Schweizerische Eidgenossenschaft
Confédération suisse
Confederazione Svizzera
Confederaziun svizra

Federal Department of Home Affairs DHA
Federal Office of Public Health FOPH
Health and Accident Insurance Directorate

Frequently asked questions (FAQ) about benefits

I. Liability for payment

1. Principle

Under the Swiss health insurance system, healthcare costs are reimbursed after services have been provided. This is known as the reimbursement principle. Service providers can be compensated for their services in two ways: (1) by policyholders, whose costs are in turn reimbursed by the insurer responsible (the *tiers garant* system), or (2) by insurers, if it has been agreed with the service providers that their services will be paid for directly (the *tiers payant* system).

2. *Tiers garant* system

Under Art. 42 para. 1 of the Federal Health Insurance Act (KVG), the *tiers garant* system is applicable in the absence of any agreement to the contrary between insurer and service provider. Policyholders are responsible for compensating service providers for their services. Accordingly, the service provider's invoice is first sent to the policyholder, who then forwards it to the insurer. The latter checks the invoice and transfers to the policyholder the amount due (minus the deductible/co-payment). Whether the invoice has to be settled before reimbursement is received from the insurer depends on the payment period specified by the service provider and the insurer's reimbursement period. This is the predominant type of invoicing for ambulatory treatment: the majority of independent medical practitioners use the *tiers garant* system.

3. *Tiers payant* system

Under Art. 42 para. 2 KVG, it may be agreed by the insurer and service provider that the former is liable for payment (*tiers payant* system). The service provider's invoice is sent to the insurer, who settles it directly. Thereafter, the insurer invoices the policyholder for the latter's contribution. The *tiers payant* system is always used in the case of inpatient treatment (second sentence of Art. 42 para. 2 KVG). This type of invoicing is mainly used in hospitals (including outpatient services), in

care homes and in the domiciliary care sector. The system has also become established for the dispensing of medication in pharmacies. Under the *tiers payant* system, the policyholder (in accordance with Art. 42 para. 3 KVG) receives a copy of the invoice sent to the insurer. In general, the copy of the invoice has to be sent to the policyholder by the service provider, but it may be agreed with the insurer that the latter is responsible for sending the copy to the policyholder (Art. 59 para. 4 of the Health Insurance Ordinance, KVV).

4. *Tiers soldant* system

The *tiers soldant* system is used in accident insurance. Here, the service provider's invoice is sent directly to the insurer. As there is no co-payment or deductible in the case of accident insurance, the insurer pays the full amount directly to the service provider. If, within the *tiers garant* system, the policyholder's claim to reimbursement vis-à-vis the insurer is ceded to the service provider (in accordance with Art. 42 para. 1 KVG), the term *tiers soldant* is also used, although it is not strictly applicable since the policyholder is still liable for the co-payment and deductible.

In practice

Under the tiers garant system, services have to be paid for by the policyholder, who then requests reimbursement from the insurer. If the policyholder cannot meet the costs of the services provided, various options are available. For example, the policyholder's claim to reimbursement from the insurer can be ceded to the service provider ("tiers soldant"), or an invoice with a later payment date can be requested (e.g. an additional period of 15 or 30 days). In the latter case, the invoice is to be forwarded to the insurer as rapidly as possible. In such situations, it is important to consult the service provider and/or the insurer.

In view of the time required by the insurer to check invoices and assess the cost-effectiveness of treatment, the legislation does not specify a time limit for reimbursement. Reimbursement is generally provided by the insurer within 30 days after receipt of the policyholder's claim (tiers garant) or the service provider's invoice (tiers payant). Insurers are required to check whether the service is reimbursable under compulsory health insurance. The reimbursement period can be extended if certain parts of the invoice are missing and the insurer requires additional information from the service provider. The checking and reimbursement periods will also be longer if the insurer's independent medical adviser has to be consulted.

If the measures undertaken to secure settlement of invoices by the insurer within an appropriate period prove unsuccessful, the policyholder can contact the health insurance ombudsperson (www.om-kv.ch).

II. Medicines

1. Which medicines are reimbursed under compulsory health insurance?

Compulsory health insurance covers the medicines which are prescribed by a physician, employed in accordance with the approved indications/uses specified in the package insert, and included on the list of reimbursable pharmaceutical specialities (Specialities List/SL).The reimbursement of SL products may be restricted to certain medical indications or specified quantities (so-called limitations, marked as "Limitatio L" in the SL).

In addition the medicines prescribed by a physician which are compounded in a pharmacy are also reimbursed, if they are included on the list of active substances and other ingredients (List of medicines with tariff/LMT).

The SL is available online (in French/German) at: www.listofpharmaceuticalspecialities.ch.

The LMT is available online (in French/German/Italian) at: www.bag.admin.ch/bag/de/home/themen/versicherungen/krankenversicherung/krankenversicherung-leistungen-tarife/Arzneimittel.html.

2. Does compulsory health insurance cover the costs of SL (Specialities List) medicines that are prescribed for me outside the approved indications (off-label use) or administered outside the specified quantities (off-limitation use)?

No, the costs of such medicines are not reimbursed as a rule.

By way of exception, the costs of such medicines are reimbursed in individual cases, provided the following conditions are met:

- the use of the medicine is an indispensable precondition for another treatment measure that compulsory health insurance does reimburse and the focus is clearly on this measure, or
- the medicine is expected to have a substantial beneficial effect against an illness that may be fatal or cause serious chronic harm to the health of the insured person, and for which a lack of therapeutic alternatives means that no other effective approved treatment is available.

Your health insurer will decide, after prior consultation with its independent medical advisory service, whether the conditions for such an exception are met and the costs of the medicine can be reimbursed.

The health insurer will, in consultation with the licence holder, decide on the amount to be reimbursed. It will assess whether the costs to be reimbursed are proportionate to the therapeutic benefit. The price may not exceed the absolute maximum price specified on the SL.

Your doctor must inform you whenever he/she prescribes medicines for you outside the approved indications or limitations.

If compulsory health insurance does not cover the costs of such medicines, you may be able to claim reimbursement under a supplementary insurance plan.

3. What happens if my doctor prescribes a medicine that is not included on one of the lists but is authorized by Swissmedic and used in accordance with, or outside, the approved indications?

As a rule, the costs of such medicines are not reimbursed under compulsory health insurance. Reimbursement is possible only in exceptional cases, under the same conditions and to the same extent as SL medicines used outside the approved indications or limitations (cf. no. 2 above).

Your doctor must inform you whenever he/she prescribes a medicine which is not included on one of the lists.

If compulsory health insurance does not cover the costs of such medicines, you may be able to claim reimbursement under a supplementary insurance plan.

4. Does compulsory health insurance reimburse the costs of imported medicines that have not been authorized by Swissmedic?

Such costs can be reimbursed only in exceptional cases if the medicine may be imported under the Therapeutic Products Act and the conditions for reimbursement of medicines used off-label or off-limitation are met (cf. no. 2). The medicine must be authorized for the indication in question by a country with an authorization system recognized as equivalent by Swissmedic.

The health insurer will reimburse the costs of importing the medicine. It will assess whether the costs to be reimbursed are proportionate to the therapeutic benefit.

Your doctor must inform you whenever he/she prescribes a medicine that is not included on one of the lists and is not authorized in Switzerland.

If compulsory health insurance does not cover the costs of such medicines, you may be able to claim reimbursement under a supplementary insurance plan.

III. Treatment/services abroad

1. Are the costs of treatment abroad reimbursed under compulsory health insurance?

Compulsory health insurance only covers reimbursable treatment and services carried out in Switzerland by licensed providers.

Exceptions are made for medical treatment that is necessary during temporary stays abroad:

- In EU/EFTA countries, the European Health Insurance Card issued by your health insurer entitles you to receive any medical services that are considered essential, taking account of the type of service and the expected length of your stay. Your medical insurance will cover the costs of the same medical services as would be provided to a resident of the country in question. Further information (in French/German/Italian) is available at:

  www.bag.admin.ch/bag/en/home/themen/versicherungen/krankenversicherung/krankenversicherung-versicherte-mit-wohnsitz-in-der-schweiz/versicherungspflicht/touristinnen-ausland-weltreisende.html.

- In countries outside the EU/EFTA area, costs will be reimbursed up to a maximum of twice the amount that the insurer would have covered if the treatment had been provided in Switzerland. In the case of inpatient treatment, this means that the insurer will reimburse no more than 90% of the costs that would have arisen for hospitalisation in Switzerland (this is because, in the case of hospital treatment in Switzerland, at least 55% of the costs are borne by the cantons, which is not the case for hospital stays abroad).

In cases where you have to go abroad for medical treatment because the treatment is not available in Switzerland, your doctor must submit an application (including a statement of reasons) to your health insurer's independent medical adviser. The insurer will decide, in consultation with the independent medical advisory service, whether the costs of treatment abroad can be reimbursed.

2. Does compulsory health insurance cover the costs of medicines I have purchased abroad?

The costs will only be reimbursed for medicines which you require because of illness during a temporary stay abroad (cf. no. 1 above).

IV. Vaccinations

1. Which vaccinations are covered by compulsory health insurance?

Compulsory health insurance covers the costs of various vaccinations in accordance with the guidelines and recommendations of the Swiss Vaccination Plan (cf. www.bag.admin.ch/bag/de/home/themen/mensch-gesundheit/uebertragbare-krankheiten/impfungen-prophylaxe/informationen-rund-ums-impfen/schweizerischer-impfplan.html; in French/German/Italian).

The most important are:

- Vaccinations against diphtheria, tetanus, pertussis (whooping cough), poliomyelitis, Haemophilus *influenzae* type B and chickenpox, and against measles, mumps and rubella (German measles) (MMR)
- Vaccinations against hepatitis B and – for certain risk groups – hepatitis A
- Vaccination against influenza for people aged 65 or over and people at increased risk of complications in the event of an influenza infection

- Vaccination against tick-borne encephalitis
- Vaccination against cervical cancer for school-age girls and young women up to the age of 26, as well as against other types of cancer caused by a human papillomavirus for boys and men between the ages of 11 and 26, if provided as part of a cantonal vaccination programme. No deductible is due for this vaccination.

Travel vaccinations and preventive treatments (e.g. yellow fever and malaria prophylaxis) are not covered.

Your doctor can provide further information and advice if you have any queries about vaccinations.

V. Coverage of maternity services

1. What check-ups can be performed during pregnancy and after childbirth?

For a normal pregnancy, seven antenatal check-ups will be reimbursed. The first visit includes a medical history, general clinical and gynecological examinations and advice, and screening for varicose veins and leg edema; in addition, laboratory tests are ordered as required according to the Analyses List. Subsequent visits include monitoring of bodyweight, blood pressure and fundal height, urinalysis and auscultation of fetal heart tones; in addition, laboratory tests are ordered as required, according to the Analyses List.

For a high-risk pregnancy, these examinations may be repeated if necessary. Cardiotocography (electronic fetal monitoring) is also covered in the case of a high-risk pregnancy.

A postpartum check-up can be performed 6 to 10 weeks after delivery, including further history, clinical and gynecological examinations and advice.

2. How many ultrasound scans are covered per pregnancy?

For a normal pregnancy, one ultrasound scan between the 12th and the 14th week and one between the 20th and the 23rd week are reimbursed. In the case of a high-risk pregnancy, additional scans are covered if they are considered necessary by the gynaecologist on the basis of a clinical assessment.

3. What about the costs for birth preparation?

A contribution of CHF 150 is paid for individual or group birth preparation classes run by a midwife, or for a consultation with the midwife with regard to the birth, domestic puerperium planning or breastfeeding preparation.

4. Is a first-trimester test covered?

Yes, this test is covered for prenatal assessment of the risk of trisomy 21, 18 and 13 based on ultrasound measurement of fetal nuchal translucency (12th to 14th week of pregnancy) and the assessment of certain maternal blood factors and other maternal and fetal factors (e.g. maternal age).

5. When is non-invasive prenatal testing (NIPT) covered?

Compulsory health insurance covers NIPT from the 12th week of a singleton pregnancy if there is an increased risk of trisomy 21, 18 or 13. This risk must previously have been determined by a first-trimester test (see no. 4). An increased risk is defined as 1 in 1000 or higher. A positive NIPT result should be confirmed by amniocentesis (cf. no. 6).

6. Is amniocentesis always covered?

Amniocentesis, chorionic villus sampling (placental biopsy) or cordocentesis (umbilical blood sampling) is covered in cases where:

- there is a strong suspicion (based on NIPT) or the first-trimester test indicates a risk of 1 in 380 or higher that the fetus is affected by trisomy 21, 18 or 13
- ultrasound findings, family history or other factors indicate a risk of 1 in 380 or higher that the fetus is affected by a genetic disorder
- the fetus is at risk due to a complication of pregnancy, maternal illness, or a non-genetic fetal illness or developmental disorder.

7. Can I give birth at a hospital, at home or at a birthing centre?

Compulsory health insurance covers home births or births at a hospital or birthing centre, provided that the latter facilities are included in the Hospital List of the canton of residence. Services provided by a physician or midwife are covered.

8. Are breastfeeding consultations covered?

Yes, three breastfeeding consultations with a midwife or specially trained nurse are covered.

9. What services provided by a midwife are covered by compulsory health insurance?

a) Seven check-ups can be carried out by a midwife during a normal pregnancy. The midwife informs the pregnant woman that a medical examination is indicated during the first trimester. In a high-risk pregnancy without any signs of disease, the midwife collaborates with the physician. In a pathological pregnancy, the midwife provides services as directed by the physician.

b) At check-ups, the midwife can order an ultrasound scan.

c) The midwife can perform cardiotocography, postpartum check-ups, antenatal preparation and breastfeeding consultations.

d) Certain laboratory tests can be ordered by the midwife.

e) In the first 56 days after delivery, the midwife can make home visits, providing care and monitoring the health of mother and child. Support and advice on infant care and feeding can also be provided for the mother.

The midwife can make a maximum of 16 home visits following a premature or multiple birth, for first-time mothers and after a Caesarean section, and a maximum of 10 home visits in all other situations. In the first 10 days after delivery, the midwife can additionally make a second visit on no more than 5 days. For further home visits, a medical prescription is required, even after the 56 days that follow the delivery.

10. Are all services provided in connection with pregnancy or childbirth exempt from cost-sharing?

Insured women are not required to contribute to the costs of special maternity services according to nos. 1 to 9.

In addition, they are no longer required to contribute to the costs of general services or care services in the event of illness from the 13th week of pregnancy until eight weeks after childbirth. This means that they no longer have to contribute to the costs of treatment for non-pregnancy-related illnesses.

11. Whose health insurer covers the costs of care for the newborn?

Care provided for a healthy newborn and his/her hospital stay are covered by the mother's health insurer and are considered to be maternity services not liable to cost-sharing. In cases where the newborn has medical problems, treatment costs are not considered to be maternity services and are thus - together with the associated hospital stay - to be covered by the newborn's health insurer.

VI. Hospital stays

1. Is supplementary insurance offering a free choice of hospitals across Switzerland still necessary?

Yes, it may still prove worthwhile even though insured persons have a free choice among hospitals which are suitable for treatment of their condition and included in the Hospital List either of their canton of residence or of the canton where the hospital is situated (listed hospital). The insurer and the canton of residence make their respective contributions – up to a maximum of the costs which would have arisen if the treatment had been carried out at a listed hospital in the policyholder's canton of residence. If the extra-cantonal hospital tariff is higher than that of a listed hospital in the policyholder's canton of residence, the difference has to be borne by the policyholder, or by the supplementary insurance – if such a policy has been purchased.

Compulsory health insurance covers the full costs in all cases where extra-cantonal hospital treatment is necessary for medical reasons, i.e. in an emergency or if the specific treatment is not offered at a listed hospital in the patient's canton of residence.

VII. Dental treatment

1. Is dental treatment covered by compulsory health insurance?

As a general rule, the costs of dental treatment are not covered. Costs are only reimbursed in cases where dental treatment is necessitated by a serious, non-preventable disease of the masticatory system or by serious non-dental condition or its sequelae, or where measures are required to treat a serious non-dental condition or its sequelae. According to Federal Supreme Court rulings, the list of conditions likely to necessitate dental treatment covered by compulsory health insurance is exhaustive, and these conditions are enumerated in Articles 17–19 of the Health Insurance Benefits Ordinance:

www.admin.ch/opc/de/classified-compilation/19950275/index.html (German),
www.admin.ch/opc/fr/classified-compilation/19950275/index.html (French)