Information for persons who are staying temporarily in Switzerland and are insured with an official health insurance in the EU/EFTA

We build bridges

Gemeinsame Einrichtung KVG

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1. Temporary stay

EU/EFTA* nationals, family members of EU/EFTA-nationals, stateless persons and refugees, who are insured with an official health insurer of the EU/EFTA, have a claim to unanticipated medical treatment in case of illness, recreational accident or maternity during a temporary stay in Switzerland. The Gemeinsame Einrichtung KVG is responsible for the whole of Switzerland for the examination of a claim and then coordinates the billing of the treatment costs as well as the subsequent invoicing to the relevant health insurance abroad.

A temporary stay is considered such if the person intends to stay in Switzerland for a limited period of time and for a certain purpose and plans to return to his/her home country afterwards. Thus, the length of stay in Switzerland is known in advance. An exact date for the return journey is not compulsory, it is sufficient if the person states an approximate time period (e.g. “I intend to stay in Switzerland for studies for one and a half years). The precondition is that the centre of his/her life (main place of residence) remains in the home country during this time.

Possible reasons for a stay in Switzerland can be:

- Holidays
- Studies
- Posting
- Business travels
- Visiting family or friends
- etcetera

*EU: Austria, Belgium, Bulgaria, Cyprus, Czech Republic, Denmark, Estonia, Finland, France, Germany, Greece, Hungary, Ireland, Italy, Latvia, Lithuania, Luxemburg, Malta, Netherlands, Poland, Portugal, Romania, Slovakia, Slovenia, Spain, Sweden. EFTA: Iceland, Liechtenstein, Norway.

If a visitor to Switzerland requires medical treatment during his/her temporary stay, he/she has to present his/her valid claim certificate as well as a proof of identity (e.g. identity card, passport) to the medical service provider.

Claim certificates are:

- European Health Insurance Card
- Provisional Replacement Certificate for the European Health Insurance Card

Important: The European Health Insurance Card does not cover costs, if the visitor has entered Switzerland for the purpose of medical treatment.

2. Travel with the purpose of receiving medical treatment

Should someone intend to travel to Switzerland for the purpose of receiving medical treatment, it is compulsory to apply for the acceptance of the costs with a competent health insurance **before** entering Switzerland. This applies for in-patient as well as out-patient treatment. If the coverage of costs is granted, your health insurance issues the certificate S2 (entitlement to scheduled treatment)

Warning: The treatment costs can only be processed by the Gemeinsame Einrichtung KVG if the claim certificate S2 is valid.

3. Claim to benefits

The medical service providers are bound to grant the same legally applicable benefits to a person from an EU/EFTA state as a person insured in Switzerland has a right to. Therefore, claims to benefits, applicable tariffs as well as cost sharing arrangements are subject to Swiss regulations in respect of health insurance.

According to Swiss health insurance law KVG, insured persons have the right to choose any medical service provider who has been approved by the Swiss health insurance and who is appropriate for the treatment in question.

4. Auditing of accounts

The Gemeinsame Einrichtung KVG coordinates the assessment of claims, examines invoices in respect of conformance to the legal regulations as well as the contractual and negotiated conventions for the whole of Switzerland. It settles treatment costs and subsequently invoices the competent health insurance abroad.

Cash benefits are not paid by the Gemeinsame Einrichtung KVG but have to be claimed direct from the competent health insurance abroad.

5. Summary of medical benefits

The following list gives a summary of the benefits which are covered by the compulsory health insurance according to the regulations of the Swiss Federal Health Insurance Law KVG. The list is not necessarily complete.

Benefits	Comments
Ambulatory treatment according to the methods of traditionally taught and practised medicine	Payment is made for costs resulting from approved physicians, chiropractors and midwives. Further, if prescribed, also for logopaedists, physio- and ergotherapists, nurses or organisations of home care as well as nutrition advisers.
Ambulatory treatment in respect of alternative healing methods (complementary medicine)	Treatment administered by physicians with recognised further education (FMH) in the respective fields of treatment. • Acupuncture • Anthroposophical medical science • Medication therapy in connection with traditional Chinese medicine (TCM) • Classical homeopathy by a physician • Phytotherapy
Medication	Medication handed out or prescribed by a physician if this appears in the list of approved medicines or speciality list for the considered purpose (other medication will not be paid for, not even in part).
Aids and appliances	Devices prescribed by a physician, for examination purposes or treatment e.g. bandages, walking aids, orthoses, incontinence aids etc., according to the list of specialities (MIGEL).
Dental treatment	Payment is made in case of damage caused by • an accident, if no accident insurance is responsible • a serious disease of the masticatory system or if it is due to any other serious illness according to the cases listed in the decree (KLV).
Congenital infirmity	Payment is made for the same benefits as for illness if not covered by the Swiss Invalidity Insurance.
Psychotherapy	Payment is made for treatment by an approved physician or if treatment is delegated to a psychologist/psychotherapist (however only under the supervision of and in the consulting room of the delegating physician).
Laboratory analysis	Analysis ordered by a physician according to the analysis list.
Hospital in-patient treatment	Payment is made for medically required in-patient treatment in the general ward. Hospitals are approved if they appear on the Cantonal hospital list with the appropriate mandate.
Medical rehabilitation	Payment is only made based on a prior cost guarantee by the health insurance and after having been explicitly approved by its medical examiner. In case of in-patient rehabilitation, costs are covered for treatment in the general ward if the necessity has been proven. Hospitals are approved if they figure on the Cantonal hospital list with the ap-

	propriate mandate.
Home care or Nursing home	Payment of costs for nursing measures and other ambulatory measures if applied by • Nurses • Approved home care organisations • Nursing homes
Spa treatment	Daily contribution of CHF 10 for a maximum of 21 days per calendar year in an approved therapeutic bath if prescribed by a doctor as well as doctor's fees, medication and physiotherapies.
Recuperation	Payment for doctor's fees, prescribed medication and physiotherapy.
Maternity	• Seven examinations before birth by a midwife or a physician and one post-natal examination by a physician. • Two ultra-sonic scans • Fees for delivery at home, in a hospital (public ward) or in a quasi-hospital establishment • Three breast-feed consultations by midwives or by nurses with a special training for giving advice on breast feeding • A contribution of max. CHF 150 to pre-natal preparatory courses provided by midwives • Midwife care in childbed max. 10 home visits within 56 days.
Prescribed prevention measures	Payment is made for the following medical preventive measures: • Prophylactic vaccinations • Measures for the prevention of illnesses • Examination of the general state of health • Measures for the early detection of illnesses for certain high-risk groups • Measures for the early detection of illnesses in the general public or certain age groups
Precautionary examination by a gynaecologist	The first two examinations including cancer smear tests at a yearly interval and afterwards every three years.
Contribution towards transport costs	50% of the costs of medically necessary transports to an approved and for the treatment appropriate medical service provider, if transport is not feasible by public or private means: • Max CHF 500 per calendar year for ambulance transport • Max CHF 5000 per calendar year for rescue costs

6. Cost participation

Insured persons have to participate in the costs of their medical treatment. For those staying temporarily in Switzerland (e.g. tourists) this cost participation is charged as a lump sum. Further, in case of in-patient hospital treatment a daily contribution has to be paid by them.

- The lump sum amounts to CHF 92.00 per 30 treatment days for adults and CHF 33.00 for children up to the completed age of 18.
- The daily contribution to the costs of an in-patient hospital stay amounts to CHF 15.00 for persons over the age of 25.
- No cost participation is charged for maternity benefits.

The 30 day period for the calculation of the cost participation starts with the first day of treatment.

If the invoice is paid by the Gemeinsame Einrichtung KVG direct to the medical service provider (tiers payant), the cost participation will be charged to the insured person separately afterwards. In case of a reimbursement (tiers garant) to the insured person, the cost participation will be deducted from the amount due.

7. Reimbursement of costs

The invoicing by the medical service provider occurs according to the different Cantonal contracts and tariffs, either to the Gemeinsame Einrichtung KVG (tiers payant) or to the insured person (tiers garant).

To be able to deal with a reimbursement efficiently and free of charge, we need the original invoice, a copy of the claim certificate and of a proof of identity (e.g. identity card, passport) as well as the complete bank details of the insured person:

- IBAN (International Bank Account Number)
- BIC (Bank Identifier Code)
- Name and address of the bank
- Name and address of the account holder

8. Duty of participation, request for information, professional discretion, data protection

The Gemeinsame Einrichtung KVG is subject to the legal regulations of the general part of the social insurance law (ATSG) and the health insurance law (KVG) in respect of professional discretion and the data protection Act (DPA). On this basis the Gemeinsame Einrichtung has the authorization to deal with personal data which is needed to fulfill our duty (Art. 84 KVG). The handling of data is specified in the regulations which you can find on our website (www.kvg.org/about us/corporate governance). If the clarification of your claim demands further information, you are obliged to answer truthfully. When needed, the Gemeinsame Einrichtung KVG is entitled in this connection to request a detailed diagnosis as well as additional medical information from your doctors for the attention of its medical advisor. All Gemeinsame Einrichtung KVG employees are subject to professional discretion. If you like to have more information about your personal data which we deal with, please contact our legal service in writing together with your ID.

9. Ombudsman

Insured Persons who have problems with their health insurance, can contact the Ombudsman (Ombudsstelle) for health insurance. The Ombudsstelle attends to questions and problems which arise between the insured person and the health insurance.

Ombudsstelle Krankenversicherung, Morgartenstr. 9, Postfach 3565, 6002 Luzern

Telephone German:	+41 41 226 10 10
Telephone French:	+41 41 226 10 11
Telephone Italian:	+41 41 226 10 12
Website:	www.om-kv.ch

10. Legal process

For significant benefits, claims and decrees with which the person in question does not agree, the insurance has to issue a written declaration. Such declarations are forwarded with an instruction on the right of appeal. An appeal against an insurance declaration can be lodged within 30 days with the enacting organisation.

Decisions on appeals have to be issued within a reasonable period. They have to be justified and include an instruction on the right of appeal. The appeal process is free of charge. As a rule, no compensation is paid to those involved.

A complaint can be made against appeal decisions or decrees, even when an appeal has been barred. Every Canton appoints an insurance court as sole authority for the judgment of decisions in respect of social insurance.

The jurisdiction lies with the insurance court of the Canton of residence of the insured person or a third person lodging a complaint.

Notes:
The details given in this information sheet do not establish a legal claim. Legally binding are the competent legal regulations (the Swiss Federal Health Insurance Law and the adherent decree in respect of the execution and the dispensation of justice). Please find this information also on our website (www.kvg.org/Private persons/Assistance).