Gemeinsame Einrichtung KVG
Institution commune LAMal
Istituzione comune LAMal

Information for persons who are domiciled in Switzerland and are insured with an official health insurance in the EU/EFTA or in UK

We build bridges

Gemeinsame Einrichtung KVG

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Please find this information sheet on our website (www.kvg.org/Private persons/Assistance).

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EU/EFTA* or UK nationals and their family members, who are insured with an official health insurer of the EU/EFTA or UK, have a claim to medical treatment in case of illness, recreational accident or maternity if they are resident 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.

Persons, who take up residence in Switzerland and continue to be insured in their home country, can be registered at the Gemeinsame Einrichtung KVG by means of the valid certificate S1 issued by their health insurance.

With these forms there is a claim to all benefits provided for by the Swiss health insurance system if they prove to be medically necessary – with the exception of cash benefits (daily allowance). The same rule applies to the non-earning, dependent members of the family.

*EU: Austria, Belgium, Bulgaria, Croatia, 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, Norway.

1. Registration

Please send us, as a first step, your valid claim certificate S1. Alternatively, your health insurance company can send us the entitlement certificate electronically. You will subsequently receive a questionnaire from us. Your statements on the questionnaire are instrumental in clarifying whether a registration is basically possible or whether you are subject to compulsory health insurance in Switzerland. This e.g. can be the case, if you are either working in Switzerland or draw a pension or unemployment benefits from Switzerland. Children have to be insured in Switzerland if at least one parent is subject to Swiss compulsory health insurance because of employment. A registration for mutual benefits assistance is, in this case, impossible (see item 10).

The questionnaire can also be downloaded on our website (www.kvg.org/Private persons/Assistance).

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

Persons who can be registered for benefits assistance, will receive an insurance card. This serves as proof of a right to benefits for service providers in Switzerland e.g. hospitals, doctors, physiotherapists etc.

Should, for any of the afore-mentioned reasons, the registration for benefits assistance be denied, the relevant Cantonal authorities will be notified. Basically, it is their responsibility to control the adherence to the health insurance obligation in Switzerland (Art. 6 KVG). We will also inform your health insurance about the registration or non-registration.

2. Entitled family members

The group of eligible family members includes the non-working spouse as well as the children until the age of 18. Children, who go to school or studying at university, can only stay registered until the age of 25. Beyond this age, it is checked whether the children are dependent or not. Children who are in an apprenticeship must be insured in Switzerland.

3. Additional information for pensioners

Not gainfully employed persons, who change their official domicile to Switzerland before the official Swiss pension age (64 for women and 65 for men), are obliged to make contributions to the Swiss AHV (old age-, widow/er's and orphan's insurance scheme). Payments into this scheme generate a claim to a pension. The amount of the pension is dependent on the length of time of the contributions. More information in this respect can be obtained at your local AHV/AVS offices. As mentioned under item 3, even a small pension can result in the obligation to be insured with a Swiss health insurance. The amount of the pension does not have an influence on the necessity for being covered by a Swiss health insurance. An application on a pension must be forwarded to the Gemeinsame Einrichtung KVG immediately.

4. 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.

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

5. 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.

6. 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. Detailed information can be found on the website of the Federal Office of Public Health.

Benefits	Comments
Ambulatory treatment	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.
Alternative healing methods (complementary medicine)	Treatment administered by physicians with recognized 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 specialty 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 specialties (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	Cost coverage in the case of medical psychotherapy or psychological psycho-therapy on a doctor's orders.
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. The costs of in-patient treatment will be covered up to the maximum of the tariff of the Canton of residence. This rule applies if there are no medical reasons which make a treatment outside the Canton of residence necessary. Medical reasons exist in case of an emergency or if the necessary treatment cannot be carried out in the Canton of residence.
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 appropriate 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 gynecologist	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

7. Cost participation

Insured persons have to participate in the costs of their medical treatment. This participation includes a fixed annual amount (franchise), plus 10% of the costs exceeding the amount of the franchise (share). Further, in case of in-patient hospital treatment, a daily contribution has to be paid.

- The lump sum (franchise) amounts to CHF 300 per calendar year. No franchise is charged for children.
- The maximum yearly amount of the 10% share amounts to CHF 700 for adults and CHF 350 for children up to the completed age of 18.
- The contribution to the costs of an in-patient hospital stay amounts to CHF 15 per day, except for the day of discharge, for persons aged 25 and over.
- No cost participation is charged for maternity benefits.

If the invoice is paid by the Gemeinsame Einrichtung KVG directly 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.

8. 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 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

9. 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.

10. Compulsory registration

By means of the details you have given us on your questionnaire, we will assess whether benefits assistance is possible for you or whether an obligation to be insured in Switzerland exists (see also item 1). In Switzerland it is only possible to take out health insurance retrospectively for a maximum of three months. Therefore, it is important for you to inform us about changes without delay. If you do not duly inform us, you risk an insurance gap between the end of your health insurance abroad and the beginning of your insurance cover in Switzerland. This can lead to a situation where you will have to pay for medical costs yourself which occur during the insurance gap. Even without medical treatment during the time in question, an interruption of your insurance protection can have considerable consequences in respect of future claims to benefits or insurance cover.

11. Ombuds Office

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

Ombudsstelle Krankenversicherung, Morgartenstr. 9, Postfach 519, 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

12. 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).