Manual for National Contact Points

Reimbursement of Cross-border Healthcare

Health and Food Safety

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Reimbursement of Cross-border Healthcare

Social Security Regulations *vs.* Directive 2011/24/EU

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Disclaimer

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1 The general principles of two coherent systems at EU level

Since the adoption of Directive 2011/24/EU[1] on the application of patients' rights in cross-border healthcare[2], in March 2011, patients are entitled to reimbursement[3] for cross-border healthcare[2] under a dual, yet complementary system:

- **Social Security Regulations (EC) No 883/2004 and 987/2009[4]**
- **Directive 2011/24/EU[1]**

Both legal instruments apply coherently to the situation where a patient seeks reimbursement[3] for treatment outside the Member State of residence. As a result, patients are free to choose under which route they prefer to exercise their rights in cross-border healthcare[2]. However, in some cases a priority rule applies in favour of the application of the Social Security Regulations (see section 4).

The two different routes for assumption of costs for cross-border healthcare[2] (i.e. healthcare abroad) result in different consequences for patients regarding the legal basis, the scope of application, competent authorities, authorisation conditions, applicable reimbursement[3] tariffs, payment procedure and formalities, and level of contribution of the patient (see section 2 and 3).

NOTE – national legislation

Social security remains within the competence of Member States. Therefore, besides the two legal instruments at EU level[5], **national frameworks** for patients to enjoy reimbursable cross-border healthcare[2] or in other words, healthcare abroad, should be kept in mind at all times. These consist of national cross-border projects between neighbouring countries/border regions and agreements between stakeholders and foreign healthcare providers not necessarily sharing a geographical border. Patients are as much entitled to receive reimbursable healthcare abroad under these national routes, as under the two legal instruments at EU level[5]. As a result, the range of possible options for patients to enjoy assumption of costs for healthcare abroad or for cross-border treatment[2] will differ for each specific Member State.

2 Social Security Regulations (EC) No 883/2004 and 987/2009

General principle: *Patient's right to reimbursement[3] for cross-border treatment[2] as though s/he was insured under the national health service[6]/ statutory health insurance[7] scheme of the Member State of treatment[8] and thus equally as locally insured patients*

What?

- Reimbursement[3] for treatment during a temporary stay in another EU[5]/EEA[9] Member State or Switzerland[10]:
  - ⇒ Situation of physical movement of the patient to another Member State (telemedicine[11] is not included under the Social Security Regulations)
  - ⇒ Only applicable to public healthcare[12] *(public healthcare providers[13] and in some Member States private healthcare providers[14] who are contracted/affiliated with the statutory health system[15])*
- Distinction between planned[16] and unplanned[17] cross-border treatment[2]

Who?

- Nationals, stateless persons and refugees residing in an EU[5]/EEA[9] Member State or Switzerland[10] who are or have been subject to the social security legislation of one or more of these States, as well as the members of their families and their survivors

- Third country nationals (non-EU[5]/EEA[9] nationals) legally residing in an EU[5]/EEA[9] Member State or Switzerland[10], excluding third country nationals[18] in Denmark, Norway, Iceland, Liechtenstein and Switzerland

When?

- The treatment must be included in the covered health services…

    - In case of unplanned[17] cross-border care[2]: …of the national health service[6] / statutory health insurance[7] scheme of the Member State of treatment[8]
    - In case of planned[16] cross-border care[2]: …of the national health service[6] / statutory health insurance[7] scheme of the competent Member State[19]

- Need for **prior authorisation**[20]?

Unplanned care[17]:

- Patients are entitled to treatment which becomes necessary on medical grounds during their stay, taking into account the nature of the treatment and the expected length of stay

- Generally, no need for prior authorisation[20] (Simple display of a valid European Health Insurance Card (EHIC) suffices)

- Exception: prior agreement will be needed in case of benefits provided by a Decision S3 (i.e. European document of proof of entitlement to healthcare in the country of previous work activity, especially important for retired frontier workers who are no longer insured under the social security system of the country of previous work activity)

NOTE – restrictions to the use of the European Health Insurance Card (EHIC)

- Non-EU nationals[18] legally residing in an EU[5]/EEA[9] country can't use their European Health Insurance Card for unplanned[17] treatment during a temporary stay in Denmark, Norway, Iceland, Liechtenstein and Switzerland
- The European Health Insurance Card can't be used for unplanned[17] care provided by a private healthcare provider[14] (unless s/he is contracted/affiliated with the social security system)
- The European Health Insurance Card can't be used when the purpose of the stay abroad is to receive treatment, i.e. in case of planned treatment

Planned care[16]:

- Under the condition of prior authorisation[20] (S2 form[21]/ old E112 form) from the national health service[6] authority / statutory health insurer[22]…

    - …of the competent Member State[19]
    - …of the Member State of residence, in case of :

- family members residing in another Member State than the insured person or pensioners and their family members residing in another Member State than the competent Member State[19], and additionally
- the Member State of residence applies a mechanism for compensation between Member States based on lump sums, or in other words fixed amounts[23] (annex III Regulation (EC) 987/2009[24])

(for information on which institution will be competent for issuing the S2 form[21], see fig. 2, section 6)

- Prior authorisation[20] under the Social Security Regulations[4] may not be refused (N.B. cumulative requirements):

1. Where the treatment is included in the covered health services of the national health service[6] / statutory health insurance[7] scheme of the Member State of residence, and
2. Where such treatment cannot be given there within a time limit which is medically justifiable, taking into account the current state of health of the patient and the probable evolution of his/her condition

How?

- **Reimbursement[3]** done at the expense of the competent Member State[19], according to:
  - Payment procedure and formalities of the Member State of treatment[8] under public healthcare[12]
    ⇒ Often third-party payment[25] (the patient only pays the co-payment[26])
  - Tariffs applicable in the Member State of treatment[8]
    ! Exception in case of unplanned care:
    - Tariff of the competent Member State[19] in case the patient agrees to its application
    - Tariff of the competent Member State[19] in case the legislation of the Member State of stay does not provide for reimbursement for the treatment, but the treatment is, however, covered under the legislation of the competent Member State[19] and the latter decides to reimburse the treatment (no agreement of the patient needed)
  - ! Additional compensation rights for patients in case of planned care[16]:
    - *Vanbraekel* supplement[27] (art. 26(7) Regulation 987)
    - *Extra costs of travel and stay:*
- In case of planned care, costs of travel and stay for the patient or for a person who must accompany him or her, are covered by the competent Member State[19] where the national legislation provides for the reimbursement of such travel and stay costs which are inseparable from the treatment (art. 26(8) Regulation 987)
- Reimbursement[3]:
  - Between national health service[6] authorities/ statutory health insurers[22] in case of third-party payment[25]
  - To the patient in case of upfront payment.

    The patient may choose to file a claim for reimbursement[3]
    - from the national health service[6] / statutory health insurer[22] of the country of treatment, which will later claims it from the patient's own national health service[6] authority/ health insurer[22], or

- directly from the patient's own national health service[6]/ statutory health insurer[22] back home, where the patient is insured

The institution of which Member State is competent for prior authorisation and reimbursement?

Table 1. Defining the MS competent for authorisation and reimbursement

	Prior authorisation[20] (S2 form[21])	Reimbursement[3]	At the expense of
• Insured person working and residing in MS A (+ family members)	Competent MS A	Competent MS A	--
• Insured person residing in MS A and working in MS B (+ family members) = *Art. 17 Reg. 883/2004*	Competent MS B (See NOTE below)	MS of residence A	Competent MS B
When residing in another MS than the competent MS, the insured person and his/her family members are entitled to healthcare during a temporary stay in the competent MS, under the social security scheme of that MS = *Art. 18 Reg. 883/2004* ! Not applicable for family members of a frontier worker[30] in case MS B is listed in **annex III Regulation 883/2004[28]**	--	*Competent MS*	--
• Family member residing in another MS A than the insured person, who resides and works in MS B	Competent MS B (See NOTE below)	MS of residence A	Competent MS B
! N.B Exception when MS A is a MS under fixed amounts[23] (i.e. lump sums) listed in **annex III Reg. 987/2009[24]**	MS of residence A	MS of residence A	Competent MS B
• Pensioner residing in MS A where s/he has worked all his/her life (+ family members)	Competent MS A	Competent MS A	--
• *Pension in two or more MS, including the MS of residence:* Pensioner residing in MS A entitled to pension under the legislation of MS A, MS B and MS C. (+ family members) = *Art. 23 Reg. 883/2004*	Competent MS A	Competent MS A	--
• *Pension in one or more MS, other than the MS of residence:* Pensioner residing in MS A with a pension under the legislation of MS B (+ family members) = *Art. 24 Reg. 883/2004*	Competent MS B (See NOTE below)	MS of residence A	Competent MS B
! N.B Exception when MS A is a MS under fixed amounts[23] (i.e. lump sums) listed in **annex III Reg. 987/2009[24]**	MS of residence A	MS of residence A	Competent MS B
I case of pension under two or more MS, other than the MS of residence, the competent MS will be the MS to whose legislation the pensioner has been subject for the longest period of time, or in case of equal periods, the MS to whose legislation the pensioner was last subject: = *Art. 24 Reg. 883/2004*			
Pensioner residing in MS A with a pension under the legislation of MS B and MS C, who has worked the longest period in MS B	Competent MS B (See NOTE below)	MS of residence A	Competent MS B
! N.B Exception when MS A is a MS under fixed amounts[23] (i.e. lump sums) listed in **annex III Reg. 987/2009[24]**	MS of residence A	MS of residence A	Competent MS B

Pensioner residing in MS A with a pension under the legislation of MS B and MS C, who has worked 15 years in MS B, followed by 15 years in MS C	Competent MS C (See NOTE below)	MS of residence A	Competent MS C
! N.B Exception when MS A is a MS under fixed amounts[23] (i.e. lump sums) listed in **annex III Reg. 987/2009**[24]	MS of residence A	MS of residence A	Competent MS C
When the pensioner is residing in another MS than the competent MS[19], s/he and his/her family members may be entitled to healthcare during a temporary stay back in the competent MS[19], under the social security scheme of that MS ! Only applicable when the competent MS B is listed in **annex IV Reg. 883/2004**[29]	--	*Competent MS*	--
• Retired frontier worker[30], residing in MS A, may be entitled to healthcare during a temporary stay back in the MS of previous work, the competent MS[19] B *= Art. 28 Reg. 883/2004* The retired frontier worker[30] and his/her family members are entitled to **continuation of treatment** in MS B	--	*Competent MS B*	--
! For MS listed in **annex V Reg. 883/2004**[31] the retired frontier worker[30] and his/her family members stay entitled to healthcare in MS B regardless of continuation of treatment	--	*Competent MS B*	--
! Not applicable for family members of a retired frontier worker[30] in case MS B is listed in **annex III Regulation 883/2004**[28]			

NOTE – Prior authorisation[20]

When residing in another Member State than the competent Member State[19], the insured patient shall always request authorisation from the patient's national health service[6] authority/ statutory health insurer[7] in his/her Member State of residence. The latter shall forward the request to the institution in the competent Member State[19].

3 Directive 2011/24/EU

General principle: Patient's right to reimbursement[3] for cross-border treatment[2] as though the treatment was provided in the patient's own Member State

What?

- Reimbursement[3] for treatment during a temporary stay in another EU[5]/EEA[9] Member State:
  - ⇒ Situation of physical movement of the patient to another Member State or cross-border treatment[2] through telemedicine[11]
  - ⇒ Applicable to both public and private healthcare
  - ⇒ With the exception of long-term care[32], organ transplantation[33] and public vaccination programmes[34]

NOTE – Switzerland[10]

Directive 2011/24/EU[1] is not applicable in the situation of cross-border healthcare[2] in Switzerland[10]. As a result, only the Social Security Regulations[4] route applies in this situation.

! National legislation may go further than the Directive. National law may apply the principles of Directive 2011/24/EU also for cross-border healthcare in Switzerland (this is for example the case in Belgium), besides other bilateral agreements may exist on cross-border healthcare in Switzerland.

- No distinction between planned[16] and unplanned[17] cross-border treatment[2] (in case of no valid European Health Insurance Card (EHIC) – in case of valid EHIC, the Social Security Regulations (EC) No 883/2004 and 987/2009[4] apply)

Who?

- Nationals, stateless persons and refugees residing in an EU[5]/EEA[9] Member State who are or have been subject to the social security legislation of one or more of these States, as well as the members of their families and their survivors

- Third country nationals (non-EU[5]/EEA[9] nationals) legally residing in one of the abovementioned States, including third country nationals[18] in Denmark, Norway, Iceland, Liechtenstein and Switzerland

When?

- The treatment must be included in the covered health services of the national health service[6] / statutory health insurance[7] scheme or of the Member State of affiliation[35]

- Need for prior authorisation[20]?
    - General rule: no prior authorisation[20] needed, unless the Member State of affiliation[35] specifies otherwise
    - Exception: prior authorisation[20] depending on implementation of a system of prior authorisation[20] (margin of discretion Member State) and only for:

        1. Healthcare which is subject to planning requirements[36] and which involves…
            - overnight hospital stay, or
            - highly specialised and cost-intensive medical infrastructure or medical equipment
        2. Treatments that present a patient safety risk[37] or general population safety risk[38]
        3. Quality and safety concerns related to the healthcare provider abroad

    - Prior authorisation[20] under the Directive[1] may not be refused (N.B. cumulative requirements):
        - Where the treatment is included in the covered health services of the national health service[6] / statutory health insurance[7] scheme of the Member State of residence, and
        - Where such treatment cannot be given there within a time limit which is medically justifiable, taking into account the patient's specific current, future or past health situation, the degree of the patient's pain and the nature of the patient's disability

- Prior authorisation[20] may only be refused, in case of:
    - Patient safety risk[37]
    - General population safety risk[38]
    - Quality and safety concerns related to the healthcare provider abroad
    - Treatment that can be provided on the Member State's own territory within a justifiable time limit, taking into account the current state of health and the probable course of the illness of the patient concerned

How?

- Reimbursement[3] by the Member State of affiliation[35] (or in certain cases of residence outside the competent Member State[19], the competent Member State[19] during a temporary stay back on its territory, see fig. 3, section 5), in accordance with:
    - The formalities and conditions defined by the Member State of affiliation[35] (e.g. GP[39] referral system)
    - Upfront payment
    - Tariffs applicable in the Member State of affiliation[35], without exceeding the actual cost of treatment accessed

- Extra costs of travel and stay abroad may only be covered when specifically envisaged for cross-border treatment[2] in the legislation of the patient's home country

- Reimbursement[3] to the patient by the own national health service[6] authority/ health insurer[22]
  (Member States may opt for a system of financial compensation directly between institutions)

NOTE – Margin of discretion Member State

The implementation of Directive 2011/24/EU[1] in the national legal order or bilateral agreement can end up being more favourable to patients than provided for in the Directive[1] itself.

The institution of which Member State is competent for prior authorisation and reimbursement?

The Member State of affiliation[35] = the Member State competent for prior authorisation[20] under the Social Security Regulations (EC) 883/2004 and 987/2009[4] (see table 1), is competent for

- Prior authorisation[20]
- Reimbursement[3]

In case of residence in another MS and a temporary stay back in the competent Member State[19], two exceptions may apply (See fig. 3):

- Pensioners and their family members, residing in another Member State than the competent Member State[19] + the competent Member State[19] is listed in annex IV Regulation (EC) 883/2004[29] are entitled to healthcare during a temporary stay back in the competent Member State[19], under the social security system of the latter

- The Member State that according to the Social Security Regulations[4] in the end is responsible for the costs of reimbursement[3] ("at the expense of"), will provided

healthcare at its own expense and according to its own legislation when the healthcare

- is provided in accordance with the Directive[1],
- Is not provided in accordance with the Social Security Regulations[4], and
- is not subjected to prior authorisation[20]

4 Priority of the Social Security Regulations

Attention!

When the conditions for authorisation under the Social Security Regulations[4] are met, thus

- where the treatment is included in the covered health services of the national health service[6] / statutory health insurance[7] scheme of the Member State of residence, and
- where such treatment cannot be given there within a time limit which is medically justifiable, taking into account the current state of health of the patient and the probable evolution of its condition

⇒ authorisation will be automatically granted under the Social Security Regulations[4]
⇒ Directive 2011/24/EU[1] will only apply on explicit request of the patient (in line with article 8(3) of Directive 2011/24/EU[1])

Some reasons for preference of planned care[16] under the Social Security Regulations[4]:

- In general no financial burden for the patient of upfront payment
- In general better guarantees of coverage since the tariffs of the Member State of treatment[8] will apply
- Financial risk that the level of costs abroad exceeds the level of costs of the treatment at home is borne by the national health service[6] / statutory health insurer[22] instead of the patient
- Coverage of costs for travel and stay when envisaged in the legislation of the competent Member State[19] in case the treatment would have taken place within its own territory

Some reasons for preference of planned healthcare[16] under Directive 2011/24/EU[1]:

- Private healthcare providers[14], who are not contracted/affiliated with the statutory health system[15], are also covered
- Potentially higher rates of reimbursement[3] in the Member State of affiliation[35] (e.g. patient's co-payment[26] is more favourable in the Member State of affiliation[35])
- For a wide range of treatment, no obligation to obtain prior-authorisation

5 Advantages and disadvantages of the two possibilities of reimbursement under EU law

Table 2. Advantages and disadvantages of the two possible routes

Social Security Regulations (EC) 883/2004 and 987/2009	Directive 2011/24/EU[1]
Advantages	**Advantages**:
• The patient will be treated as a public patient with statutory health insurance[7]/ under national health service[6] • Financial risk that the level of costs abroad exceeds the level of costs of the treatment at home is borne by the national health service[6] / health insurer[22] • In most cases, the patient will enjoy third-party payment[25], which reduces the financial burden • Coverage of costs for travel and stay when envisaged in the legislation of the competent Member State[19] in case the treatment would have taken place within its own territory • By application of the Vanbraekel supplement[27], the patient's national health service[6] authority/ health insurer[22] may refund all or part of the costs of co-payment[26] • When the costs are settled directly between the healthcare provider and the national health service[6] authority/ health insurer[22] (third-party payment[25]), no costs will incur for translations of invoices • In case of malpractice, the patient will be treated as a locally insured person	• For a wide range of treatment, there is no obligation to obtain prior-authorisation • Limited grounds of refusal in case prior-authorisation is needed • The patient is free to consult both public[13] and private[14] healthcare providers • In case of higher rates of reimbursement[3] in the Member State of affiliation[35] (e.g. patient's co-payment[26] is more favourable in the Member State of affiliation[35]), the patient may enjoy treatment at a lower cost • In case no prior authorisation[20] is required, the patient may be able to enjoy cross-border treatment[2] more quickly
Disadvantages:	**Disadvantages**:
• Prior authorisation[20] (S2 form[21]) from the national health service[6] authority/ health insurer[22] is required for all cross-border healthcare[2] • Does not apply to private hospitals and healthcare providers[14] / non-contracted providers[15] • When no valid EHIC[40] / prior authorisation[20], the patient will not be entitled to reimbursement[3] under the Regulations[4]	• The patient will be treated as a private patient • Financial risk that the level of costs abroad exceeds the level of costs of the treatment at home is borne by the patient him or herself • Uncertainty on reimbursement[3] before departure • The costs may exceed the amount that is reimbursed by the own national health service[6] authority/ health insurer[22] • The patient will have to pay upfront • The patient may incur costs for translation of invoices requested by his/her national health service[6] authority/ health insurer[22]

6 Accompanying figures

Fig.1 Will the Social Security Regulations (EC) 883/2004 and 987/2009 or/and Directive 2011/24/EU apply in case of planned cross-border healthcare?

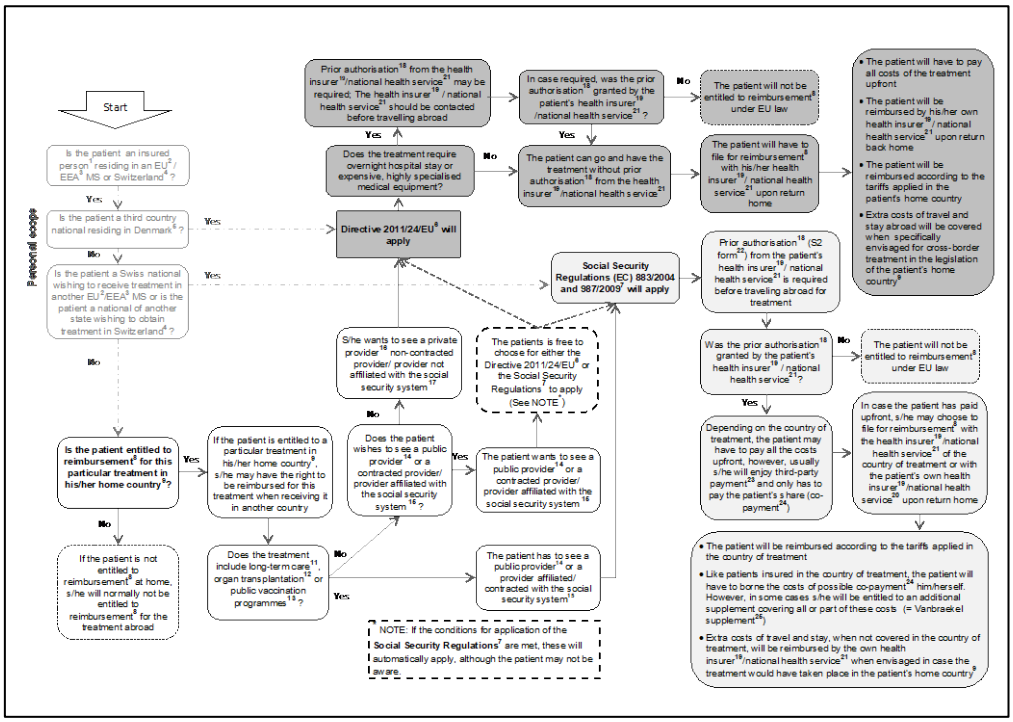


Fig. 2 The institution of which MS will be responsible for prior authorisation (S2 form) and reimbursement to the patient in planned cross-border healthcare under the Social Security Regulations (EC) 883/2004 and 987/2009?

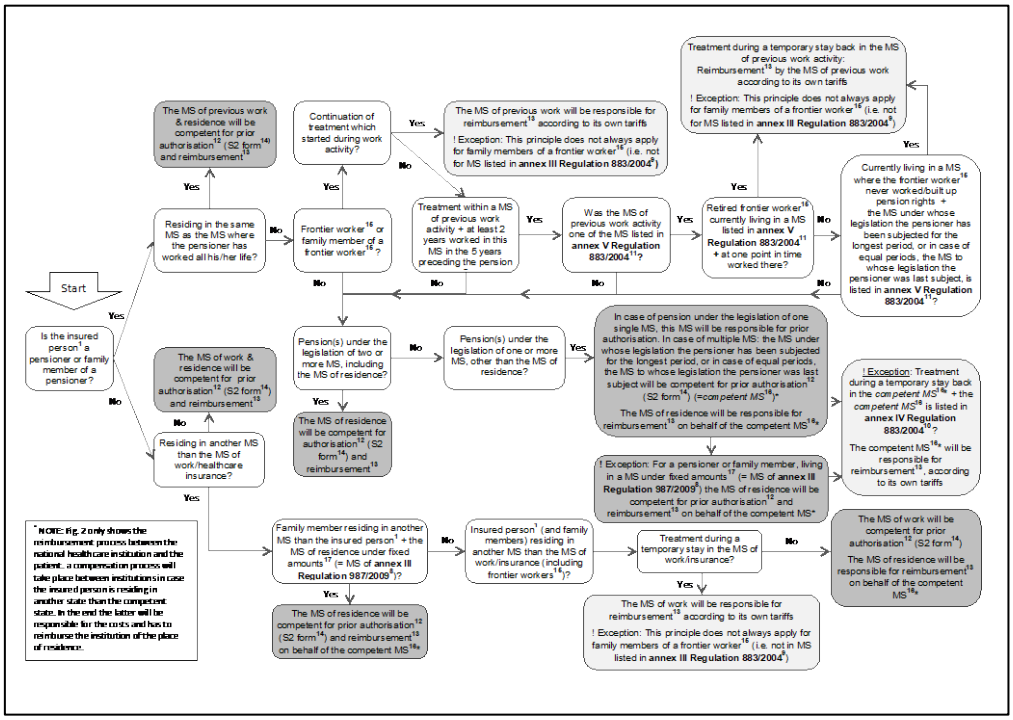
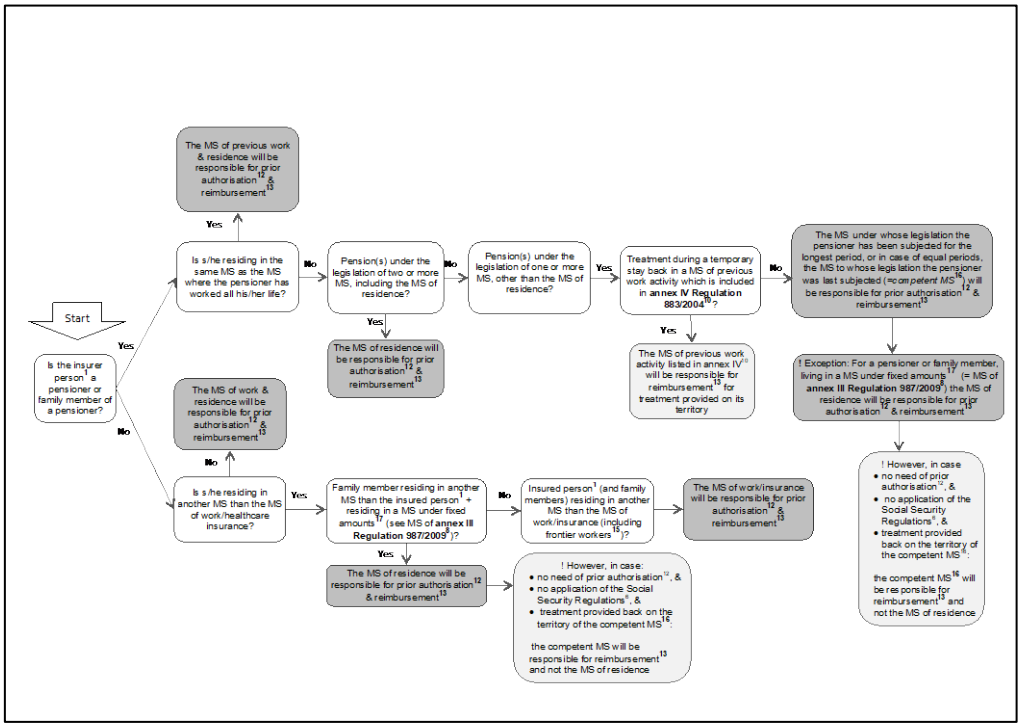


Fig.3 Which institution is responsible for granting prior authorisation when required and for reimbursement under Directive 2011/24/EU?



7 Summary

Table 3. Summary Social Security Regulations *versus* Directive 2011/24/EU

	Social Security Regulations (EC) 883/2004 and 987/2009[4]		Directive 2011/24/EU[1]
	Unplanned care[17]	**Planned care[16]**	**(Un)planned care**
Scope of Application	– *Citizens of EU[5]/EEA[9] and Switzerland[10]* – *Third country nationals[8]* (*excl. Denmark, Norway, Iceland, Liechtenstein and Switzerland!)*		– *Citizens of EU[5]/EEA[9]* – *Third country nationals[18]* (*incl. Denmark, Norway, Iceland, Liechtenstein and Switzerland!)*
Covered services	**Benefit package MS of treatment** • Medically necessary treatment	**Benefit package Competent MS[19]**	**Benefit package MS of affiliation[35]** With exception of: • Long-term care[32] • Organ transplantation[33] • Public vaccination programs[34]
	Public healthcare[12]	**Public healthcare[12]**	**Public[12] and private healthcare[41]**
Provided by	national health service[6] / statutory health insurer[22] of the MS of treatment	national health service[6] / statutory health insurer[22] of the MS of treatment	national health service[6] / statutory health insurer[22] of the MS of treatment
At the expense of	**Competent institution**	**Competent institution** (or institution of residence, annex III Reg. 987/2009[24])	**Institution of the MS of affiliation[35]** (or competent institution, annex IV Reg. 883/2004[29])
Authorisation	**No authorisation** (on basis of a valid EHIC[40])	**Prior authorisation[20]** (on basis of an S2 form[21])	Exception: **prior authorisation[20]** (no European form) **depending on implementation and only in limited cases:** • Overnight hospital stay or highly specialised and cost-intensive medical equipment or medical infrastructure • Patient safety risk[37] • General population safety risk[38]
		No refusal: • Treatment provided in the MS of residence, and • Cannot be provided within a medically justifiable time limit, taking into account the current and anticipated state of health	No refusal: • Treatment provided in the MS of residence, • Cannot be provided within a medically justifiable time limit taking into account the current, anticipated and past state of health Limited grounds of refusal: • Patient safety risk[37] • General population safety risk[38] • Quality and safety concerns • Treatment can be provided on the Member State's own territory within a justifiable time limit, taking into account the current

			and anticipated state of health

Reimbursement	**Payment procedure and formalities MS of treatment (often third-party payment[25])**
	• Compensation between institutions
	• Reimbursement[3] to the patient in case of upfront payment:
	  • By the institution of the Member State of treatment[8]
	  • Directly from the own institution upon return home
		Payment procedure and formalities MS of treatment (often third-party payment[25])
		• Compensation between institutions
		• Reimbursement[3] to the patient in case of upfront payment
			Upfront payment in full to the healthcare provider Reimbursement[3] formalities MS of affiliation[35]
			• Reimbursement[3] to the patient

Tariffs that apply	**Tariffs MS of treatment** (Exceptions under unplanned treatment, e.g. patient agreement: tariff of competent MS)	**Tariffs MS of treatment** Exception: ***Vanbraekel suppl.*** [27]	**Tariffs MS of affiliation[35]** (or actual costs)
		Extra costs travel and stay where national legislation provides for reimbursement of travel and stay costs which are inseparable from the treatment	Free choice Member State of affiliation[35] to foresee in its legislation coverage of costs of travel and stay for cross-border treatment[2]

8 Glossary

Term	Concise explanation
[1] Directive 2011/24/EU	DIRECTIVE 2011/24/EU OF THE EUROPEAN PARLIAMENT AND OF THE COUNCIL of 9 March 2011 on the application of patients' rights in cross-border healthcare
[2] Cross-border healthcare/treatment	Healthcare outside the country under whose social security system and legislation the insured is covered, whether or not on behalf of another Member State
[3] Reimbursement	Repayment of a patient by the national health service[6]/ statutory health insurance[7] system for health services covered by the social security scheme
[4] Social Security Regulations	- REGULATION (EC) NO 883/2004 OF THE EUROPEAN PARLIAMENT AND OF THE COUNCIL of 29 April 2004 on the coordination of social security systems - REGULATION (EC) NO 987/2009 OF THE EUROPEAN PARLIAMENT AND OF THE COUNCIL of 16 September 2009 laying down the procedure for implementing Regulation (EC) No 883/2004 on the coordination of social security systems Repealing: REGULATION (EEC) NO 1408/07 OF THE COUNCIL of 14 June 1971 on the application of social security schemes to employed persons and their families moving within the Community
[5] European Union (EU)	The following 28 countries are members of the European Union (EU): *Austria, Belgium, Bulgaria, Croatia, Cyprus, Czech Republic, Denmark, Estonia, Finland, France, Germany, Greece, Hungary, Ireland, Italy, Latvia, Lithuania, Luxembourg, Malta, Netherlands, Poland, Portugal, Romania, Slovakia, Slovenia, Spain, Sweden, and the United Kingdom.*
[6] National health service or national health service-type healthcare systems	Government-controlled healthcare systems that are responsible for the provision of publicly funded health services to all citizens in their country (e.g. UK NHS)
[7] Statutory health insurance	Financing system, which may be tax funded or based on social insurance contributions, within the social security scheme that covers the citizens of a country against healthcare expenses from the financial risks of illness and injury
[8] Member State of treatment	Member State where the cross-border treatment[2] is provided (or in case of telemedicine[11], where the healthcare provider is located)
[9] European Economic Area (EEA)	The European Economic Area (EEA) includes, besides the 28 EU Member States, Iceland, Liechtenstein and Norway
[10] Switzerland	As the Directive 2011/24/EU[1] route excludes Switzerland, under EU law[5] Swiss nationals/third country nationals residing in Switzerland are only able to enjoy cross-border healthcare[2] under the Social Security Regulations (EC) 883/2004 and 987/2009.
[11] Telemedicine	The provision of healthcare services at a distance through the use of ICT, e.g. teleconsultation, telemonitoring, telesurgery,…
[12] Public healthcare	Treatment provided by a healthcare provider contracted by the national health service[6]/ statutory health insurance[7] scheme: • in general only public providers[13] in some Member States also private providers[14] who are entitled to provide covered health services under the national health service[6] / statutory health insurance[7] scheme[15]
[13] Public healthcare provider	Healthcare provider working within the national health service[6]/ statutory health insurance[7] scheme
[14] Private healthcare provider	Healthcare provider working independently from the national health service[6]/ statutory health insurance[7] scheme

[15] (non-)Contracted provider/provider (not) affiliated with the social security system	Contracted healthcare providers/healthcare providers affiliated with the statutory health system are (1) public healthcare providers[13] working within the national health service[6]/ statutory health insurance[7] scheme, as well as in some Member States (2) private providers[14] who are entitled to provide covered health services under the national health service[6]/ statutory health insurance[7] scheme. Non-contracted/affiliated providers are private healthcare providers[14] who work in the private health sector and who are not entitled to provide any health services covered under the national health service[6]/ statutory health insurance[7] scheme
[16] Planned cross-border treatment/ care	Treatment provided during a travel to another Member State with the explicit purpose of receiving treatment there
[17] Unplanned cross-border treatment/ care	Treatment which becomes necessary on medical grounds during a temporary stay in another Member State for work, study or leisure (without the initial purpose to travel to another Member State for having treatment there)
[18] Third country nationals	Third country nationals (non-EU[5]/EEA[9]) residing in Denmark, Norway, Iceland, Liechtenstein and Switzerland, are excluded from the Social Security Regulations (EC) 883/2004 and 987/2009[4], as a result, in the case of third country nationals in Denmark, Norway, Iceland, Liechtenstein and Switzerland, only the Directive 2011/24/EU[1] route applies
[19] Competent Member State	Member State under whose social security system the patient concerned is insured at the time of the cross-border treatment[2], or on behalf of whose social security system the patient concerned is insured at the time of cross-border treatment[2]
[20] Prior authorisation	Authorisation patients need in advance of their travel abroad from their national health service[6] authority/ statutory health insurer[22] in order to be guaranteed reimbursement[3] for their cross-border treatment[2]
[21] S2 form	Proof of receipt of prior authorisation[20] from the patient's national health service[6]/ statutory health insurer[22] to have planned[16] cross-border treatment[2], according to the Social Security Regulations[4]
[22] (Statutory) health insurer	Provider of health insurance under the statutory health insurance[7] scheme (i.e. health insurance fund; health insurance company)
[23] Member State under reimbursement of sickness benefits between Member States on the basis of fixed amounts (MS under fixed amounts)	The Social Security Regulations[4] also deal with the financial consequences for the Member State which provide health services to a person who is entitled to sickness benefits on behalf of another Member State (e.g. the Member State of previous work activity). The costs incurred by the Member State of stay or residence has to be refunded by the institution of the State where the person is insured. Here two different mechanisms may apply, namely reimbursement of actual medical expenditures or reimbursement on the basis of fixed amounts (i.e. lump sums).
[24] Annex III (EC) 987/2009, consolidated version of 11 April 2017	Member States under reimbursement of sickness benefits between Member States on the basis of fixed amounts[23] are: *Ireland, Spain, Cyprus, the Netherlands*, Portugal, Finland*, Sweden, and the United Kingdom* *(! Sections "the Netherlands" and "Finland" will be deleted as from 1 January 2018: Commission Regulation (EU) 2017/492 of 21 March 2017)* *the annexes of the Regulations[4] are revised on a regular basis, please always consult the latest consolidated version
[25] Third-party payment	Third-party payment refers to the direct payment of the healthcare provider by the competent national health service[6]/ statutory health insurance[7] institution. As a result, the patient enjoys treatment free of charge at point of use, and only has to pay the patient's part of the costs (co-payment[26]).
[26] Co-payment	A set out-of-pocket amount, which will not be covered by the national health service[6]/ statutory health insurance[7], the insured has to pay

	him or herself directly to the healthcare provider/hospital or other institute for the provided health services; in other words, the patient's share of the medical costs
[27] Vanbraekel supplement	The Vanbraekel supplement includes an additional compensation in case the patient has actually borne all or part of the medical costs of the cross-border treatment[2] for which s/he had prior authorisation[20] (S2 form[21]) him or herself (co-payment[26]) and the reimbursement[3] tariff abroad is lower than the costs that should have been reimbursed, assuming the same treatment would have taken place in the patient's own Member State. In this case, the competent national health service[6]/ statutory health insurer[22] has to reimburse the patient, *upon request*, up to the amount representing the difference between both reimbursement[3] rates (without exceeding the actual costs incurred by the patient) (art. 26(7) Regulation (EC) 987/2009).
[28] Annex III Regulation (EC) 883/2004, consolidated version of 11 April 2017	Member States restricting rights for family members of a frontier worker[30] are: *Denmark, Ireland, Croatia, Finland, Sweden and the United Kingdom* *the annexes of the Regulations[4] are revised on a regular basis, please always consult the latest consolidated version
[29] Annex IV Regulation (EC) 883/2004, consolidated version of 11 April 2017	Member States granting more beneficial rights to pensioners returning to the competent Member State[19] for healthcare are: *Belgium, Bulgaria, Czech Republic, Germany, Greece, Spain, France, Cyprus, Luxembourg, Hungary, the Netherlands, Austria, Poland, Slovenia and Sweden* *the annexes of the Regulations[4] are revised on a regular basis, please always consult the latest consolidated version
[30] Frontier worker	Person pursuing an activity as an employed or self-employed person in a Member State and who resides in another Member State to which s/he returns on a daily basis or at least once a week
[31] Annex V Regulation (EC) 883/2004, consolidated version of 11 April 2017	Member States granting more beneficial rights to frontier workers[30] returning to the Member State of previous work activity for healthcare are: *Belgium, Germany, Spain, France, Luxembourg, Austria, Portugal* (applicable only if the competent Member State[19] responsible for the costs of the sickness benefits provided to the retired frontier worker[30] in his/her Member State of residence is also included in this list) *the annexes of the Regulations[4] are revised on a regular basis, please always consult the latest consolidated version
[32] Long-term care	Services in the field of long-term care the purpose of which is to support people in need of (non-medical) assistance in carrying out routine, everyday tasks, for example nursing homes
[33] Organ transplantation	The allocation of and access to organs for the purpose of organ transplants (with the exception of the surgical act of transplantation itself)
[34] Public vaccination programmes	Public programmes of vaccination against infectious diseases which are exclusively aimed at protecting the health of the population on the territory of a Member State and which are subject to specific planning[36] and implementation measures
[35] Member State of affiliation	Member State that under the Social Security Regulations[4] is competent for granting prior authorisation[20] (i.e. the S2 forms[21]/ old E112 form)
[36] Planning requirements	Planning requirements relating to the object of ensuring sufficient and permanent access to a balanced range of high-quality treatment in the Member State concerned or to the wish to control costs and avoid, as far as possible, any waste of financial, technical and human resources (most often for hospital-based services)
[37] Patient safety risk	Particular risk for the patient associated with the cross-border treatment[2], e.g. medical contra-indications for travelling
[38] General population safety risk	Particular risk for the population associated with the cross-border treatment[2], e.g. contamination risk as a result of traveling by a patient with a contagious disease

[39] GP	General practitioner
[40] EHIC	European Health Insurance Card: free card, issued by the national health service authority/ health insurer, that gives the patient access to medically necessary, state-provided healthcare during a temporary stay in another EU/EEA country or Switzerland, under the same conditions and costs (free at charge in some countries) as people covered/insured under the national health services or national health insurance scheme of that country
[41] Private healthcare	Treatment provided by a healthcare provider working outside the national health service[6] / statutory health insurance[7] (i.e. public scheme)