confinement and ending four weeks after the actual date of confinement.

11.4 Pre- and post-natal physiotherapy, both in individual or in group sessions, carried out by a physiotherapist or midwife, when prescribed by medically qualified persons or midwives, are reimbursed in accordance with the conditions for physiotherapy, kinesiotherapy and similar treatments described in Article 15.

Expenditure incurred for one childbirth preparation course per pregnancy is reimbursed at the rate of 80% for the female insured person only.

11.5 Expenditure incurred with regard to amniocenteses, laboratory tests and ultrasound scans is reimbursed at the rate of 85%.

11.6 Expenditure for non-invasive pre-natal screening for chromosomal disorders is reimbursed at the rate of 85%, provided that the insured person has obtained prior authorisation, as provided for in Article 16 of Annex III to the Staff Rules.

Prior authorisation is granted if there is an increased risk for foetal aneuploidy, which may be due to one or more of the following conditions:

- the mother is above the age of 35;
- previous ultrasound scanning and/or pre-natal screening resulted in an increased risk of a foetal aneuploidy;
- the mother had a previous pregnancy with a foetal aneuploidy;
- genetic predisposition to a foetal aneuploidy.

Non-invasive pre-natal screening for reasons other than detecting chromosomal disorders is not eligible for reimbursement.

11.7 The following are not eligible for reimbursement:

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- (a) expenditure incurred for assistance by third persons for the performance of regular household activities in the pregnant insured person's household;
- (b) expenditure incurred for haptonomy sessions and swimming pool charges; and
- (c) expenditure incurred for 4D ultrasound scans.

12. Confinement and post-natal care**12.1 In hospital**

- (a) Expenditure incurred relating to confinement is reimbursed at the rate of 100% for the following services:
 - fees for the medically qualified person and/or midwife;
 - the fees for a labour room, anaesthesia, a physiotherapist; and
 - all other fees relating to services directly connected with the confinement.
- (b) Expenditure incurred for accommodation in hospital is reimbursed as provided for in Article 3.2.
- (c) Expenditure incurred for post-natal midwife care (including reimbursement of travel costs unless these expenses are already covered under Article 11) after the hospital stay is reimbursed at the rate of 85%.

12.2 Home confinements

- (a) The expenditure incurred relating to home confinements and post-natal midwife care is reimbursed:
 - (i) at the rate of 100% for the day of confinement and the subsequent 10 days; and
 - (ii) thereafter at the rate of 85%.

Where complications arise, the period for which reimbursement is made at the rate of 100% may be extended beyond 10 days for the duration of such medical complications. The following expenditure incurred shall be reimbursed under this point:

- the fees of the medically qualified person and/or midwife;
 - the costs of the nurse;
 - all other medical expenses directly connected with the confinement;
 - travel-related costs of the midwife or medically qualified person, unless these costs are already covered under Article 11.
- (b) Where the home confinement cannot take place due to medical reasons, without prejudice to Article 12.1, expenditure incurred for retaining medically qualified persons or midwives on call is reimbursed in an amount equal to that reimbursed in respect of home confinements.

12.3 Confinement at a birth centre

- (a) For the purposes of this paragraph "birth centre" means a non-clinical environment operated by midwives or medical qualified persons and approved by the competent health authorities.
- (b) Expenditure incurred for confinement at a birth centre is reimbursed under the same conditions as a confinement in a hospital.

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- (c) Expenditure incurred for post-natal care and accommodation at a birth centre is reimbursed at the rate of 100% for up to 24 hours after confinement.
- (d) Expenditure incurred following confinement at a birth centre with respect to post-natal care provided at home by midwives and medically qualified persons is reimbursed at the rate of 100% for a maximum of ten days after confinement and thereafter at the rate of 85%.
This shall include expenditure incurred for the travel costs of midwives and medically qualified persons, unless these expenses are already covered under Article 11.
- (e) Where complications arise, the period for which reimbursement is made at the rate of 100% may be extended for the duration of such medical complications.

13. In vitro fertilisation**13.1 General conditions**

Expenditure incurred for in vitro fertilisation shall be reimbursed up to EUR 2 500 per attempt. The maximum number of eligible attempts is limited to five attempts per lifetime of the insured person suffering from sterility.

Reimbursement is subject to the following conditions:

- (i) the need for in vitro fertilisation is due to sterility connected with a pathological condition of an insured person;
- (ii) the attempt for which reimbursement is claimed commences before the mother's 45th birthday;
- (iii) prior authorisation, as provided for in Article 16 of Annex III to the Staff Rules, is obtained.

13.2 Special conditions

- (a) The following expenditure incurred is reimbursed at the rate of 85%:
 - the costs of retrieval of the oocyte or spermatoocyte, fertilisation and culturing;
 - the costs of stimulation, tests, analyses, laboratory work and conservation of oocytes and spermatoocytes for a maximum period of one year.
- (b) The costs of pre-implantation genetic diagnosis in respect of the embryo are reimbursed at the rate of 85% subject to prior authorisation, as provided for in Article 16 of Annex III to the Staff Rules, if a serious disease or genetic abnormality has been identified in a biological relative of the unborn child in the first or second degree.
- (c) The costs of egg or sperm donation (costs of stimulation and retrieval from the donor, excluding all other costs) are not reimbursed. The costs of implantation of the donated egg or sperm are reimbursed at the rate of 85%.

Any expenditure incurred relating to surrogacy is not eligible for reimbursement.

13.3 Treatment for male infertility

- (a) Treatment for male infertility, provided that it does not result from previous voluntary sterilisation, is reimbursed at the rate of 85% as follows:

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- artificial insemination with sperm from the insured person or from a donor;
 - in vitro fertilisation, including intra-cytoplasmic sperm injection (ICSI), subject to the conditions laid down in Article 13.1;
 - sperm retrieval (deferential, epididymal or testicular sperm aspiration) and preparation for ICSI.
- (b) If such treatment requires a stay in hospital, expenditure incurred for care is reimbursed at the rate of 100% for the following treatments:
- vasovasostomy;
 - epididymo-deferential anastomosis;
 - ejaculatory duct resection;
 - varicocele repair.

Expenditure incurred for accommodation in hospital is reimbursed as provided for in Article 3.2.

14. Abortion

Expenditure incurred for abortion is reimbursed at the rate of 100%, provided that the abortion is performed in compliance with the applicable legal framework in the respective country of treatment.

15. Physiotherapy, kinesiotherapy and similar treatments

15.1 Expenditure incurred for treatments listed in Articles 15.2 and 15.3 that are prescribed by a medically qualified person or dental practitioner is reimbursed at the rate of 80%. The maximum number of sessions per calendar year and the maximum reimbursement per session is specified in Article 15.2. By way of exception and on production of a medical certificate duly substantiating the medical reasons, a higher number of sessions may be reimbursed subject to prior authorisation, as provided for in Article 16 of Annex III to the Staff Rules.

For the purpose of this Article, a session is a single treatment or a combination of multiple treatments in the same category, performed in a single day, by one or more medically qualified persons, for one or more medical diagnoses regarding one organ/extremity or body area.

15.2 Treatments must correspond to the treatments specified on the medical prescription and must be carried out by a medically qualified person.

Category Number	Type of treatment	Maximum number of sessions • per calendar year; and • per category of treatment	Maximum reimbursement per session
1	Kinesiotherapy,	60	EUR 50

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	physiotherapy and similar treatments ⁴		
2	Aerosol therapy Inhalation Insufflation Irrigation Nebulisation or spray treatment	30	EUR 40
3	Infra-red radiation Ultrasound therapy	40	EUR 40
4	Radium therapy Radiotherapy Röntgenotherapy	unlimited	EUR 40
5	Acupuncture performed by a medically qualified person	30	EUR 40
6	Chiropractic treatments	24	EUR 40
7	Osteopathy	20	EUR 40

15.3 Reimbursement in respect of the treatments listed below is subject to prior authorisation, as provided for in Article 16 of Annex III to the Staff Rules.

Type of treatment	Maximum number of sessions per calendar year	Maximum reimbursement per session
Laser therapy	20	EUR 40
Ultraviolet radiation	40	
Medical chiropody-podology	12	
Mesodermal microinjection therapy	30	
High energy focused shock wave therapy performed by a doctor	6	EUR 160

16. Psychological care

16.1 In this Article, the following definitions apply:

⁴ Similar treatments include 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, standard shock wave therapy etc.

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- “qualified counsellor” means a person with a Master’s degree in the area of psychology or medicine, who has received additional formal training in either cognitive behavioural therapies, psychodynamic approaches or psychoanalysis and is a registered healthcare professional with a national body or any other healthcare professional officially registered with a national body and legally entitled to provide psychological care in that country;
 - “session of psychological care” means any type of psychotherapeutic treatment or analysis, including emergency treatment, performed on one day by one qualified counsellor.
- 16.2** Expenditure incurred for psychotherapeutic treatments, examinations and analysis, performed by a qualified counsellor, is reimbursed at the rate of 80%. The maximum number of sessions of psychological care per calendar year and the maximum eligible amount for reimbursement is as follows:
- one full psychological examination per cycle of treatments, up to EUR 125;
 - 60 sessions of psychological care, up to EUR 100 per session.
- 16.3** An initial cycle of five sessions of psychological care and one full psychological examination shall be reimbursed without the need for prior authorisation.
- Subsequent cycles for the continuation of psychological care are subject to prior authorisation as provided for in Article 16 of Annex III to the Staff Rules. The authorisation shall in principle cover the reimbursement of up to 25 sessions of psychological care and one full psychological examination per cycle, unless the medical condition of the insured person requires a higher number of sessions of psychological care per cycle.
- 16.4** In the case of family sessions, the limits pursuant to Articles 16.2 and 16.3 are increased by 50%, provided only one invoice is issued per family session and the names of all attending family members are included on the invoice. In the case of group sessions, these limits are reduced by 50%.
- 16.5** A decision to grant prior authorisation shall be based on a medical report drawn up by the qualified counsellor containing the anamnesis, the diagnosis, the proposed treatment cycle and the prognosis after having performed the initial sessions of psychological care or the full psychological examination. Expenditure incurred for the preparation of this report is reimbursed at the rate of 80%, subject to a maximum eligible amount for reimbursement of EUR 150.
- 16.6** Subject to prior authorisation as provided for in Article 16 of Annex III to the Staff Rules, and where medically indicated, psychological care via videoconference and telephone may exceptionally be reimbursed following the completion of at least five face-to-face sessions with the respective qualified counsellor.
- 16.7** Expenditure incurred for coaching, career counselling, educational counselling, sexual counselling and relationship counselling is not eligible for reimbursement. This provision shall not result in the exclusion of treatment of medical conditions which may be triggered or aggravated by one of these counselling treatments.

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16.8 By way of exception and on production of a duly substantiated medical certificate, a higher number of sessions may be reimbursed subject to prior authorisation, as provided for in Article 16 of Annex III to the Staff Rules.

17. Speech therapy

17.1 Subject to prior authorisation, as provided for in Article 16 of Annex III to the Staff Rules, expenditure incurred for speech therapy, prescribed by medically qualified persons, is reimbursed at the rate of 80% without any limit for reimbursement.

17.2 The maximum number of sessions per calendar year for which costs may be reimbursed is as follows:

- for insured persons up to age of 12: 60 sessions;
- for insured persons between 12 and 18 years: 30 sessions;
- for insured persons over the age of 18: without any limit on the number of sessions, subject to the underlying medical condition being recognised as a serious illness as provided for in Article 22 of Annex III to the Staff Rules.

17.3 Expenditure incurred for a logopaedic assessment is reimbursed separately at the rate of 80%.

17.4 A decision to grant prior authorisation shall be based on a medical report drawn up by the speech therapist describing the deficiencies and the proposed treatment cycle after having performed a logopaedic assessment. No prior authorisation is required for insured persons up to the age of 12 for an initial amount of 20 sessions.

17.5 By way of exception and on production of a duly substantiated medical certificate, a higher number of sessions may be reimbursed subject to prior authorisation, as provided for in Article 16 of Annex III to the Staff Rules.

18. Graphomotor and psychomotor therapy

18.1 Expenditure incurred for the treatments set out below, prescribed by medically qualified persons, and subject to prior authorisation as provided for in Article 16 of Annex III to the Staff Rules, is reimbursed at the rate of 80% without any limit for reimbursement. The maximum number of sessions per calendar year for which costs may be reimbursed is as follows:

- graphomotor therapy: 60 sessions;
- psychomotor therapy: 60 sessions.

18.2 Expenditure incurred for graphomotoric or psychomotoric assessments is reimbursed separately at the rate of 80%.

18.3 A decision to grant prior authorisation shall be based on a medical report drawn up by a medically qualified person describing the deficiencies and the proposed treatment, including the expected number of sessions, after having diagnosed the graphomotoric or psychomotoric deficiencies.

18.4 By way of exception and on production of a duly substantiated medical certificate, a higher number of sessions may be reimbursed subject to prior authorisation, as provided for in Article 16 of Annex III to the Staff Rules.

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19. Alternative therapeutic treatments and medicine

Expenditure incurred for the following alternative therapies and medicine is reimbursed at the rate of 80%, subject to a maximum eligible amount for reimbursement of EUR 500 per calendar year:

- (a) expenditure incurred for the consultation of and examination by a 'Heilpraktiker' or equivalent who does not fall within the definition of a medically qualified person;
- (b) medication other than medication used in conventional medicine, as defined in Article 8.1, if prescribed by a 'Heilpraktiker' or equivalent;
- (c) vitamins and food supplements for the treatment of medical conditions not included in Article 8.4, if prescribed by a medically qualified person;
- (d) physiotherapy, kinesiotherapy and similar treatments, as defined in Article 15, if performed by a physiotherapist who does not fall within the definition of a medically qualified person;
- (e) courses and medication supporting smoking cessation.

20. Telemedicine & e-health

The reimbursement of expenditure incurred for telemedicine or e-health is subject to prior authorisation in accordance with Article 16 of Annex III to the Staff Rules.

21. Nursing care**21.1 Treatment by nurses in a clinic, hospital or similar setting**

Expenditure incurred for medical treatment by nurses in a clinic, hospital or similar setting is reimbursed at the rate of 80% on the condition that it is prescribed by a medically qualified person.

Expenditure incurred for non-medical, long-term care services provided by nurses is not eligible for reimbursement under the ECB health insurance.

21.2 Nursing attendance at home after hospitalisation

- (a) Expenditure incurred for necessary medical nursing attendance at home after hospitalisation, which is prescribed by a medically qualified person, is reimbursed at the rate of 80%, subject to a maximum eligible amount for reimbursement of EUR 95 for each day or night, for a period not exceeding 45 days, subject to prior authorisation, as provided for in Article 16 of Annex III to the Staff Rules. However, the maximum eligible amount for reimbursement for each 24-hour period of attendance is EUR 120.
- (b) In cases of absolute necessity, duly substantiated by a medically qualified person, the period referred to in point (a) may be extended by up to 45 additional days, subject to prior authorisation, as provided for in Article 16 of Annex III to the Staff Rules. The maximum eligible amount for reimbursement referred to in point (a) shall apply.
- (c) In cases of absolute necessity, duly substantiated by a medically qualified person, the period referred to in point (b) may be extended further by up to 90 additional days, subject to prior authorisation, as provided for in Article 16 of Annex III to the Staff Rules. In such cases, the maximum eligible amount for reimbursement is EUR 95 for each 24-hour period of attendance.

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- (d) In cases of absolute necessity, duly substantiated by a medically qualified person, the period referred to in point (c) may be extended further by up to six additional months, subject to prior authorisation, as provided for in Article 16 of Annex III to the Staff Rules. In such cases, the maximum eligible amount for reimbursement is EUR 2 650 per month.
- (e) No reimbursement is made in respect of the nurse's travel expenses, board and lodging, or any other ancillary costs.

22. Medical stays at a facility for the preservation or recovery of health**22.1 General conditions**

The reimbursement of expenditure incurred for a medical stay at a facility for the preservation or recovery of health is subject to the following conditions:

- (a) the stay must be prescribed by a medically qualified person;
- (b) the stay is carried out under medical supervision; and
- (c) prior authorisation, as provided for in Article 16 of Annex III to the Staff Rules, has been granted. No prior authorisation is required if a stay is prescribed by the ECB's medical adviser.

Insured persons are reimbursed for this expenditure only once every two years with respect to the date of years.

22.2 Accommodation

Expenditure incurred for accommodation, excluding costs of subsistence (meals and other similarly necessary costs), for a medical stay at a facility for the preservation or recovery of health is reimbursed at the rate of 80%, subject to the following limits for reimbursement:

- (a) stays due to convalescence, chronic medical conditions or serious illnesses: the maximum eligible amount for reimbursement is EUR 45 per day, for a maximum period of 28 days per calendar year;
- (b) stays for insured persons under the age of 16 years: the maximum eligible amount for reimbursement is EUR 45 per day, for a maximum period of six weeks per calendar year;
- (c) joint stays for insured persons and their insured dependent children under the age of 18: the maximum eligible amount for reimbursement is EUR 45 per day per insured person, for a maximum period of 28 days per calendar year.

22.3 Medical treatment and supervision

The expenditure incurred for medical treatment and supervision during medical stays at a facility for the preservation or recovery of health is reimbursed in accordance with these rules.

22.4 Waiting period

Expenditure incurred under this Article is only reimbursed where the insured person has been insured under the ECB health insurance for more than one year.

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23. Hearing aids

23.1 Expenditure incurred for hearing aids prescribed by a medically qualified person is reimbursed at the rate of 85%, subject to a maximum of EUR 1 725 per apparatus (per ear).

23.2 In case of replacement of hearing aids, the reimbursement specified in Article 23.1 is not granted unless a period of five years has elapsed from the date of purchase of the replaced hearing aids. This shall not apply where there is a variation in the audiometric conditions of the insured person and replacement has been prescribed by a medically qualified person.

23.3 Expenditure incurred for batteries for hearing aids and for repairing a hearing aid is reimbursed at the rate of 85%.

24. Medical aids and equipment

Expenditure incurred for purchasing or renting the medical aids and equipment listed below which are prescribed by a medically qualified person is reimbursed at the rate of 85%. Expenditure incurred for repairing the medical aids and equipment referred to in points (f) to (h), is reimbursed at the rate of 85%.

- (a) Made-to-measure orthopaedic footwear, subject to a maximum eligible amount for reimbursement of EUR 600 per pair of shoes. Reimbursements are limited to two pairs of shoes per calendar year. Prior authorisation, as provided for in Article 16 of Annex III to the Staff Rules, is required for the purchase of orthopaedic shoes. When applying for prior authorisation, the insured person must provide a cost estimate.
- (b) Orthopaedic soles, subject to a maximum eligible amount for reimbursement of EUR 150 per pair of soles. Reimbursements are limited to two pairs of soles per calendar year.
- (c) Elastic bandages and similar items, e.g. maternity belts, knee bandages, ankle supports, lumbar girdles, without being subject to a maximum reimbursement limit and without a limit on the number of purchases per year, provided the number of purchases is considered reasonable in the circumstances.
- (d) Elastic stockings, without being subject to a maximum reimbursement limit but subject to a maximum of three pairs per calendar year.
- (e) Anti-allergic duvet covers, mattress or pillow covers, in the case of proven allergic reactions, subject to a maximum eligible amount for reimbursement of EUR 100 per calendar year.
- (f) Artificial limbs and segments thereof, crutches and walking sticks, without being subject to a maximum reimbursement limit and without a limit on the number of purchases per year, provided the number of purchases is considered reasonable in the circumstances. Prior authorisation, pursuant to Article 16 of Annex III of the Staff Rules, is required for the purchase and renewal of artificial limbs and segments thereof.
- (g) Wheelchairs and similar medical aids and equipment intended to facilitate the mobility of an insured person. Prior authorisation, as provided for in Article 16 of Annex III to the Staff Rules, is required for the acquisition of these items. When applying for prior authorisation, the insured person must provide a cost estimate.

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- (h) Other reasonable and customary orthopaedic or medical aids and equipment, upon prescription by a medically qualified person, who has determined that they are necessary due to the medical condition of the insured person. This reimbursement is subject to prior authorisation, as provided for in Article 16 of Annex III to the Staff Rules.

25. Vision**25.1 Waiting periods**

Expenditure incurred under this Article is only reimbursed where the insured person has been insured under the ECB health insurance for more than one year.

25.2 Spectacle lenses

- (a) Expenditure incurred for a pair of corrective spectacle lenses obtained on medical prescription is reimbursed at the rate of 85%. Expenditure incurred for non-corrective lenses, non-corrective sunglasses and lenses for work on a computer screen is not reimbursed.
- (b) The reimbursements referred to in point (a) shall only be granted:
 - (i) once per calendar year in the case of insured persons up to the age of 18, except where a medically qualified person certifies a change to the vision of an insured person; or
 - (ii) once per two calendar years for all other insured persons, except where a medically qualified person certifies a change to the vision of an insured person.

25.3 Spectacle frames

- (a) Expenditure incurred for the purchase of one frame per pair of corrective spectacle lenses is reimbursed at the rate of 85% up to a maximum eligible amount of EUR 210 per frame. Any unused amount may be used for repairing frames.
- (b) The amount referred to in point (a) shall only be granted:
 - (i) once per calendar year in the case of insured persons up to the age of 18; or
 - (ii) once per three calendar years for all other insured persons.

25.4 Contact lenses

- (a) Expenditure incurred for hard contact lenses, prescribed by a medically qualified person, is reimbursed at the rate of 85% up to a maximum eligible amount of EUR 250 per calendar year.
- (b) Expenditure incurred for soft contact lenses, prescribed by a medically qualified person, is reimbursed at the rate of 85%, up to a maximum eligible amount of EUR 150 per calendar year.
- (c) During any calendar year, the reimbursement for hard contact lenses excludes the reimbursement for soft contact lenses and vice versa.

25.5 Artificial eyes

Expenditure incurred for artificial eyes is reimbursed at the rate of 85%.

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26. Transport costs and travelling expenses

26.1 Without prejudice to Article 26.2, expenditure incurred for transportation of the insured person to the location where treatment is provided is reimbursed at the rate of 80%, after prior authorisation is obtained, as provided for in Article 16 of Annex III to the Staff Rules.

No such prior authorisation is necessary in the following cases:

- (a) if such transport was undertaken as a matter of urgency;
- (b) in the event of absolute medical necessity as certified by a medically qualified person prior to the transport.

26.2 Travelling expenditure incurred for the purpose of receiving in-patient treatment in a location other than where the insured person is employed or resides is reimbursed subject to prior authorisation as provided for in Article 16 of Annex III to the Staff Rules and only in the following cases:

- (a) in exceptional circumstances; or
- (b) where the sum of the travel expenses incurred and the expenditure incurred for treatments that take place in a location other than where the insured person is employed or resides, is significantly lower when compared to the expenditure that would have been incurred if the treatments were received in the location where the insured person is employed or resides.

26.3 Expenditure incurred for ambulance transport to the nearest suitable hospital in case of emergency is reimbursed at the rate of 100%.

27. Funeral expenses

In the event of death of an insured person, a lump sum of EUR 2 585 is paid to the legal heir(s).

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Appendix II**European Central Bank health insurance (Annex III to the Staff Rules)****List of serious illnesses**

The following medical conditions are considered to be “serious illnesses”:

- invalidating cerebrovascular accident;
- aplastic crisis;
- chronic and progressive (including coronary) arteriopathy with clinical ischemic manifestations;
- complicated bilharzia;
- badly tolerated congenital cardiopathy, severe cardiac insufficiency and severe valvulopathy;
- decompensated cirrhosis of the liver;
- serious primitive immunodeficiency syndrome requiring prolonged treatment and serious acquired immunodeficiency syndrome;
- insulin-dependent or non-insulin-dependent diabetes that cannot be controlled solely by diet;
- severe neuro-muscular affection (such as myopathy);
- homozygous hemoglobinopathy;
- hemophilia;
- severe arterial hypertension;
- myocardial infarction (occurring within the last six months);
- chronic severe respiratory insufficiency;
- leprosy;
- Parkinson's disease;
- hereditary metabolic diseases requiring prolonged special treatment;
- cystic fibrosis;
- chronic severe nephropathy and pure primitive nephrotic syndrome;
- paraplegia;
- polyarteritis nodosa, disseminated lupus erythematosus, progressive systemic scleroderma;
- severe progressive rheumatoid arthritis;
- psychosis, severe personality disorder, mental retardation;
- ulcerative colitis and progressive Crohn's disease;
- invalidating multiple sclerosis;
- progressive structural scoliosis (of which the angle equals or exceeds 25 degrees up to rachitic maturation);
- severe ankylosing spondylitis;
- consequences of organ transplantation;

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- active tuberculosis;
- neuromyelitis optica;
- malignant tumour, malignant affection of the lymphatic or haematopoietic tissue;
- amyotrophic lateral sclerosis;
- chronic pain syndrome;
- anorexia;
- bipolar disorder;
- Hodgkin's disease;
- ulcerative colitis with primary sclerosing cholangitis;
- major ischemic stroke;
- hepatitis B.