

Circular No. 368

Guide to cover under the healthcare insurance scheme (Article 83a Service Regulations and Implementing Rules thereto)

This circular contains a general description of the medical cover provided pursuant to section F of part I of the Implementing Rules for Articles 83a, 84 and 84a of the Service Regulations, as well as detailed information on the conditions for reimbursement of the costs of specific products and treatments. It is a compilation of the reimbursement policies that have been applied since the healthcare insurance scheme was set up.

This guide is not exhaustive. It focuses on those items which typically lead to questions or where special conditions apply. As medical technology is continuously evolving, new items will be added in the future as the need arises.

This guide is not limiting. If a particular product or treatment is not included, this does not mean that it does not qualify for reimbursement. In such cases, an assessment will be made by the administrator of the scheme (Cigna) to establish whether the product or treatment concerned meets the criteria for reimbursement (see "General criteria for reimbursement" and "Procedural aspects").

This circular shall apply as of 1 January 2025. The attached guide shall replace the previous version as from that date.

Munich, 12 December 2024.

The President of the European Patent Office



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Contents

Guide to cover under the healthcare insurance scheme

1.	General	3
2.	List of benefits	7
2.1	Fees	7
2.1.1	General practitioners and specialists	7
2.1.2	Licensed qualified medical service providers (other than doctors)	9
2.2	Pharmaceutical products	11
2.3	Hospitalisation	14
2.3.1	In-patient treatment	14
2.3.2	Out-patient treatment	17
2.3.3	Transportation	18
2.4	Special treatments and examinations	18
2.4.1	Pregnancy and childbirth	18
2.4.2	Laboratory/medical imaging	21
2.4.3	Physiotherapy, kinesitherapy and related treatments	21
2.4.4	Psychotherapy and psychoanalysis	22
2.4.5	Cures	24
2.4.6	Cancer screening	26
2.4.7	Vaccinations	26
2.4.8	Ambulatory treatment combinations (DBC) in the Netherlands	27
2.4.9	Gender reassignment treatment	27
2.5	Orthopaedic appliances and medical devices	27
2.5.1	Optical care	27
2.5.2	Hearing aids	29
2.5.3	Pacemakers	29
2.5.4	Other orthopaedic appliances and medical devices	29
2.6	Dental care	31
2.6.1	Dentists	31
2.6.2	Orthodontic care/dental prostheses	32
2.6.3	Preventive dental care	33
2.7	Funeral expenses	34

1. General

What	Definition
General criteria for reimbursement	<p>According to section A of part I of the Implementing Rules for Articles 83a, 84 and 84a of the Service Regulations, the aim of the EPO healthcare insurance scheme is to provide cover for medical treatment,¹ prescribed by medically qualified persons, resulting from illness, accident, pregnancy² or confinement. This cover includes the preventive measures and examinations listed in this guide.</p>
Procedural aspects	<p>In order to determine whether a certain act can be considered as a medical treatment, it is tested against:</p> <ul style="list-style-type: none"> - The principles of evidence-based medicine and the connection between the treatment and the underlying pathology and corresponding symptoms. The administrator of the scheme (Cigna) verifies whether the underlying pathology has been identified and is being treated (in as far as it can be treated). It then verifies whether the symptoms relating to the pathology are being/have been suppressed. - The appropriateness and necessity³ of the treatment (including frequency of sessions, length of stay in hospital, etc.) <p>As such, Cigna may ask you to provide, if available, a consultation summary from your healthcare provider, including a diagnosis and treatment recommendation.</p> <p>Consultations with healthcare providers can be in person, online and by phone.</p> <p>Notwithstanding the above, since the scheme was set up it has been agreed to reimburse the costs of some treatments and products which do not necessarily comply with these principles (e.g. homeopathy, acupuncture, etc.).</p> <p>In Germany all reimbursements are limited to a GOÄ or GOZ factor of 2.3 or, where justification is provided, up to a maximum GOÄ or GOZ factor of 3.5. Up to this maximum limit the healthcare provider should exercise "reasonable discretion" in fixing the fee, having due regard to the complexity of the treatment, the time needed for it,</p>

¹ Treatment: All examinations, procedures or measures carried out or required in order to restore health, as performed or prescribed by a doctor in accordance with generally accepted medical standards.

² Pregnancy: The term pregnancy is interpreted in its broadest sense and includes all medical care relating to pregnancy and childbirth.

³ See ILO-AT judgments 2063 and 1288 and EPO Circular No. 236.

What	Definition
	<p>the circumstances in which it is carried out and local conditions. As a general rule, the fee must lie within a narrower band of GOÄ or GOZ factor 1 to 1.8, or 2.3 times the basic rate (standard maximum). The standard maximum may be exceeded only if justified using the above-mentioned criteria, in which case the justifications must be submitted in writing (with the invoice).</p> <p>Travel expenses and surcharges for home and night visits are reimbursable in cases of medical necessity or medical emergency only. Prior approval is strongly recommended.</p>
Validity of prescriptions	One year (even for prescriptions referring to "permanent use"). ⁴
Deadline for submission of claims	All claims must reach Cigna within three years after the end of the year in which the invoice was issued. The application of section H of part I of the Implementing Rules for Articles 83a, 84 and 84a of the Service Regulations (formerly "Article 22") can also be requested three years back in time.
Insurance year	An insurance year is equal to a calendar year.
Reimbursement	<p>This guide provides more details on the coverage provided by the EPO healthcare insurance scheme. If you are still unsure after reading this guide or if your case is not described, please contact Cigna. As stated in Circular No. 236, to avoid disappointment, if you think you may be about to incur substantial medical costs and/or you are unsure about what exactly will be covered, you are advised to seek prior approval from Cigna. Prior approval is not required in cases of emergency.</p> <p>Some healthcare providers might request upfront payment (e.g. of admission fees, deposits) before the start of treatment. If you would like to avoid making any advance payments, contact Cigna to discuss alternatives (Cigna may, for example, be able to issue payment guarantees or advance payments on your behalf).</p> <p>Costs incurred in a currency other than EUR will be converted at the average exchange rate in force on the day reimbursement is processed. This conversion rate might under certain circumstances be disadvantageous to you (without there being any speculative intent). You may therefore request reimbursements of these costs in the original currency. In this case, since the costs are always converted first to EUR and then back to the original currency, the exact amount you receive might differ due to the applicable conversion rates.</p>

⁴ Validity of one year is based on the fact that regular follow-ups should be provided even in case of chronic conditions to guarantee that the patient is still receiving adequate treatment. It should also be noted that validity is not the same in all the member states (e.g. three months in Germany).

What	Definition
<p>Additional reimbursement under section H⁵ of part I of the Implementing Rules for Articles 83a, 84 and 84a of the Service Regulations</p>	<p>If, over a 12-month period, the amounts not reimbursed under section F as a result of the ceilings imposed and the 20% excess on certain expenses exceed 20% of the employee's average basic salary during those 12 months, the employee is entitled to an additional reimbursement.</p> <p>The additional reimbursement amounts to the difference between the overall amount not reimbursed and 20% of the said average monthly salary.</p> <p>For pensioners under the old pension scheme, the average monthly basic pension over 12 months is used as a reference instead of the basic salary.</p> <p>For pensioners under the new pension scheme, 70% of the last monthly basic salary is used as a reference instead of the pension.</p> <p>During periods of parental/unpaid/family leave, the average basic monthly salary is used in full as a reference.</p> <p>During periods of part-time work, extended sick leave or incapacity, the reduced monthly salary is used as a reference.</p> <p>See also Article 83a(6) ServRegs.</p>
<p>Long-term care insurance</p>	<p>The EPO provides a separate long-term care insurance scheme.</p> <p>This insurance is intended to provide financial support when an insured person's autonomy becomes seriously impaired on a long-term basis and they therefore need help carrying out everyday activities such as dressing, washing, eating and drinking, using the toilet and mobility.</p> <p>Non-medical appliances and services for long-term care purposes (e.g. stairlift, adaptation of the home, etc.) are <u>not</u> covered by the EPO healthcare insurance scheme.⁶</p>
<p>Prior approval</p>	<p>Prior approval by Cigna may be required for certain treatments or products or for cost estimates which exceed certain ceilings mentioned in this guide. The purpose of prior approval is to ensure that the claim is in fact reimbursable before the insured person incurs the costs concerned. This will avoid disappointment and protect the insured person from inappropriate treatment or overcharging. If prior approval is not sought (e.g. due to an acute situation), reimbursement may still be possible if Cigna's medical adviser can confirm the medical necessity and appropriateness of the treatment. Prior approval is not required in cases of emergency.</p>

⁵ Formerly Article 22 of the Collective Medical Insurance Contract.

⁶ See ILO-AT judgment 2976.

What	Definition
	<p>An emergency is a serious and unexpected situation involving illness or injury that may threaten someone's life, limb, or vital function and requires immediate action.</p>
<p>Disputes relating to reimbursement of medical expenses (Circular No. 236)</p>	<p>In case of disagreement over reimbursement, Circular No. 236 applies. Accordingly, you must first contact Cigna to clarify the matter (using the form on the Cigna website or by email). The matter will first be considered by Cigna's medical adviser. If the matter cannot be resolved, it will be escalated further to Cigna's medical director (chief medical officer). Cigna will inform you about the final result. No response from Cigna within two months of the objection being raised implies a confirmation of the original decision.</p> <p>If the original decision is confirmed by Cigna's senior medical consultant, you may refer the matter to the EPO within three months (Article 89 ServRegs). To do so please use the online form in MyFIPS. More information can be found on the intranet under Services > HR services > Social security > Cigna reimbursement disputes. Pensioners should contact Occupational Health Services and Wellbeing by phone (ext. 4040) or email (healthandsafety@epo.org). The matter will then be submitted to an EPO medical practitioner for a (first) medical opinion. All relevant medical information should be forwarded to the designated medical practitioner by online form, by post, in person or by email. You will also be asked to consent to the necessary exchange of relevant and confidential medical information.</p> <p>The medical practitioner will give an opinion based on the information you provide and in consideration of the opinion of Cigna's medical adviser and chief medical officer. The medical practitioner can also seek the opinion of a medical specialist. You can request access to the information taken into account for the medical opinion.</p> <p>You will then receive the decision on your request for reimbursement and the medical opinion on which the decision is based.</p> <p>If you disagree with the decision, you can request an additional (second) medical opinion within two weeks of receipt of the decision (Article 90 ServRegs).</p> <p>If the first and second medical opinions differ, a third medical opinion will be requested by the EPO. This third opinion will be final and binding.</p>

2. List of benefits

Section F of part I of the Implementing Rules for Articles 83a, 84 and 84a of the Service Regulations sets out the extent of cover and the reimbursement ceilings for medical expenses. This guide provides further information about how section F is applied in practice. As stated above, this list is not exhaustive, as medical technology is continuously evolving.

2.1 Fees

2.1.1 General practitioners and specialists

GENERAL RULE

Treatments should be given by medically qualified persons.

Reimbursement is subject to a maximum of EUR 2 249.69 per person per calendar year.

Item	Cover	Remarks
General practitioner consultations, night visits, home visits, second opinions, etc.	100%	
Routine paediatric examinations (e.g. "U- und J-Untersuchungen" in Germany)	100%	In Germany, examinations U1 to U11, J1 and J2 are covered. For examinations in Germany, if this information is not mentioned in the invoice, please provide Cigna with the examination number concerned.
Specialists	100%	In the Netherlands, where part of a "Diagnose Behandelend Combinatie" (DBC), reimbursement is 97% (see 2.4.8).
Consultations with a psychiatrist without further psychotherapy on the same day.	100%	Psychotherapy is reimbursed under 2.4.4.
"Heilpraktiker", homeopaths, anthroposophic therapists and the like	100%	Homeopaths in the Netherlands and "Heilpraktiker" in Germany are equivalent for the purposes of the scheme. Psychotherapy provided by a "Heilpraktiker" is covered only if the "Heilpraktiker" has an appropriate qualification in psychotherapy. It is reimbursed under 2.4.4.

Item	Cover	Remarks
Medical procedures		
Medical procedures performed by a doctor	100%	"Eigenbluttherapie", ⁷ "Reinfusionen" and "Sauerstoff-Mehrschritt-Therapie" are normally <u>not</u> covered. ⁸
Acupuncture performed by a doctor	100%	If performed by a recognised acupuncturist, see 2.1.2.
Allergy testing and treatment	Medical procedure: 100% Product: 80%	For example, skin allergy tests (e.g. scratch tests) and allergen immunotherapy administered by a doctor with the aim of desensitisation.
"Aderlass" or bloodletting	100%	Covered for example in cases of hemochromatosis or polycythaemia. In other cases prior approval is recommended. ⁹
Chemical peeling	100%	Reimbursable where there is an underlying medical problem, such as, for example, acne and rosacea.
"Extrakorporale Stoßwellentherapie" (shock wave therapy - ESWT)	100%	If not performed by a doctor a prescription is required. Reimbursable for all orthopaedic pathologies.
Ozone therapy	See 2.4.3 Physiotherapy and kinesitherapy.	
Hyaluronic acid injections	Medical procedure: 100% Product: 80% (see 2.2 Pharmaceutical products).	Reimbursable for the treatment of all joints for certain diagnoses such as arthrosis.
Platelet-rich plasma (PRP)/ autologous conditioned plasma (ACP) therapy	Medical procedure: 100% Product: 80% (see 2.2 Pharmaceutical products).	Reimbursable for orthopaedic diagnoses, for healing purposes and for medically indicated plastic surgery.

⁷ A distinction is made between "Eigenbluttherapie" and medically indicated pre-operative autologous blood cell and platelet donation, autotransfusion or dialysis, which are reimbursed.

⁸ According to general medical opinion there is no (evidence-based) consensus on the effectiveness of these treatments. Please check first with Cigna if they are reimbursable for certain pathologies.

⁹ According to general medical opinion there is no (evidence-based) consensus on the effectiveness of these treatments. Please check first with Cigna if they are reimbursable for certain pathologies.

Item	Cover	Remarks
Botulinum toxin therapy	Medical procedure: 100% Product: 80% (see 2.2 Pharmaceutical products).	Only in cases of medical necessity, e.g. for very serious muscle spasms/overactive muscles, hyperhidrosis, neurological disorders, gastrointestinal issues, urological and ophthalmologic diagnoses. Prior approval is required. Not eligible for reimbursement if used for cosmetic purposes.
Administrative expenses		
Travel expenses and surcharges for a doctor for home and night visits	100%	Only in cases of medical necessity, e.g. due to incapacity to move or medical emergency. Prior approval is strongly recommended.
Ambulatory DBC ("Diagnose Behandelend Combinatie")/ ambulatory treatment combinations	97%. See 2.4.8 Ambulatory treatment combinations (DBC).	Medical procedures, medical products and administrative expenses covered under ambulatory DBCs are reimbursed under 2.4.8.
Compulsory annual subscription fees for healthcare providers	Depends on category of expenses (doctor, dentist, etc.).	For example in the Netherlands.
Pharmaceutical products and materials used by a doctor		
Pharmaceutical products and materials used by a doctor within the framework of an ambulatory treatment	See 2.2. Pharmaceutical products.	Reimbursable at 80% under 2.2.

Items which are typically not covered: Appointments not attended, postal and administrative expenses (including shipping costs), pre-recruitment medical examinations, "Organometrie".

2.1.2 Licensed qualified medical service providers (other than doctors)

GENERAL RULE

A doctor's prescription is required for treatment given by a person holding a paramedical degree (e.g. nurse, speech therapist, dietician, etc.)

Reimbursement is subject to an overall maximum of EUR 843.64 per person per calendar year.

Physiotherapy is covered as set out in 2.4.3.

Item	Cover	Remarks
Speech therapy by speech therapist ("Logopädie")	80%	<p>Covered in cases of medical necessity such as shortened lingual frenulum, stroke, significant developmental disorders, hearing difficulties, stuttering, etc.</p> <p>Prior approval is required.</p> <p>Other cases not based on medical necessity, such as delayed speech development before the age of four years, are not covered.</p>
Educational therapy carried out by medical, paramedical and educational specialists	80%	<p>Reimbursable in cases of developmental disorders.¹⁰</p> <p>Prior approval is required.</p>
Applied behaviour analysis (ABA) therapy	80%	<p>Reimbursable for children with an autistic disorder.</p> <p>Prior approval is required, based on a medical report from the therapist. A follow-up report is required every six months. Maximum of three years.</p>
Medical pedicure	80%	<p>Covered for example in cases of diabetic feet, ingrown nails and warts.</p> <p>Persons with medical or paramedical qualifications include e.g. podiatrists, providers of "medizinische Fußpflege" in Germany, and providers of pedicures in the Netherlands.</p>
Dietician	80%	<p>Covered for example in cases of severe obesity (i.e. BMI > 30), diabetes, bowel-related diseases or Crohn's disease.</p> <p>The number of reimbursable sessions is dependent on the appropriateness and medical necessity given the underlying pathology. Prior approval is recommended.</p>
Eye test to determine dioptre by optometrist or optician	80%	
Hearing test by audiologist / audiometrist to determine level of hearing loss	80%	

¹⁰ Examples include reading disability/dyslexia, mathematics disability/dyscalculia, writing disability/dysgraphia, speech disorders, autism, attention deficit hyperactivity disorder (ADHD), emotional and behavioural disorders.

Item	Cover	Remarks
Auditory integration training	80%	This is related not to hearing aids but to the treatment of cognitive and/or behavioural problems, etc. Patients learn to be less disturbed by certain sounds (i.e. they learn to hear in a more normal way).
Bio-mechanical stimulation treatment	80%	
Acupuncture carried out by a recognised acupuncturist	80%	Reimbursement is limited to medical acupuncture. In the Netherlands, reimbursable if carried out by an acupuncturist recognised by the Dutch acupuncturist association ("Nederlandse vereniging voor Acupunctuur"). Reimbursable under 2.1.1 if performed by a doctor.

Items which are typically not covered because in general they do not treat a pathology: Medical supervision other than by a nurse ("garde-malade"), curative/therapeutic eurhythmy, Ayurveda, colon hydrotherapy, foot reflexology, MORA therapy, kinesiology, Moerman therapy, "sensomotorische Körpertherapie",¹¹ haptonomy/haptotherapy, chelation therapy, AtlasPROfilax, fitness or sports, swimming pool subscriptions, permanent laser epilation, domestic help / custodial care.¹²

2.2 Pharmaceutical products

GENERAL RULE

All pharmaceutical products must be prescribed by a qualified doctor, Heilpraktiker (in Germany), homeopath (in the Netherlands), or the like.

Item	Cover	Remarks
Pharmaceutical products	80%	Materials used as part of an ambulatory treatment (i.e. not in an operating theatre), such as bandages, disinfectants, etc., are also reimbursed as pharmaceutical products.
Aerosol inhaler (e.g. PARI BOY)	80%	Rental is reimbursed, unless it would be cheaper to buy. Purchase instead of rent is always reimbursable if a chronic condition exists.

¹¹ "Sensomotorische perzeptive Therapie" is however reimbursable as ergotherapy (see 2.4.3).

¹² Domestic help / custodial care (assistance with activities of daily living) may be covered by the long-term care insurance if the overall assessment results in granting a benefit.

Item	Cover	Remarks
Metered dose inhaler for asthma prescribed by a doctor	80%	
Glucose meter, material for diabetes	80%	
Self-monitoring of coagulation status (e.g. CoaguChek)	80%	Covered for example for mechanical heart valve replacements, heart rhythm disorders not controlled by medication or pacemakers, DVT (deep venous thrombosis) and lung embolisms, and when anti-coagulants are prescribed.
Sphygmo(mano)meter	80%	
Allergen immunotherapy products	80%	An allergy test is recommended to clarify the need before starting the therapy.
Chinese medicines	80%	
Phytotherapy	80%	
Homeopathy	80%	Homeopathic injections are <u>not</u> covered.
Food/nutritional supplements	80%	Covered in cases of medical necessity (e.g. glucosamine, MSM (methylsulfonylmethane) and chondroitin in the case of cartilage deterioration).
Probiotics	80%	Covered in cases of medical necessity (e.g. during or after the use of antibiotics)
Vitamins and minerals	80%	Covered in cases of medical necessity
Food or baby food in cases of metabolic disorder	80%	Reimbursable in very serious cases only. <u>Not</u> reimbursable in cases of, for example, lactose intolerance.
Anorectic agents (e.g. Xenical)	80%	Reimbursable only in cases of long-term obesity (BMI > 30), co-morbidity and child obesity (BMI > 30).
Contraceptives	80%	
Hair tonics, medical shampoo	80%	Reimbursable only if there is an underlying medical problem (e.g. corticosteroids, PUVA therapy, topical immunotherapy or minoxidil (for women) may be reimbursable).
Skin care products	80%	Reimbursable only if there is an underlying medical problem.
Growth hormones	80%	Reimbursable only if there is an underlying medical problem.

Item	Cover	Remarks
Bisphosphonates or diphosphonates (medication to treat osteoporosis, such as Fosamax, Evista, etc.)	80%	<p>The result of a BMM (bone mass measurement) taken before the treatment starts and mentioning the T- and Z-scores must be provided.</p> <p>Reimbursable only if the BMM results show that the patient is suffering from osteoporosis (i.e. if the T-score is -2.5 or below and the Z-score is -1.0 or below). Reimbursement of such products is limited to a period of five years.</p>
Emtricitabine and tenofovir disoproxil fumarate (Truvada) for pre-exposure prophylaxis (PrEP)	80%	<p>Reimbursable only for extremely high-risk groups, e.g. HIV serodiscordant couples where the seropositive partner has not yet undergone an antiretroviral therapy or where the results of the latter have so far been unsuccessful, or for persons in high-risk jobs where the employer, who should normally cover occupational risks, does not provide cover.</p> <p>Also reimbursable during pregnancy and while breastfeeding for HIV serodiscordant couples.</p> <p>Prior approval is required.</p>
Emtricitabine and tenofovir disoproxil fumarate (Truvada) for post-exposure prophylaxis (PEP)	80%	Reimbursable after HIV exposure or infection following a risky activity as certified by the patient's doctor.
Medication against alcohol addiction (e.g. Campral, Antabus, Refusal, etc.)	80%	Reimbursable only as a support when undergoing detoxification.
Medication to (temporarily) treat impotence (Viagra, Cialis, Levitra, Uprima, Ixense, Sildenafil, etc.)	80%	<p>Reimbursable only in the following cases:</p> <ul style="list-style-type: none"> - After a nerve-conserving radical prostatectomy (i.e. in most cases a complete removal of the prostate, the seminal vesicles and the lymph glands of the smaller pelvis, mostly following cancer). - In cases of diabetic neuropathy and/or arteriopathy. - In cases of degenerative neuropathy. <p>For all other diagnoses, a medical report should be provided.</p>
DHEA hormones (dehydroepiandrosterone)	80%	Reimbursable only if there is an underlying medical problem (<u>not</u> for e.g. anti-aging treatment).

Item	Cover	Remarks
Substitutes for Class A-type controlled ¹³ drugs (e.g. methadone)	80%	Reimbursable only if there is an underlying medical problem and if part of a treatment.
Items which are typically <u>not</u> covered: Nicotine substitutes, non-medical toothpaste, tonic wines and beverages, products for cosmetic, hygienic, aesthetic or dietary purposes or for personal comfort, organotherapy products.		

2.3 Hospitalisation

2.3.1 In-patient treatment

Item	Cover	Remarks
Fees for surgeon, anaesthetist, assistant, etc.	100%	
In-patient stays	100% of the cost of a semi-private room (two-bed room). In cases of medical necessity: 100% of a private room in the lowest price category available. If the patient is admitted to a facility which does not have semi-private rooms, coverage will be 80% of the price of the lowest price category available for a private room (excluding all other items of the bill, such as fees, medication, etc.).	Where a private room is chosen, the difference between the cost of a semi-private room and a private room can be carried forward for additional reimbursement under section H of part I of the Implementing Rules for Articles 83a, 84 and 84a ServRegs.
ICU or an incubator	100%	
Accompanying person	Limited to one accompanying person, 80% reimbursement of the additional costs.	For children under the age of 12 only.
Transplants: registration fees	100%	
Transplants: pre-operative testing	100%	
Transplants: costs for donor if insured is recipient	Hospital stay coverage is applied.	
Transplants: costs for donor if insured is donor	Not covered.	

¹³ Commonly referred to as "hard drugs"; for example substances listed as Class A drugs in the UK Misuse of Drugs Act.

Item	Cover	Remarks
Transplants: urgent transport to clinic (e.g. helicopter)	100%	In general, for reasonable distances, on a case-by-case basis.
Separate nurse during hospitalisation	100%	Reimbursable only in cases of medical necessity or where customary in a particular country.
Surgery for chronic venous disease	100%	Endovascular surgery and vein stripping do not require prior approval. Prior approval is required for endovenous ablation therapy and you must also provide a CEAP (clinical, etiologic, anatomic, pathophysiologic) classification and a pre-operative Echo Doppler.
Hospital stay for intensive physiotherapy	100% for treatment. 100% for the stay, limited to a semi-private room.	Reimbursable only in cases of medical necessity. Some institutions provide very intensive physiotherapy for a limited period of time to avoid surgery or to treat patients who cannot be helped by surgery.
Removal of defective breast implants	100%	Regardless of the original cause (aesthetic/medical). For example, PIP implants.

Special institutions, institutional care and drug and alcohol abuse

Rehabilitation or convalescence after an intervention or serious illness, e.g. surgery, cancer treatment, stroke treatment	Stay: 100%, up to the cost of a semi-private room. If the facility does not have semi-private rooms, 80% of the cost of a room in the lowest price category available for private rooms (excluding all other items on the bill, such as fees, medication, etc.). Treatment: 100%.	A medical report is required. The difference in cost between a semi-private room and a private room can be carried forward for additional reimbursement under section H of part I of the Implementing Rules for Articles 83a, 84 and 84a ServRegs.
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Item	Cover	Remarks
Palliative care	In-patient stay/treatment in a hospice or special palliative care centre: 100%. Out-patient palliative treatment (e.g. by a palliative care team or out-patient hospice service): 100%.	Palliative centres and hospices normally only have private rooms (possible for family to stay with patient).
Home for the elderly, nursing home or institution for people with disabilities	Stay: not covered. Treatments: depends on the type of treatment. If the institution does not distinguish between medical costs and non-medical care-related costs, 40% of the invoice is reimbursed under the healthcare insurance scheme, unless the institution can prove that the percentage is higher.	Any remaining costs (non-medical care-related costs and costs related to the stay) might be financed by the long-term care insurance if the overall assessment results in granting benefits. For further details, please contact Cigna. The same cover applies to home care by a medical service provider.
In-patient alcohol and drug dependency treatment	Stay: 100% Fees: 100%	Reimbursable only in cases of treatment in a recognised medical facility. Limited to 100% of the cost of a semi-private room. The difference between the cost of a semi-private room and a private room can be carried forward for additional reimbursement under section H of part I of the Implementing Rules for Articles 83a, 84 and 84a ServRegs.

Items which are typically not covered: Clinics for various types of fasting (e.g. Buchinger or F.X. Mayr clinics) are not covered as in-patient treatments or for A and B cures. In very rare cases exceptions can be made for very serious metabolic conditions where all out-patient treatments have failed.

2.3.2 Out-patient treatment

Item	Cover	Remarks
Out-patient chemotherapy	100%	All fees, medication, use of material.
Out-patient radiotherapy	100%	
Out-patient haemodialysis	100%	
Out-patient surgery ¹⁴	100%	
Minor out-patient surgery	See cover for specialists under 2.1.1 General practitioners and specialists.	Minor surgery means that the use of a conventional operating theatre is not required.
Surgery for chronic venous disease	100%	<p>Prior approval is required for phlebotomy and sclerotherapy. You must provide a CEAP (clinical, etiologic, anatomic, pathophysiologic) classification and a pre-operative Echo Doppler.</p> <p>Superficial laser therapy used for spider or reticular veins is considered cosmetic and is therefore excluded.</p>
Out-patient rehabilitation/day clinic treatment ¹⁵	100% for treatment and meals invoiced by the medical centre.	<p>Reimbursable in cases of medical treatment carried out in a qualified outpatient centre and equivalent to in-patient treatment.</p> <p>Prior approval is required. Rehabilitation treatments must be for at least 6-8 hours/day and at least five days/week.</p> <p>Duration: three weeks maximum (extension possible only with approval of Cigna).</p>

¹⁴ Out-patient surgery: Surgery requiring the use of a conventional operating theatre and performed on an in-and-out same-day basis without an overnight stay.

¹⁵ Treatment in a hospital for which the patient does not have to stay overnight but for which room charges are applicable.

2.3.3 Transportation

GENERAL RULE

Reimbursable only in cases of in-patient admissions, out-patient surgery, chemotherapy, radiotherapy, haemodialysis or upon proven medical necessity.

Item	Cover	Remarks
Ambulance	100%	Also reimbursable in cases of emergency.
Medical transport by professional services other than ambulance	100%	
Taxi	100%	The taxi must be medically necessary and be prescribed by a qualified and registered doctor. Not for out-patient treatments.

Items which are typically not covered: Search & rescue, own transportation, public transportation, repatriation of patient to home country, repatriation of deceased person.

2.4 Special treatments and examinations

2.4.1 Pregnancy and childbirth

GENERAL RULE

All medicines and treatments must be prescribed by qualified and registered doctors. Exception: A doctor's prescription is not required for midwife services for prenatal care and for postnatal care for eight consecutive days following delivery.

Item	Cover	Remarks
Confinement other than in a hospital or clinic	100%	
Confinement in a hospital or clinic	See item 2.3 Hospitalisation.	
Caesarean	100%	
Amniocentesis, chorionic villus sampling or "Chorionzottenbiopsie"	100%	Reimbursable for example in cases of medical necessity, or for women over the age of 35 in all cases, and after the procedure has been explained by a doctor.
Prenatal care by midwife	100%	
Postnatal care by midwife for eight consecutive days following delivery	100%	

Item	Cover	Remarks
Postnatal care by midwife for any time in excess of eight days following delivery	100% reimbursement under 2.1.1 General practitioners and specialists.	Doctor's prescription needed.
Maternity care/ assistance ("kraamzorg"), i.e. medical and domestic help	100%, up to a maximum of EUR 3 504.60 ¹⁶ per person per calendar year, for a maximum of 65 hours and a maximum of 15 days after the day of delivery.	For each supplementary day in hospital after the delivery, the maximum number of hours is reduced by eight and the maximum amount reduced by EUR 420.42. In countries where midwives deal with medical issues only, domestic help in the form of cooking, childcare, shopping and cleaning carried out by a professional service-provider may be reimbursable.
Maternity packs for home delivery ("kraampakket")	80%	Reimbursable only in cases of home delivery.
Home nurse/other medical expenses	80% up to EUR 843.64 per person per calendar year.	
Pre- and postnatal exercises	See cover for physiotherapy under 2.4.3 Physiotherapy and kinesitherapy.	Prescription needed. For the mother only (<u>not</u> for the father).
SIDS monitors (cot/crib death)	See 2.5.4 Other orthopaedic appliances.	
Abortion	Medical fee: 100% Stay in medical establishment: 100% Medication: 80% Hospital expenses: see 2.3 Hospitalisation.	Reimbursable if linked to a pathology, e.g. in the case of a life-threatening situation for the mother, psychological pathologies, or if the foetus is not viable or it has a genetic abnormality (determined through chromosome examination). Depending on national legislation, it may only be allowed under certain conditions, or may be illegal.
Laboratory tests	100%	For example, Rh factor, antibody titer, HIV (AIDS), diabetes, smear tests, toxoplasmosis tests.

¹⁶ Amount for 2025, adjusted annually in accordance with the Harmonised Index of Consumer Prices produced by Eurostat (European Union global index) for the month of October in the preceding year (see EPO Circular No. 260).

Item	Cover	Remarks
Fertility treatment		
IVF (in-vitro fertilisation), ICSI (intracytoplasmic sperm injection), etc.	Hormone treatment: 80% Pick-up: 100% Transfer: 100%	Reimbursable in cases of physical pathologies. In the case of artificial insemination a physical pathology is not a prerequisite.
Artificial insemination	See cover for specialists under 2.1.1 General practitioners and specialists.	Reimbursable only up to three attempts per successful pregnancy. If the pregnancy is interrupted but lasted for at least 26 weeks, three additional attempts are reimbursable. For persons aged 45 and under. Costs are only reimbursable for medical procedures carried out on the insured person, i.e. not on an uninsured partner, even if they are the source of the medical issue.
Cryoconservation of egg or sperm cells	80% See cover for laboratory fees under 2.4.2 Laboratory/medical imaging.	Reimbursable only in case of serious illness, e.g. a cancer that affects fertility. Cell pick-up is also covered under this item. For persons aged 45 and under.

Items which are typically not covered: Surrogate mothers, birth premiums, adoption premiums, "Rufbereitschaftspauschale"/"Säuglingspflegekurse", yoga, swimming, haptonomy, "Partnergebühr", contraceptives (except those reimbursed under section 2.2), sterilisation, reversal of sterilisation, egg donation, donor semen, vasectomies, costs related to the use of contraceptives.

2.4.2 Laboratory/medical imaging

Item	Cover	Remarks
Laboratory tests	80% In the Netherlands, if it is part of a DBC, reimbursement is 97% (see 2.4.8).	Genetic tests are reimbursed on a case-by-case assessment of the medical necessity (i.e. how it impacts the management of the insured person's condition). Prior approval is recommended.
Laboratory tests during pregnancy	See 2.4.1 Pregnancy or childbirth.	
X rays, CT scans, MRI, ECG, etc.	100%	
Histological tests	100%	

2.4.3 Physiotherapy, kinesitherapy and related treatments

GENERAL RULE

A doctor's prescription is required for treatment given by a person holding a paramedical degree (e.g. physiotherapist).

Reimbursement is subject to an overall maximum of EUR 562.43 per person per calendar year.

In the Netherlands, no prescription is needed for physiotherapy, chiropractic, manual therapy, Mensendieck therapy, Cesar therapy and osteopathy, because of the nature of the qualifications of the physiotherapists/osteopaths carrying out these treatments.

Item	Cover	Remarks
Physiotherapy	100%	This includes medical acts such as inhalation, "Krankengymnastik" (KG), medical massage (KMT), "Bindegewebsmassage" (BGM), "Chirogymnastik" (CHG), "hydroelektrische Bäder" (HEB), "gerätegestützte Krankengymnastik" (KG-Gerät), "Kältetherapie" (KT), manual therapy (MT), "Periostmassage" (PM), "Segmentmassage" (SM), "Traktionsbehandlung" (TR), "Unterwasserdruckstrahlmassage" (UWM), "Übungsbehandlung" (ÜB), hydrotherapy/ "packings", "Wärmebehandlung" (WT), "Elektrotherapie" (ET), "Elektrostimulation" (EST), light therapy. Radontherapy is reimbursable only if part of an A cure. If physiotherapy is carried out by a doctor, it

Item	Cover	Remarks
		falls under doctor's fees (see 2.1.1).
Osteopathy, chiropractic	100%	
Rolfing	100%	Reimbursable only if the caregiver is a certified physiotherapist, doctor or "Heilpraktiker".
Spinal fitness training (e.g. MedX system)	100%	Reimbursable only if the treatment is given by a specially trained therapist and under supervision of a doctor.
"Pulsierende Magnetfeldtherapie" (PMT)	100%	Reimbursable only where justified by the pathology, e.g. hip, shoulder or knee pathologies, after accidents, etc. The treatment must be given by a doctor.
"Pulsierende Signaltherapie" (PST)	100%	
Ozone therapy	100%	Only in cases of arterial affection. A prescription is required.
Sophrology	Not covered	
Etiopathy	Not covered	
Occupational therapy/ ergotherapy	100%	Reimbursable in cases of serious mental, physical and/or cognitive impairment which have existed since birth, are genetic or are due to illness, injury or accident. Prior approval is required.

2.4.4 Psychotherapy and psychoanalysis

GENERAL RULE

With the exception of DBC in the Netherlands, prior approval, based on a request from a qualified specialist, including diagnosis and proposed number of sessions, is required for therapy/analysis in excess of 10 sessions.

A report on the medical necessity of the therapy/analysis must be submitted to Cigna if the therapy exceeds 40 sessions. Cigna will indicate the number of additional sessions granted. Further possible extensions will be assessed on the basis of evaluation reports.

To facilitate the prior approval process, two templates are available on the Cigna website.

In the Netherlands, prior approval is not required for treatments which are part of a DBC invoice. Such cases are reimbursed under 2.4.8.

Reimbursement is subject to a maximum of EUR 1 406.06 per person per calendar year.

Item	Cover	Remarks
Consultation with a psychiatrist without further psychotherapy on the same day.	See 2.1.1 General practitioners and specialists.	
Psychotherapy performed by a psychiatrist	100%	Reimbursable only where justified by the pathology. Prior approval is strongly recommended for therapy in excess of 10 sessions, especially for children.
Psychotherapy performed by a psychotherapist or psychological psychotherapist or "Heilpraktiker"	100%	Reimbursable only where justified by the pathology. Prior approval is strongly recommended for therapy in excess of 10 sessions, especially for children. Covered only if the "Heilpraktiker" has an appropriate qualification in psychotherapy.
Psychoanalysis performed by a psychiatrist, psychotherapist or psychological psychotherapist	100%	Reimbursable only where justified by the pathology, up to a maximum of three sessions per week. Prior approval is required for analysis in excess of 10 sessions.
Cognitive-behavioural therapy (CBT)	100%	Reimbursable only where justified by the pathology (e.g. anxiety disorders, depression, eating disorders, chronic pain, personality disorders, substance use disorders, attention deficit hyperactivity disorder (ADHD)). Prior approval is strongly recommended for therapy in excess of 10 sessions.
Bio-feedback treatment (including neuro-feedback)	100%	Reimbursable only where justified by the pathology, e.g. incontinence, bruxism, anxiety disorders, depression, chronic pain, migraine, attention deficit hyperactivity disorder (ADHD).
Relationship therapy	100%	Reimbursable only for individuals (not couples) within the context of a broader medical problem (e.g. depression).

Item	Cover	Remarks
Treatment of phobias	100%	
"Autogenes Training" and "übende Verfahren"	100%	Reimbursable only where justified by the pathology.

Items which are typically not covered (this list is not exhaustive): Hypnosis, play therapy, dog therapy, art therapy, paint therapy, hagiography therapy, hippotherapy (exception: if performed by a physiotherapist, see 2.4.3), music therapy. Some of these medical acts may be reimbursable if part of a wider-ranging in-patient treatment.

2.4.5 Cures

GENERAL RULE

All treatments must be prescribed by qualified and registered doctors.

Cures must start within six months of the date of the prescription.

Item	Cover	Remarks
Cure of absolute medical necessity ("A cure"): stay	100% for board and lodging up to a maximum corresponding to the daily subsistence allowance (DSA).	<p>The approval of the medical practitioner appointed by the Office is required before the start of the cure.</p> <p>Only medically acceptable treatments carried out by medical/paramedical staff qualify for reimbursement.</p> <p>The cure centre has to be a clinic or a centre under medical direction and supervision 24/7 and appropriate to the pathology to be treated.</p> <p>In exceptional cases, if accommodation in the cure establishment is not possible, hotel costs (board and lodging) are reimbursed up to a maximum corresponding to the DSA. The DSA can only be paid upon receipt of an official invoice proving that expenses for the stay were incurred.</p>
Cure of absolute medical necessity ("A cure"): treatment (incl. doctors' fees, medication, etc. during the cure)	100%	An accompanying person may be reimbursed upon prior approval from Cigna's medical adviser only if the person to be accompanied is a child younger than 12 years of age.

Item	Cover	Remarks
Five-yearly cure ("B cure"): stay	<p>Where the cure is followed by one person from the same household: 50% of the DSA per day.</p> <p>Where the cure is followed by two or more people from the same household: 80% of the DSA.</p>	<p>The approval of Cigna is required before the start of the cure.</p> <p>A prescription from the doctor treating the patient is required.</p> <p>Maximum of one cure per person per five calendar years and a maximum of 21 calendar days per cure. The first claim for reimbursement can be made at any time. Any subsequent claim can be made five years after the last claim.</p> <p>Only medically acceptable treatments carried out by medical/paramedical staff qualify for reimbursement. The treatment plan must include at least two treatments per day (not including weekends).</p> <p>The cure centre must be under medical supervision.</p> <p>If the patient stays in a facility other than a cure hotel, the DSA can only be paid upon receipt of an official invoice proving that expenses for the stay were incurred.</p>
Five-yearly cure ("B cure"): treatment (incl. doctors' fees, medication, etc. during the cure)	100%	<p>The medical practitioner appointed by the Office provides their opinion on the medical necessity of the cure only for the purposes of granting 50% sick leave.</p> <p>Stays in mobile homes or on campsites are not accepted.</p>

Items which are typically not covered (this list is not exhaustive): Transport is not covered. The term "board and lodging" in relation to cures refers to the cost of the room and food. It does not cover items such as alcoholic beverages, telephone bills, pay TV, laundry, etc., which are considered to be personal expenses additional to the cost of the room. Clinics for various types of fasting (e.g. Buchinger or F.X. Mayr clinics) are not covered as in-patient treatments or for A and B cures. In very rare cases exceptions can be made for very serious metabolic conditions where all out-patient treatments have failed.

Claims for reimbursement sent to Cigna: the invoice has to indicate separately (a) the doctors' fees, (b) the date and cost of individual treatments, and (c) the cost of the accommodation.

Daily Subsistence Allowance (DSA): the relevant DSA is the one applicable in the country where the cure centre is located. For a list of DSAs see the Service Regulations, Annex V, second column

Further information about cures is available on the EPO intranet under "Health and Safety".

2.4.6 Cancer screening

Item	Cover	Remarks
Mammography	100%	
Colonoscopy	100%	Reimbursable in cases of a suspected pathology. Also reimbursable every ten years from the age of 50 or, in case of family history, ten years before the age at which the family member was diagnosed.
PAP smear	100%	Reimbursable for a maximum of one smear per year.
Preventive prostate cancer test	100%	Physical prostate cancer test, reimbursable once a year. Prostate-specific antigen (PSA) test, reimbursable once every two years.
Preventive skin cancer screening	100%	Reimbursable for a maximum of one screening per year.

Items which are typically not covered: Complete check-ups. The EPO organises a free medical examination once every three years for staff below the age of 48, and every two years for staff aged 48 or over (see Circular No. 81). For more information contact Occupational Health Services and Wellbeing.

2.4.7 Vaccinations

GENERAL RULE		
All vaccinations must be prescribed by qualified and registered doctors.		
Item	Cover	Remarks
Standard vaccinations, e.g. measles, polio	80%	Excluding vaccinations required by the authorities of countries to which the insured person wishes to travel (see section F of part I of the Implementing Rules for Articles 83a, 84 and 84a ServRegs, point 4.10).
Annual influenza vaccinations	80%	Also provided by the EPO in annual vaccination campaigns (free of charge for staff members).
Preventive HPV (human papilloma vaccination) against cervical cancer	80%	

2.4.8 Ambulatory treatment combinations (DBC) in the Netherlands

Item	Cover	Remarks
Ambulatory DBC ("Diagnose Behandelend Combinatie")	97%, with no maximum.	See EPO Circular No. 315: When a DBC is performed at a hospital, Cigna pays 100% of the invoice direct to the hospital and claims 3% of the amount (provided this 3% is greater than EUR 50) from the insured person.

2.4.9 Gender reassignment treatment

GENERAL RULE		
<p>Prior approval is required for all gender reassignment treatments. Please provide the following information: psychiatric evaluation report, treatment plan, endocrinological assessment and a medical report from the surgeon who will perform the gender reassignment surgery, including proof of social gender role transition.</p>		
Item	Cover	Remarks
Hormonal treatment	See 2.2	<p>Prior approval is required. Minimum age for surgery is 18 years. Contact Cigna, who will tell you what information you need to provide.</p>
Psychological assessment and treatment	See 2.1.1 and 2.4.4	
Gender reassignment surgery	See 2.3	

2.5 Orthopaedic appliances and medical devices

2.5.1 Optical care

Item	Cover	Remarks
(Disposable) contact lenses	80%	
Spectacle lenses (glasses or sunglasses with dioptré)	80%	Reimbursable max. two pairs per person per two calendar years, starting from 1 January 2020. Lenses reimbursed as a result of a change in dioptré (minimum 0.25) or for any other medical reason are

Item	Cover	Remarks
		excluded from the above limitation of max. two pairs per person per two calendar years.
Frames	EUR 42.19 per person per two calendar years, starting from 1 January of the employee's year of entry into service.	
Computer glasses	<p>Computer glasses are not reimbursed under the healthcare insurance scheme but processed by Cigna using a dedicated EPO budget.</p> <p>Lenses: 100%</p> <p>Frames: EUR 42.19</p> <p>One pair per two calendar years, starting from 1 January of the employee's year of entry into service.</p> <p>Deadline for submission: six months (Article 76(3) ServRegs).</p>	<p>Not reimbursable for family members or pensioners.</p> <p>Lenses and frames reimbursed as a result of a change in dioptre (minimum 0.25) or for any other medical reason are excluded from the above limitation of max. one pair per two calendar years.</p> <p>Please submit your claim to Cigna for reimbursement.</p>
Magnifying glasses	80%	A prescription and a medical report are required.
Eye test by ophthalmologist to determine dioptre	See cover for specialists under 2.1.1 General practitioners and specialists.	
Eye test by optometrist or optician to determine dioptre	See 2.1.2 Licensed qualified medical service providers (other than doctors).	
Lasik/keratotomy and other procedures to change the dioptre	100%	

Items which are typically not covered (this list is not exhaustive): Sports glasses, fluid for contact lenses, eye tests for driving licence/employment, etc. by an ophthalmologist or optometrist, sunglasses without dioptre.

2.5.2 Hearing aids

Item	Cover	Remarks
Hearing aids (external)	80% up to a maximum of EUR 281.22 per hearing aid (per ear), including batteries.	80% up to a maximum of EUR 281.22 for repairing a hearing aid.
Hearing test by audiologist / audiometrist to determine level of hearing loss	See 2.1.2 Licensed qualified medical service providers (other than doctors).	
Hearing test by ENT specialist to determine level of hearing loss	See cover for specialists under 2.1.1 General practitioners and specialists.	

Items which are typically not covered (this list is not exhaustive): hearing test by audiologist / audiometrist or ENT specialist for driving licence/employment, etc.

2.5.3 Pacemakers

Item	Cover	Remarks
Pacemaker	100%	

2.5.4 Other orthopaedic appliances and medical devices

GENERAL RULE

All appliances and digital health apps must be prescribed by qualified and registered doctors.

An orthopaedic appliance is something carried on or by the body in order to replace or support the function of a limb. Wheelchairs are one example.

Reimbursement is subject to a maximum of EUR 562.43 per person per calendar year.

Item	Cover	Remarks
Orthopaedic appliances (crutches, wheelchairs, walkers, standing frames, etc.)	80%	It is advisable to verify whether renting is possible, provided that it is less expensive depending on the length of use. Prior approval is required for motorised devices (e.g. electric wheelchairs, mobile scooters).
Hospital beds	80%	Reimbursable as an alternative for hospital admission, either rented or purchased, whichever is less expensive. Prior approval is recommended.
TENS (transcutaneous electrical nerve stimulation) devices	80%	Prior approval is recommended.

Item	Cover	Remarks
Medical infrared lamps/UVA lamps	80%	Reimbursable only in cases of psoriasis vulgaris.
CPAP appliances	80%	Prior approval is recommended. Reimbursable only in cases of sleeping disorders. A sleep study must be carried out and the results submitted. Approval is lifelong (a new sleep study is not needed to purchase a new device), except for people with a BMI of 35 or above.
Decubitus material (special pillows, mattresses required in case of bedsores)	80%	Other types of pillow or mattress (e.g. Tempur mattresses) are <u>not</u> reimbursable.
Orthopaedic shoes	80%	Reimbursable only if custom-made.
Inlays (inner soles)	80%	
Support stockings, arch supports	80%	Reimbursable only if medically indicated.
Wigs	80%	Prior approval is recommended. Reimbursable only in cases of chemotherapy or alopecia totalis.
Vacuum pumps for erection disturbance	80%	Prior approval is recommended. Never reimbursable in combination with Viagra, etc.
Bed-wetting alarms ("Klingelmatte")	80%	
Anti-allergic bed linen	80%	Prior approval is required. Results of allergy test (blood test) must be submitted with the request for approval. Max. one set of bed linen reimbursable per person per two calendar years, starting from 1 January 2025.
Digital health apps	80%	Prior approval is required. Need assessed on a case-by-case on the basis of medical necessity (reimbursable e.g. for monitoring of blood sugar levels in diabetes patients, or after cardiological intervention).
SIDS monitors (cot/crib death)	80%	Prior approval is recommended. Reimbursable only in certain cases such as premature birth.
Inhalers or nebulisers	80%	Normally for children only. Reimbursable for adults with asthma, sinusitis, etc.
Sleeping/anti-snoring masks ("Schlafmaske")	80%	

Item	Cover	Remarks
Oxygen concentrators	80%	Prior approval is required.
Insulin pumps	80%	

Items which are typically not covered: Patient aids such as wall handles, toilet seats, hoists, adapted baby chairs, home trainers, "Geradehalter", stability balls and fitballs. See also the long-term care insurance scheme in part 13 of the EPO Codex.

2.6 Dental care

2.6.1 Dentists

GENERAL RULE

Reimbursement is subject to a maximum of EUR 562.43 per person per calendar year. Half-yearly check-ups are not subject to this maximum.

Prior approval is required for dental treatments in excess of EUR 7 500.

Item	Cover	Remarks
General dental care	80%	
Orthodontic treatment: fees	80%	If the invoice does not make a clear distinction between fees and devices/material, costs will be reimbursed under 2.6.2.
Dental prostheses, crowns, implants done by a dentist	See 2.6.2 Orthodontic care/ dental prostheses.	
Fees charged for implants or dental surgery by a dental surgeon, "Oralchirurg" or "Mund-, Kiefer- und Gesichtschirurg" or stomatologist	In cases of one implant per consultation: Fees (not the implant itself) are covered as for specialists under 2.1.1 General practitioners and specialists, i.e. 100% cover up to a maximum of EUR 2 249.69. In cases of more than one implant per consultation: 100% reimbursement of the fees, with no ceiling under 2.3.2 Out-patient treatment.	In Germany: reimbursable under 2.1.1 if done by an "Oralchirurg" or "Mund-, Kiefer- und Gesichtschirurg". In France: reimbursable under 2.1.1 if done by a stomatologist.
Parodontosis treatment performed by a specialist doctor (e.g. "Oral- oder Mund-, Kiefer- und Gesichtschirurg")	See cover for specialists, 2.1.1 General practitioners and specialists.	

Item	Cover	Remarks
Paradontosis treatment performed by a paradontist (dentist) or trained dental hygienist ("Mondhygiënist")	Cover as for dentists (80% up to a maximum of EUR 562.43).	
Surgical tooth extraction (e.g. wisdom teeth)	Under local anaesthetic: see cover for specialists, 2.1.1 General practitioners and specialists. Under general anaesthetic: 100%.	
Splint in case of bruxism: device	See 2.6.2 Orthodontic care/dental prostheses	
Orthodontic treatment: device	See 2.6.2 Orthodontic care/dental prostheses	

Items which are typically not covered: Gum shields for sports.

2.6.2 Orthodontic care/dental prostheses

GENERAL RULE

Reimbursement is subject to a maximum of EUR 1 124.85 per two calendar years (2015-2016, 2017-2018, and so on).

Prior approval is required for expenses in excess of EUR 7 500.

Item	Cover	Remarks
Dental prostheses, crowns, implants done by a dentist , etc.	80%	This refers to laboratory expenses (materials) only, and not to dentist's fees
Orthodontic treatment: devices	80%	Reimbursable as from IOTN (Index for Orthodontic Treatment Need) grade 3. If the invoice does not make a clear distinction between fees and devices/material, costs will be reimbursed under this category.
Splint in case of bruxism	80%	

2.6.3 Preventive dental care

Item	Cover	Remarks
Half-yearly check-ups (preventive ¹⁷ examination) by a dentist	80%, with a maximum of two consultations per calendar year. Not subject to the maximum of EUR 562.43.	Preventive examinations in excess of two per year are not covered and are not taken into account for additional re-imbursment under section H of part I of the Implementing Rules for Articles 83a, 84 and 84a ServRegs.
Preventive care by a dental hygienist, prophylaxis assistant or the like	80%, with a maximum of two consultations per calendar year. Not subject to the maximum of EUR 562.43.	Preventive care acts in excess of two per year are not covered and are not taken into account for additional re-imbursment under section H of part I of the Implementing Rules for Articles 83a, 84 and 84a ServRegs.

¹⁷ In Germany, GOZ codes which are in general used for preventive purposes are codes 0010, 1000, 1010, 1020, 1030, 1040, 2000, 4050, 4055 and 4060. In the Netherlands, dental codes which are in general used for preventive purposes are codes C11, M01, M02, M05, M10, M20, M32, M30, M40 and M03. These codes may also be used for general dental care, in which case the related costs will be processed as general dental care and thus be subject to the annual maximum for dental care.

2.7 Funeral expenses

Item	Cover	Remarks
Funeral costs	Lump sum of EUR 1 687.27 per person.	<p>Paid upon receipt of the death certificate. For stillborn babies (minimum 20 weeks of pregnancy), proof of funeral costs is required. These will be reimbursed up to a maximum of the lump sum.</p> <p>If the bank account indicated on the (deceased) plan member's file at Cigna has not been closed, the amount will be paid to this account. If the bank account is closed, Cigna will need a notary certificate and the banking details of the legal heir before a payment can be issued.</p>

Items which are typically not covered (this list is not exhaustive): Repatriation, mortuary costs (in hospital).

If you cannot find an answer to your question here, please see the FAQ section on Cigna's website for more information (www.cignahealthbenefits.com) or contact Cigna or your HR department.