

SECTION ONE

BACKGROUND AND INTRODUCTION

A. About the Medical Schemes Act

To consolidate the laws relating to registered medical schemes;
To provide for the establishment of the Council for Medical Schemes as a juristic person;
To provide for the appointment of the Registrar of Medical Schemes;
To make provision for the registration and control certain activities of medical schemes;
To protect the interest of beneficiaries of medical schemes;
To provide for measures for the coordination of medical schemes; and
To provide incidental matters.
(Date of commencement: 1 February, 1999)

B. Who is the CMS?

The Council for Medical Schemes (CMS) is a body, which watches over South Africa's medical schemes industry as approved by the Minister of Health. CMS is entrusted with the responsibility of regulating the activities of the industry and protecting consumers against deceptive and unfair practices in terms of the Medical Schemes Act, No.131 of 1998.

C. Vision

A Medical Schemes industry, which is regulated to protect the interest of beneficiaries and to promote fair and equitable access to medical schemes.

D. Mission Statement

The Council will act in an administratively fair and transparent manner with integrity and professionalism and will achieve this vision by:

- ❑ Informing the public about their rights and obligations in respect of access to medical schemes;
- ❑ Ensuring that all entities conducting the business of medical schemes comply with the Act;
- ❑ Ensuring that complaints raised by members and the public are handled appropriately and speedily;
- ❑ Improving the management and governance of medical schemes; and
- ❑ Advise the Minister of appropriate regulatory interventions that will assist in attaining national health policy objectives.

E. What are the Powers vested in CMS?

The Council for Medical Schemes has the power to approve the registration, suspension, and cancellation of registration, of any medical scheme or its benefit options. Responsible for coordinating investigations and inspections of schemes where required.

F. How is CMS funded

- ✓ Appropriations from Government

- ✓ Levies from Medical Schemes
- ✓ Additional sources of income, such as broker accreditation and schemes registration fees.

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SECTION TWO

What is the purpose of this manual?



This manual is intended to provide users with a tool, which will enable them to assist members of the public in any problems related to medical schemes.

The manual will, amongst other things, give a step-by-step explanation on how to lodge a complaint and the necessary procedures to follow to settle a complaint.



A. What is the “business of a medical scheme”?

The definition of the business of a medical scheme is found in section 1 of the Act and reads as follows:

“Business of a medical scheme” means the business of undertaking liability in return for a premium or contribution-

- *To make provision for the obtaining of any relevant health service*
- *To grant assistance in defraying expenditure incurred in connection with the rendering of any health service;*
- *Where applicable, to render a relevant health service, either by the medical scheme itself, or by any supplier or group of suppliers of a relevant health service or by any person, in association with or in terms of an agreement with a medical scheme.*

B. What are the types of medical schemes?

There are TWO types of medical schemes



- A. Open Scheme and
B. Restricted Schemes (Employer-based schemes)

OPEN SCHEMES	RESTRICTED SCHEMES (Employer-based schemes)
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Membership is open to anyone wish to join a medical scheme, and can afford the contributions.

Restricted to a certain group of employees, or professions. Not open to the public.

Types of Products

A. Traditional Medical Scheme

All medical expenses are paid with money from your medical schemes account

- ➡ Money in a risk pool
- ➡ Limits start a fresh each year
- ➡ What you don't use, you lose

In essence traditional cover generally means all your medical expenses are paid in full. Whenever you need medical attention, it is paid for by the scheme, major or day –to – day visits to the General Practitioner (GP)

B. New Generation Medical Schemes

This product can be divided in to TWO:

1. **Risk Pool** – cover uncontrollable expenses or major claims e.g.: major surgery.
These can be typical low frequency events but high cost items that you really have no control over. This is, generally covered by the risk pool of the scheme

2. **Medical Savings Accounts**- cover controllable expenses.

Day-to day expenses like Primary care and visits to the GP, over-counter medication is normally paid out of the savings account

More about Medical Savings Accounts

- ➡ Savings account not to exceed more than 25% of the annual contributions
E.g.: 25% = a total of 3 months of annual contribution
- ➡ Some schemes gives members the option of 10%, 15% or to use 25% of savings

- ➡ Money in savings account get carried over if not used to the next year and added to the new years 25%
- ➡ Upon termination of membership with one scheme to join another scheme with a savings account, moneys are transferred to the new scheme.
- ➡ Should a member decide to join a scheme that has no savings component, the money in the previous medical savings account is due to the member

C. When can a medical scheme suspend or cancel membership?

A medical scheme shall not cancel or suspend a member's membership or that of his/her dependants, except on the grounds of-

- a member fails to pay the contribution, within the time allowed in the medical scheme's rules;
- failure to pay any debt due to the medical scheme;
- not pay the full amount due each month (arrears)
- submission of fraudulent claims;
- committing any fraudulent act (buying toiletries on medical card);
- the nondisclosure of health status (current/past)

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SECTION THREE

Member Rights and Obligations under the Medical Schemes Act, 131(1998)

A. Medical Schemes Members Have Rights.....

⇒ **The right not to be unfairly discriminated against on the basis of:**

Race

Age

Gender

Marital status

Ethnic or social origin

Sexual orientation

Pregnancy

Disability

State of health

⇒ **The right to join a medical scheme of their choice.**

Anyone can join an open medical scheme as long as they can afford the contribution and provided your employer does not require you to join a specific scheme. Employer-based schemes must accept every applicant in the relevant employee grouping as defined in the schemes rules.

⇒ **The right to acquire cover for dependants:**

Who is a dependant Spouse/partner

Children < 21 financially dependent on member

Children > 21, financially dependent on member due to mental or physical disability.

Mother, father, brother, sister of member, in respect of whom member is legally liable for care and support; other persons recognised as dependants in terms of the scheme's rules.

⇒ **The right to as a dependant, to continue membership**

After the death principal of member, dependants must be covered until they choose to leave the scheme or to join another scheme, as long as they can afford the contributions.

⇒ **The right not to be charged more because of OLD AGE or ILL HEALTH.** Contributions can only be based on:

A. INCOME, and

B. NUMBER of DEPENDANTS

⇒ **The right to at least a Basic Set of Benefits**

(Prescribe Minimum Benefits PMB) - As a minimum, schemes must offer the benefits listed in a Schedule to the Act at full cost, for diagnosis, treatment and care, at least in a public hospital

⇒ **The right to have claims paid timeously**

A medical scheme must, subject to the rules of the scheme, pay to a member or health care provider any benefit owing within 30 days of the claim being received

⇒ **The right to receive regular statements**

In addition to paying an account, a scheme must furnish the member with statements detailing-

- Name of supplier
- Date of service rendered
- Total amount charged
- Amount of benefit paid.

⇒ **The right to rectify erroneous claims**

If a medical scheme believes that an account or claim is incorrect or unacceptable, it must –

- Inform the member with reason, within 30 days of receipt, and
- Allow the member opportunity to correct and resubmit the account or claim

⇒ **The right to participate in schemes governance**

- At least 50% of the members of a scheme's board of trustees must be elected from amongst members
- Annual general meetings must be held, at which members may voice opinions and present motions

⇒ **The right to access to scheme information**

A scheme must furnish a member with information, on demand

- Schemes rules
- Latest annual financial statements
- Management accounts accompanying annual financial statements.

⇒ **The right to advance notice of change in:**

- Contributions
- Benefits or

- Any other condition affecting membership.

⇒ **The right to confidentiality of medical information**

Pertaining to the diagnosis, treatment or health status of any member or dependent.

⇒ **The right to obtain proof of membership**

A scheme must issue to each member written proof of membership including:

- Date of entitlement to benefits
- Details of any condition-specific waiting period or general waiting period
- If applicable, details of limitations on health care providers.

⇒ **The right to complain**

When a member is dissatisfied with a service from a medical scheme, it is his/her duty to express this dissatisfaction to the medical scheme so that the latter can rectify or resolve the issue satisfactory. Always follow the proper complains procedures as explained in this manual

B. Members have a duty to.....

⊕ **To be open and honest!!**

- Not to submit fraudulent claims
- Not to commit fraudulent acts, e.g.: buying sunglasses, toiletries, AMC pots on medical scheme account
- Disclose any material information on request fill out the health history form open and honestly

⊕ **To pay contributions (timeously)**

- Directly to a medical scheme not later than 3 days after the payment becomes due.

C. Limitations on member rights.....

➔ **Member rights are limited insofar as schemes rules define benefit limits**

Subject to the Act and prescribed minimum benefits, scheme rules may restrict benefits covered and limit amounts payable in respect of particular benefits. Some options can cover 100% on all benefits; another only covers 60% of benefit the member than pays the outstanding 40%.

➔ **Member rights are limited insofar as manage care interventions may be applied**

Schemes rules may provide for various interventions designed to promote cost-effectiveness and appropriateness of service, e.g. preauthorisation for certain expensive benefits

➔ **Member rights are limited insofar as late claims refused**

A scheme may refuse to pay a claim that is submitted 4 months after:

- The last date of service rendered, as stated on the account, or
- The date on which the account was returned for correction.

➡ **Member rights are limited insofar as membership of, and claims against, more than one scheme is prohibited**

No person may:

- Be a member of more than one scheme
- Be a dependant of more than one scheme, e.g. a child cannot be registered on both parent medical schemes
- Or cannot claim against more than one scheme this can be regarded as fraud

➡ **Member rights are limited insofar as frequency of change of benefit options may be limited**

A scheme may restrict change between options to the beginning of a year, with 3 months notice

➡ **Member rights are limited insofar as waiting periods may be applied**

On admission to membership a scheme impose a:

- 3 month general waiting period
- 12 month condition-specific waiting period, or
- Waiting period on certain PMB's

Except:

1. A child born to a member
2. Change between benefit options
3. Termination of membership due to employment or employer changing schemes.

NEW PROVISION APPLICABLE TO WAITING PERIOD

CATEGORY	3-Month General W/P	12-Month Conditional W/P	Application to PMB
New applicants, or persons not members for preceding 90 days	Yes	Yes	Yes
Applicants, who were members for less than 2 years	No	Yes	No
Applicants who were members for more than 2 years	Yes	No	No
Change of benefits	No	No	N/A
Child-dependent born during period of membership	No	No	N/A
Involuntary transfers due to change of employment or employer changing scheme	No	No	N/A

SECTION FOUR

Complaint Procedures



A. Introduction

The Complaints Unit at the Council is responsible for dealing with written complaints in relation to any matters provided for in the Act

If your rights as a medical scheme member have been violated, you should complain effectively following the proper complaints procedures, so that your complaint can be resolved quickly, and it is your duty as a member to complain when you have a genuine grievance

B. How to complain

Four easy steps in resolving a complaint

➡ First Step: Complain to your scheme

- You can make use of the scheme's **toll free number** at first to raise your concern or complaint,

if not satisfied write to the

- **Principal Officer** of the scheme, giving him/her full details of your complaint:
 - Your full name and surname
 - Your membership number, and
 - Your contact details
 - Any supporting documentation

The Principal Officer will then investigate the matter and take it up with the Administrator of the scheme. If not satisfied with the response from the Principal Officer, the member can ask the Principal Officer to refer the complaint to the **Disputes Committee**

The Principal Officer must convene a meeting of the Dispute Committee. The complainant and members of the Disputes Committee must be given 14 days notice in writing with:

- The date
- Time, and
- Venue of the meeting and details of the dispute

Who sits on the Disputes Committee?

3 Members, who are not members of the board of trustees, employees of the administrator, or officers of the scheme. They serve for **3 years**. At least ONE of the members must be legally qualified.

The Disputes Committee decides on the procedures to be heard, either in person or through a representative.

An aggrieved person has a right to appeal to the Full Council against a decision taken by the Disputes Committee. Such an appeal must be made within 3 months of the decision, in the form an affidavit to the Registrar of the Medical Schemes.

➔ **Second Step: Complain to the Registrar of Medical Schemes**

A complaint must be in writing (section 47(1) of the Medical Schemes Act) detailing the following:

- Name and surname of the complainant
- Membership number
- Contact details of the complainant
- Nature of the complaint.

This information is necessary to investigate the matter, and can be faxed, posted or hand delivered to the Registrar's Office.

- A complaint must be accompanied by any documents or information that substantiate the claim. The Complaints Unit also gives telephonic advice and personal consultations, when necessary.
- The Complaints Unit gives the Scheme details of the complaint, and requires a response within 30 days.

Process of resolving a complaint

- After receiving the complaint from the Scheme the reply is forwarded to the member, giving him/her 21 days to notify the unit of any dissatisfaction. If there is no response from the member, the file is then closed
- The Registrar may give a ruling in matters where the member is not satisfied after the arbitration or medication meeting with both parties to the dispute.
- The Registrar can either resolve the complaint or refer it to the Council, which will take any action necessary to resolve the complaint.

- The penalty for failing to provide information on request or to reply to an inquiry from the Registrar of Council is R1000.00 per day.
- Where there are many complaints against one Scheme, a meeting will be arranged to discuss and resolve this.

➞ **Third Step: Complain to the Council**

- Any person aggrieved by any decision of the Registrar, may lodge an appeal with the Council. This must be done within 30 days of the decision
- The complainant may appear in person or through a representative and tender evidence or submit any argument or explanation to the Council in support of his/her case

Appeal against the decision of Council

A person aggrieved by a decision of the Registrar acting in the concurrence of the Council under the power conferred to it by the Act, may within the period of 60 days after the date on which such decision was given and upon payment to the Registrar of the prescribed fee of R2000.00, appeal against such decision to the Appeal Board



➞ **Fourth Step: Appeal Board**

- The Appeal Board consists of 3 persons appointed by the Minister, of whom one is appointed on account of knowledge in law, two appointed on account of their knowledge of medical schemes

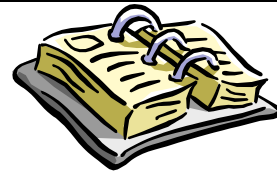
C. How to avoid complaints

1. Make sure you know all the provisions in your schemes rules
2. Read all correspondence from your scheme, e.g. Newsletters, statements
3. Study your benefit guide and familiarise yourself with the Benefit Option that you have chosen
4. Make sure that your contributions are paid in full each month

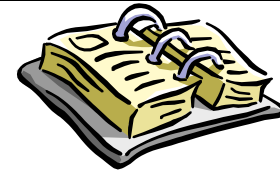
REMEMBER! Avoid complaints by informing yourself

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CAPACITY BUILDING DRIVE

