Benefits

The compulsory basic health insurance scheme covers illness, accidents and maternity, although for accidents it intervenes only when the insured person has no other compulsory or optional coverage. It also covers certain preventive measures. The principal points are explained below.

All insurers who offer compulsory health insurance must provide the same benefits, which are defined by law. They may not cover other "optional" benefits under the compulsory health insurance scheme.

The law establishes that compulsory health insurance covers only benefits that are effective, appropriate and efficient.

When a service provider (physician, physiotherapist, etc.) provides or prescribes a benefit, treatment, etc. that is not covered by compulsory health insurance, he must inform the patient of this fact.

You will find further practical information in the brochure "Die Krankenversicherung kurz erklärt."

Sie fragen – wir antworten

Die obligatorische Krankenversicherung kurz erklärt
Last update: 04.04.2006 | Size: 349 kB | Typ: PDF

1. Medical benefits

The basic assumption concerning medical benefits is that they comply with legal provisions relative to effectiveness, appropriateness and efficiency. Therefore there is no special list specifying which forms of treatment, benefits, etc. are subject to compulsory insurance coverage, with the exception of maternity, preventive, and dental treatment services.

Whenever coverage for a specific service is contested, an expert commission (Eidg. Kommission für allgemeine Leistungen, ELK) examines the case and voices a recommendation for or against coverage. The Federal Department of Home Affairs takes the final decisions, and publishes them in a special list (Anhang 1 der Krankenpflege-Leistungsverordnung, KLV). Certain benefits are subject to compulsory coverage for a limited period and under specific conditions, pending the results of relevant studies (complementary medical treatment, for example) allowing for a definitive decision.

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Contact a specalist

http://www.bag.admin.ch/themen/krankenversicherung/00263/00264/02418/index.html?lang=en

2. Supplementary benefits

Chiropractors or other persons providing services prescribed by physicians and who fulfil the requirements pursuant to the Health Insurance Ordinance (KVV Art. 38 bis 52) (physiotherapists, occupational therapists, outpatient services, nutrition counselling, diabetes counselling, speech therapists, pharmacists), are reimbursed to the extent specified in the Health Care Benefits Ordinance (Krankenpflege-Leistungsverordnung KLV).

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5. Maternity benefits

Besides delivery, special screening tests during pregnancy and after parturition are covered, as well as the costs of antenatal classes, breast-feeding counselling, and midwifery. All these are listed in full in Articles 13 to 16 of the Health Care Benefits Ordinance 13 bis 16 der KLV.

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6. Dental treatment

The compulsory health insurance reimburses dental treatment only in cases of severe unavoidable diseases of the mastication system, dental treatment required due to a critical general medical condition, or treatment needed to back up and ensure medical treatment for a critical general medical condition. In the case of accidents, reimbursement sets in only if no other insurance covers the costs of treatment. The costs of normal fillings for caries or corrective treatment (braces for children) are not covered. Articles 17 bis 19a der Krankenpflege-Leistungsverordnung (KLV) list all indications that are grounds for coverage in full.

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7. Costs of medical spas, ambulance and rescue

For a prescribed cure at an authorised medical spa (see decision [in German] from 17th January 2001 and from 21st December 2001 1), CHF 10 per day are reimbursed for a maximum period of 21 days. Additional costs of medical treatment or physiotherapy are reimbursed separately.

If for medical reasons a special means of transport (an ambulance, for example) is required, or the patient's health status makes transport by regular public or private means impossible, half the costs are reimbursed up to a maximum amount of CHF 500 per year. These provisions are valid abroad.

The basic health care insurance also pays half the costs of the rescue of persons in a critical condition (e.g. after a heart attack or accident in the mountains), up to a maximum of CHF 5000 per year (in Switzerland only).

(1) Those medical spas are reserved, which required a permission but there are still no valid decisions.

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8. Contribution to costs

The insured persons must pay a part of the costs themselves. Contributions consist of:

- the ordinary flat rate ("franchise") of CHF 300 per year, to which children and adolescents under 18 years of age are not subject. Optional lower insurance premiums with a higher franchise may be chosen.
- an excess of 10 percent of the costs exceeding the "franchise", but only up to a maximum amount of CHF 700 per year (children and adolescents under 18: CHF 350).
- persons who do not live in a household with one or several family members are charged a contribution of CHF 10 per day for the costs of a hospital stay (unlimited), except for maternity.

During a normal pregnancy, benefits are exempt from cost contribution (complications during pregnancy are considered an illness and subject to cost contribution) as are certain preventive measures.

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This document was translated from French by Emilie Bérubé (Planning Branch, Strategic Directions Division, Alberta Health and Wellness, 422-9237), and was then edited by Kerry Precht (Policy Branch, Strategic Directions Division, Alberta Health and Wellness, 415-0972).

The original version of the document is attached.

HEALTH INSURANCE IN SWITZERLAND

This guide answers most frequently asked questions about Swiss health insurance. It offers a global view on legislative changes that took effect January 1, 2006. In cases of conflict, only the current legislation will prevail. For specific situations, consult your insurance company.

DEFINITIONS:

Health funds or health insurers: are organizations that offer the compulsory health insurance. They are non-profit and must be recognized by the Federal Department of the Interior (DFI). Health funds and health insurers can also offer supplementary insurance packages.

Compulsory health insurance (LAMal): compulsory, or basic, health insurance guarantees access to quality health care and to a large range of services that are the same for all insured.

Supplementary insurance: optional, supplementary insurance covers particular needs (e.g., private or semi-private hospital rooms) or additional services (e.g., naturopaths, osteopaths, ordinary dental treatments, etc.). Premium levels for supplementary health insurance correspond to the risk that the insured represents for the insurer. Insurers can refuse to provide insurance to a person, as well as impose restrictions depending on the health status of the insured.

Q. DO I HAVE TO BE INSURED?

A. Yes. In Switzerland, health insurance is mandatory. You must have insurance, if:

- Your permanent address is in Switzerland (regardless of your nationality). Both adults and children pay individual insurance premiums (no family insurance);
- You have a temporary visa that is valid for 3 months or longer;
- You work in Switzerland for a short period of time (less than 3 months with a work permit or visa) and if your insurance coverage is not equivalent to the minimum Swiss health insurance;
- You just moved to Switzerland with the intention of staying permanently; or

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- You are Swiss, or you are a citizen of the European Union or of the European Free Trade Association (EFTA), and you work in Switzerland but your permanent address is in an EU country, Iceland or Norway. This also applies to all members of your family that do not work.

The law stipulates that your insurance company will reimburse any costs you have paid for covered health services since your arrival in Switzerland, or since the birth of a child, if you obtain insurance within three (3) months of arrival. If you do not obtain insurance within three months, you may have to pay additional premiums, and your previous costs will not be reimbursed.

No, you do not have to have insurance if one of the following exceptions applies to you:

- You are insured in another EU country, Iceland or Norway (please refer to www.soziale-sicherheit-ch-eu.ch/index , "Service"); or
- You are an international public servant or a member of a diplomatic or consular mission, unless you and your family are insured from your own initiative.

Q. IN WHAT CASES IS INSURANCE VALID OUTSIDE OF SWITZERLAND?

- In case of emergency if you are temporarily in another country;
- If you are insured in Switzerland but live in another EU/EFTA country (please refer to refer to www.soziale-sicherheit-ch-eu.ch/index , "Service");
- If you are sent to another country by your employer for a limited time, you and your family remain insured in Switzerland (see p.6 "Emergencies"); and
- If you reside in another country to study or for a longer period of time, please consult your canton (see addresses, p.19 of original document).

Q. WHERE DO I GET INSURANCE?

You must contact one of the 90 available health insurance companies. If you live in a country of the EU, Iceland or Norway, your choice will be limited to a fewer number. Cantons also offer complementary information on the obligation to be insured and the exemption possibilities (see addresses, p.19 of original document).

Q. WHAT WILL BE REIMBURSED?

Doctors

In theory, the health fund reimburses the insured for all health care provided by a doctor. But before any treatment or exam, the doctor must let the patient know if the treatment in question will be reimbursed or not by compulsory health insurance.

Health care provided by other medical professionals under medical prescription (e.g., physiotherapy, dietary or diabetes consultation, speech therapy, ergo, or rehabilitation, therapy) is also reimbursed as well as measures prescribed by your doctor (such as tests, radiological exams). Conditions for reimbursement of the services offered by psychotherapists are stricter: consult your doctor or insurance company for details. If you are unsure about reimbursement by health insurance for a specific treatment, speak to your doctor or insurance company. Any treatment being contested for its efficiency, adequacy or cost-benefit ratio will not be covered by compulsory health insurance (e.g., cell therapy).

Hospitals

The costs for treatments and hospital stays in the **public sector,** provided by a facility included in the list provided by your canton, are reimbursed. Additional costs due to semi-private or private sector hospital stays are yours to pay, unless you have private, supplementary insurance for that particular treatment.

Choice of hospitals: The list of hospitals may be obtained from your insurance company or your canton (health department). If a hospital stay in another canton is necessary for a medical reason (for example, an emergency or a specific treatment), the costs will be covered by the insurance company if the facility is on your canton's list of hospitals, or that of the canton where the hospital is located. If you wish to be hospitalized in another canton, contact your insurance company before treatment.

Drugs

Drugs that are prescribed by your doctor and that are included in the "list of specialties"[1] are reimbursed. That list contains about 2,500 generic and brand-name preparations and is regularly updated to reflect the medical advancements. Since January 1, 2001, unless a doctor has explicitly prescribed a brand-name drug pharmacists can substitute brand-name preparations with generic ones, which are more affordable. Generic drugs are those with a composition and dosage that corresponds to the brand-name drug, but are significantly less expensive because expenses related to research are not included in the price.

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[1] A list of drugs covered by insurance companies can be found at www.bag.admin.ch/kv/gesetze/f/index.htm.

Prevention
The following prevention measures are reimbursed:

- **Vaccines** according to the vaccine plan from the Federal Office of Public Health (e.g., diphtheria, tetanus, whooping-cough, poliomyelitis, measles, rubella, etc.) for children and teenagers up to 16 years of age.
  - Flu vaccines (annual) shots are covered if you are 65 years old and up or if you suffer from a chronic illness for which the flu would cause significant complications.
  - Vaccines and prophylactic measures recommended for trips outside of the country (e.g., malaria drugs or yellow fever vaccines) are not covered.
- **Exams of the health status** and development of preschool children (8 exams).
- **Gynecological exams:** The first exam is covered, then one exam every three years if the results of the previous two exams were normal (including sampling for the detection of cervix cancer). Otherwise, drugs are covered if they are medically necessary.
- **Mammography** for the detection of breast cancer.
  - One preventive exam per year is covered, if cancer runs in your family (mother, daughter, sister). One mammography is covered every two years if you are 50 years or older and if it is done as part of the canton or regional campaign for breast cancer detection that meets the quality conditions required by law. Currently, only the cantons of Geneva, Vaud, Valais, Fribourg and Neuchâtel are organizing such campaigns (for more information, please contact your doctor).

Important! These are preventive measures reimbursed by compulsory health insurance, as stated. However, if a doctor suspects an illness, s/he can provide the corresponding health care without being subject to the limitations and conditions mentioned above, and resulting costs will be covered by compulsory health insurance.

In the event of a pregnancy…
During the **pregnancy,** seven routine exams and two ultrasounds (one between weeks 10 and 12; the other between weeks 20 and 23) by a doctor or a midwife are covered. In cases of dangerous or risky pregnancies, all necessary exams (including ultrasounds) are covered.

Preparation for the delivery: 100 francs if you take a class given by a midwife.

Delivery is covered if you are assisted by a doctor or a midwife, in the hospital (delivery and stay), at home or in the ambulance.

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After the delivery, one check-up exam between the weeks 6 and 10 is covered, as well as three information sessions on breastfeeding with a midwife or a nurse who has specific training.

Costs associated with the newborn
The costs for the hospitalization and general care of the newborn while in hospital with the mother are maternity costs, so they need to be taken care of by the mother's insurance. But if the newborn is sick, the costs are covered by the infant's insurance.

Physiotherapy
Physiotherapy sessions are covered if they were prescribed by a doctor and are provided by a registered physiotherapist. Doctors can prescribe a maximum of nine sessions in a three month period. However, doctors can extend the treatment if necessary.

Contrary to physiotherapy, treatments provided by a chiropractor do not need a prescription.

Glasses and contact lenses
Compulsory health insurance contributes to the purchase of glasses and contact lenses: 200 francs annually per child up to 18 years old with a medical prescription. After 19 years of age, a contribution of 200 francs is allocated every 5 years and a prescription is required only for the first purchase. Subsequent updates to an individual's prescription can be done by an optician.

A higher contribution is allocated in particular cases: severe visual problems or when visual impairment is caused by certain illnesses, whatever the patient's age. For more information, ask your ophthalmologist or your insurance company.

Means and equipment
Means and equipment such as bandages, inhalation equipment, prostheses, etc. included in the list[2] are covered by the health insurance under certain conditions.

Dental care
General dental care such as fillings of cavities and corrections of the position and/or location of teeth (with braces) are not covered. Compulsory health insurance only covers the charges if the dental problem was caused by a severe illness of the chewing (mastication) system or if the problem was related to a general illness (e.g., leukemia, cardiac valve replacement, etc.) and dental care is necessary to the treatment of that illness, or if it was caused by lesions of the chewing system brought about by an accident not covered by another insurance.

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[2] The list can be found at www.bag.admin.ch/kv/gesetze/f/index.htm.

In case of accident
If you work more than 8 hours per week, you are insured by your employer for accidents – professional and non-professional – under Swiss accident insurance (LAA). In the event of an accident, you will receive benefits from your accident insurance.

If you do not have the mandatory accident insurance (according to the LAA), you have to have insurance with your health insurance. Your premium will thus be a little higher. In the event of an accident, your health insurance will cover the same benefits as in the case of illness.

Bathing treatments
A contribution of 10 francs per day for 21 days (per year) will be given if the treatment was prescribed by your doctor and is taking place in a registered thermal facility (check with your insurance company). The costs related to the doctor, physiotherapist and drugs are reimbursed separately.

Home care or care provided in a medico-social facility
If you need to be treated at home or in a medico-social facility after an operation or an illness, compulsory health insurance covers the costs of treatments prescribed by your doctor (shots, bandages, etc.). However, compulsory health insurance does not cover the assistance of a housekeeper (e.g., meals, cleaning/housekeeping, errands), or your stay in a medico-social facility. Those costs should be taken care of by the insured.

The beneficiaries of low income assistance can ask for additional complementary payments from AVS/AI (seniors' insurance/disability insurance).

Emergencies: care provided in a European community or an EFTA country
During a short stay in a European or EFTA country (a vacation, for example), if there is an emergency, it is possible to have necessary care covered in the country where you are temporarily staying, only if you asked your insurance company for a European insurance card before your trip. This card should be presented to the doctor or to the country's health fund. The patient should be treated like a national (citizen of that country).

Treatment costs will be paid either by the facility and then charged to the Swiss insurance company, or by the patient who will then be reimbursed by his or her insurance company. The procedure is dealt with between countries.

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Emergencies: care provided in a non-European or non-EFTA country
In the event of an emergency in a country that is not part of the European community or the EFTA, for example when an illness occurs during a trip, compulsory health insurance covers the costs for up to twice the amount that would have been charged in Switzerland. Additional travel insurance may be necessary for certain countries (e.g., the United States) where the medical and transportation costs are higher than those in Switzerland. Contact your insurance company for more details.

Transportation and rescues

- 50% of special transportation costs (e.g., in an ambulance) are covered, but to a maximum of 500 francs per year. That contribution is also paid if the transportation occurs outside of the country.
- 50% of the rescue costs for people who are in danger (e.g., accidents that occurred on a mountain or a heart attack) are covered, to a maximum of 5000 francs annually and exclusively in Switzerland.

Important! In all of the examples mentioned above, the treatments are covered by compulsory health insurance without the obligation or necessity of taking an additional insurance. The enumeration of services and providers is not exhaustive. In case of doubt, ask your insurance company.

Q. WHAT DO I HAVE TO COVER?

Premium
The premium is individual and it is not income-based. Children, teenagers (up to and including 18 years of age) and young adults (19 to 25 years old inclusively) can benefit from lower premiums.

Premiums may vary among insurers, cantons and countries (if the insured lives in a European Community (EC) country, Iceland or Norway). The health funds are authorized to differentiate a maximum of three zones (premium regions) inside a canton or an EC/EFTA country. All insurance companies are obligated to respect these premium regions, as determined by the Federal Office of Public Health.

The Swiss Confederation and the cantons cover a part or the total of the compulsory health insurance premium for low-income individuals.

What are the other costs I have to cover?
A part of the treatment costs are your responsibility. Your contribution to the costs is comprised of two parts:

- The **ordinary franchise** of an amount of 300 francs annually. Children and adolescents up to 18 years of age do not have to pay that amount.
- A **share** (quotas) of 10% of the costs that rise above the franchise amount, but to a maximum of 700 francs per year for adults and 350 francs per year for children and adolescents.

The ordinary participation does not go over the amount of 1000 francs per year for an adult and 350 francs for a child or teenager.

Important! This amount varies with the franchise amount you choose. For example, if you had 2000 francs in medical costs during the year (doctors, hospital costs, drugs, etc.) you will pay 300 francs in franchise + 10% of the remaining amount to cover your share. The total of your contribution will then be 470 francs (300 francs + 10% of 1700 francs = 470 francs). Your insurer will reimburse you 1530 francs.

Maternity
A normal maternity does not require payments for costs. But, illnesses, whether or not they are related to a pregnancy require participation in the payments of the costs, according to the jurisprudence of the Federal Tribunal for insurances.

Mammography
A mammogram that is done during a canton or regional campaign of breast cancer detection is not subject to the franchise. Ask your doctor or health fund for details.

Hospitalization
A contribution of 10 francs daily will be asked of you if you do not live with a member of your family.

Important! For the hospital payments provided in another EC country, Iceland or Norway, refer to the legislation applicable in the country in question.

Q. HOW CAN I SAVE ON PREMIUMS?

Compare offers

- **Payments for compulsory health insurance are the same for all insurers.** Changing insurers will not have a negative impact on your compulsory health insurance coverage. However, there may be differences in the quality of the service provided (e.g., the speed with which reimbursement occurs, advice to the insured). No insurance company has the liberty to decline compulsory health insurance to a person.

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Important! Certain insurers charge a supplementary fee for "administrative costs" when you change insurance companies for compulsory health insurance but keep any additional insurance with your old insurer. However, the supplementary fee cannot exceed 50% of the premium in question. Contact your insurance company for details.

Overview of the premiums

- Every October, the Federal Office of Public Health publishes an overview of the premiums for compulsory health insurance in the year to come. The documents report all the premiums of the cantons and countries of the EC, Iceland and Norway. You can obtain the document free of charge from the Federal Office of Public Health or download it from the website[3].

Deadlines for cancellations

- If your compulsory health insurance has the ordinary franchise of 300 francs **you can cancel** your insurance on two dates: either June 30 or December 31 with three months notice. This means your insurer needs to receive your cancellation request by March 31 or September 30.
- If your compulsory health insurance has a higher franchise or implies a limited amount of service providers (health networks, family physicians, etc), you can cancel only at the end of the calendar year, with a three months notice. This means that your insurer must receive your cancellation request by September 30.
- If your insurer informs you that your premium has changed, you can change insurers at the end of the month preceding the beginning of the next premium payment period. The insurer must communicate the new premium amount to the insured at least two months before it comes into effect. The letter must also indicate that the insured has the right to cancel his/her insurance.
- The change of franchise or type of insurance can only be done at the beginning of the civic year (October 1).

  For example, if you wish to change insurers for compulsory health insurance on January 1, you must cancel your insurance prior to November 30. Your insurer must let you know about the new premium rate before October 31.

Consider supplemental insurance

- Compulsory health insurance guarantees quality services and a large number of services to all. Check the services that are offered by your supplemental insurance by comparing them with what is covered by the compulsory package.

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[3] Please see www.primes.admin.ch.

Important! Never cancel a supplemental insurance package without having precise information from other insurers about the conditions with which they would accept to insure you for supplemental insurance. Insurers may refuse to provide supplemental insurance to a person, set premiums according to a person's age or sex, and impose conditions depending on a person health status. Notable differences exist between insurers.

Choose a particular type of insurance

- If you choose one of the following models, you will benefit from a lesser premium.

Limited choice of doctors or hospitals
A discount of up to 20% may be offered if you accept to be looked after in a Health Maintenance Organization (HMO) or if you accept to first consult with a general physician who will decide to have you see – or not – a specialist or to have you hospitalized if necessary. This means that you give up your right to choose your doctor, unless it is an emergency.

These discounts are related to ordinary insurance premiums with coverage for accidents. If combined with a franchise with options, you can not benefit from the discounts due to conditions related to franchises with options (see below).

Franchise with options
The insurer allows a discount on the premium if you commit to taking a higher premium than the 300 francs of the ordinary franchise, only at the beginning of the civic year and for a minimum of one year. The discount depends on the franchise amount and it is limited by law.

For adults, franchises with options can go up to 500, 1000, 1500, 2000 and 2500 francs and for children franchises go up to 100, 200, 300, 400, 500 and 600 francs. The health funds are not obligated to offer all levels. They can offer for young adults (19 to 25 years old) different franchises from those offered to adults.

Discounts for franchises with options:

- The insurer has to offer a minimum premium that is 50% of the ordinary premium and that has accident coverage for the age group and level of premium of the insured. Even for an insurance package that does not have accident coverage or in the case of a combination of insurances that limits the choice of service providers, the premium can not be reduced.
- The reduction of a premium can not be more than an 80% discount of the additional risk that is being taken care of.

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Insurance with bonus
The premium is gradually reduced for every year that you do not ask for reimbursements. The starting premium is 10% higher than the regular premium. The discount can go up to 50% of the starting premium after 5 years.

Ask for the suspension of your accidents coverage

- If you work more than 8 hours per week and are insured by your employer for accidents – professional and non-professional – according to the law (LAA), you can ask to suspend your accidents coverage.

Ask for the reimbursement of your health insurance premiums in case you enter the military service for a long period of time

- If you complete more than 60 consecutive days of service in the army, the civil service or the civil protection, health insurance can be suspended for that period since military insurance covers the risk of illness for the duration of service.

Q. WHAT SHOULD I DO IF I DISAGREE WITH MY INSURER?

Ask for clarifications
Insurers are legally obligated to respond and give you information if you have questions. *If you are not in agreement…*

Speak with a mediator
The compulsory health insurance mediator or another organization can help you (see addresses p. 21 of original document). *If you still disagree…*

Ask for a formal decision
You can ask your insurer for a formal decision. That decision must be explained and must indicate how you can contest it. The insurer has to send you the decision within 30 days of your initial request for a formal decision. *If you still disagree…*

Consider the possibility to contest
You can contest the formal decision within 30 days. The insurer will send you a "decision on an opposition" that has to be justified and has to indicate how you can have recourse to a canton tribunal.

Important! The contestation procedure is free of charge. However, you cannot have recourse to the canton tribunal if you did not previously dispute (orally or in writing) your insurer's decision.

Finally…
If the canton tribunal for insurances does not give you satisfaction, you can have recourse (in writing only and within 30 days) to the Federal Tribunal for Insurances in Lucerne. That Tribunal delivers judgments that can not be contested.