



**Pick the right apple.**

Choose the right **Medical Scheme** for your needs.

# Contact the Council for Medical Schemes

**Customer Care Centre**

0861 123 267

0861 123 CMS

**Reception**

Tel: 012 431 0500

Fax: 012 430 7644

**General enquiries**

E-mail enquiries:

[information@medicalschemes.com](mailto:information@medicalschemes.com)

**Complaints**

Fax: (086) 673 2466

E-mail:

[complaints@medicalschemes.com](mailto:complaints@medicalschemes.com)

**Postal address**

Private Bag X34

Hatfield

0028

**Physical address**

Block A

Eco Glades 2 Office Park

420 Witch - Hazel Avenue

Eco Park

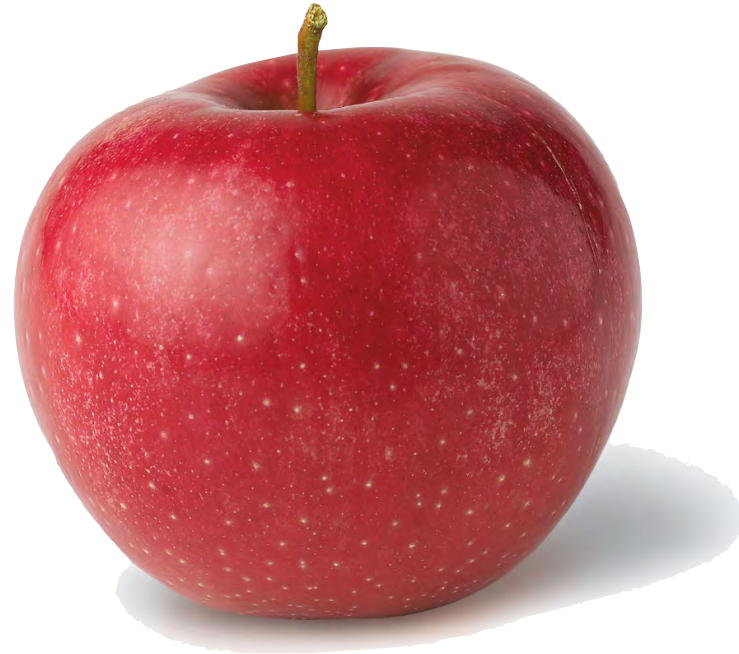
Centurion

0157



# What to consider when joining a Medical Scheme...

- Identify a few open schemes and request information about their benefits, contributions, limitations and exclusions. Compare this information given to see which one meets your needs.
- If you want to join a closed scheme of a certain employer group or association, find out if you meet the relevant eligibility criteria of that scheme.
- Late joiner penalties or waiting periods may be imposed on those applicants who have never belonged to a Medical Scheme, or have had a break in coverage for more than 90 days from the 1st of April 2001, when they decide to join a Medical Scheme after the age of 35.
- Besides the healthcare benefits also find out what the schemes' reserves are (solvency ratio), and non-healthcare expenditure, such as administration costs, to ensure they are in good financial health.
- Understand what PMBs are and under which circumstances the chosen scheme provides such cover for you. Here you can look at DSPs and their proximity to you as well as other networks that provide benefits to members.
- Remember, the sooner you join a Medical Scheme, the greater the benefits in the long run and the less penalties you may face!



# What to consider when changing your Medical Scheme...

- Read the material schemes send on the important changes to benefit options for next year.
- If you are unsure, call the scheme to explain any changes, limits, benefits and other relevant information.
- Elect an option according to your healthcare needs and what you can afford.
- You may make use of an agent or broker (intermediary). Remember it is not compulsory to use a broker, but if you do, ensure that he/she has been accredited by the CMS and that your selection of a scheme and benefit option is based on informed consent.
- Medical Schemes may appoint preferred/network providers who have contracts with the Medical Scheme to provide services. The Medical Scheme rules will determine how preferred/network providers are funded. It is as such important that you as the member ensure that you know the scheme rules and study the benefit guide in detail. It is also necessary to contact your Medical Scheme to find out who the preferred provider is before you make appointments.
- Determine how close Designated Service Providers (DSPs) are to your home and/or place of work as well as what co-payments are applicable for the voluntary use of non-designated service providers.
- No restrictions, co-payments, waiting periods or exclusions may be applied to any person in respect of the prescribed minimum benefits (PMBs) if the services are obtained from DSPs. In instances where services are voluntarily obtained from a non-DSP, co-payments may apply.
- Note that pre-authorisation, formularies (approved drugs for a specific medication) and protocols may also be used by a Medical Scheme to ensure that healthcare is cost-effective and affordable.
- Existing Medical Scheme members who wish to move to another scheme should please note that waiting periods may apply. This is a design of the Medical Schemes Act, 131 of 1998 to prevent scheme hopping, where members move from one scheme to another too frequently.





## What you must also know about your Medical Scheme option...

**Your option may have benefit limits** – mention overall limits, sub-limits, cancer, limits for devices and appliances. Most Medical Scheme options have limits on what is funded for medical care. There is a difference between the traditional benefit options and the more modern benefit options known as New Generation Options. The traditional benefit options do not have a medical savings account and fund all claims from the day-to-day benefits, whilst the more modern benefit options have a medical savings account that is used for funding of certain services such as general practitioner (GP) visits and acute medicines. The day-to-day (annual) benefits may have an overall limit of money that is used to fund day-to-day claims, but it is important to note that this limit may be divided among certain benefits/services by sub-limits.

For example, a family might have an annual limit where the overall amount is R500 000 per family per year. Included in this amount would be benefits/services regarded as “major” events, such as MRI and CT scans, which might have a sub-limit of e.g. R5 000 per family per annum. This means that if a member has scans that cost more than R5 000 (either for the family or even just one dependent) the Medical Scheme will pay up to R5 000 only. Most Medical Schemes have sub-limits on prosthesis, such as artificial joints and other devices which may include certain rules / entry criteria, e.g. prosthetic devices that are limited to internal prosthesis only. Cancer (oncology) benefits are also usually stipulated as a specific amount, e.g. R250 000 per family per year on oncology accounts. These sub-limits will be funded from the R500 000 overall limit.



It is important to take note of the various overall limits, the sub-limits for certain services and the rules that apply to the sub-limits. The most important information to remember, however, is that the specified limits and sub-limits may not be used to limit the payment of prescribed minimum benefits (PMB) accounts. PMB accounts may however be paid from these benefits first (this must be in the schemes' rules) even if it depletes the annual benefits, however PMB accounts that cost more than these limits must be funded from the scheme's risk pool.

**Your option may have a limit on what it pays doctors** who treat you in hospital. Medical Schemes may appoint designated service providers (DSPs) who must treat PMB conditions. Medical Schemes may however appoint preferred/network providers who have contracts with the Medical Scheme to provide services for non-PMB conditions. The Medical Scheme rules will determine how preferred/network providers and non-PMB conditions are funded. It is as such important that you as the member ensure that you know the scheme rules and study the benefit guide in detail. It is also necessary to contact your Medical Scheme to find out who the preferred provider is before you make appointments. In cases where a preferred provider is not used for non-PMB conditions the Medical Scheme may have a limit that they will fund towards the account.



**Your option has a network or it is a capitated option** and you have to use certain doctors, pharmacies, etc. Please see previous answer. In instances where one has used a non-network or a non-capitated provider involuntarily, the Medical Scheme must fund such claims in full; irrespective of whether the claim is a PMB or not. However, should one choose not to use a preferred/network provider, the scheme will only pay amounts they would have paid to a preferred/network provider or impose a co-payment. Medical Schemes' rules usually have a limited number of consultations that a member can have to use a non-preferred/network provider. These would be referred to as out-of-network/area visits.

**Your option has a DSP for PMBs and you aren't using it.** Regulation 8(2)(a) specifies that your Medical Scheme may appoint a DSP for the diagnosis, treatment and care of PMB conditions. If you, out of free will (voluntary) choose not to use the DSP, the Medical Scheme may charge a co-payment. The co-payments must be specified in the Medical Schemes' registered rules and can be either a percentage of the account, the difference between the scheme rate and the actual expenses or a fixed amount. It is therefore extremely important to find out who the DSPs of your Medical Scheme is and ensure that you use these providers to prevent co-payments. If you have a PMB condition and the DSP provider is not within a reasonable distance, is not available within a reasonable time period or immediate medical or surgical treatment for a PMB condition was required under circumstances, or at locations which reasonably precluded the beneficiary from obtaining such treatment from a DSP, the Medical Scheme may not implement a co-payment.

**Your scheme has a medicine formulary and your medicines are not on it.** If your Medical Scheme has a medicine formulary (list of medicines that will be paid in full by the scheme) and you voluntarily decide to use a drug that is not on the formulary, the Medical Scheme may impose a co-payment. Again such co-payment must be specified in the Medical Schemes' registered rules and can be either a percentage of the account, the difference between the scheme rate and the actual expenses or a fixed amount. In cases where you have used all the medicines on the formulary, but it is not effective, caused side-effects or may cause harm (e.g. you are allergic to the specific medicine on the formulary), Regulation 15I (c) applies and the Medical Scheme must make provision to fund the prescribed medicine without any penalty to the member.

**Your scheme has managed care protocols** that apply to certain treatments eg cancer. The protocols used by Medical Schemes must be evidence based meaning that there must be scientific studies that confirm the limits. The protocols must also take into account cost effectiveness and affordability. Doctors may prescribe treatment for PMB conditions such as cancer that is not evidence based or even when there is scientific studies available the treatment may not be cost effective. Unfortunately it is a horrible fact that cost is used to determine treatment, e.g. chemotherapy is prescribed but the costing studies state that R10 million must be spend to save one life. Unfortunately the specific treatment will then not be cost effective or affordable and as such not qualify for PMB level of care. Members should also take note that the PMBs are the minimum that Medical Schemes must fund and the regulations state that this minimum is



the same treatment that is available in the state sector. If the treatment prescribed by the doctor is not available in the state sector the Medical Scheme cannot be compelled to fund such treatment in full. In these cases the Medical Scheme may fund the treatment to the same amount as what the treatment available in the state sector would have cost.

**Your scheme has co-payments or deductibles** for certain procedures or treatments. Please refer to previous points.

**You have a medical savings account but the contributions are insufficient for your needs.** The Medical Schemes Act, 131 of 1998 prescribes that only 25% of the total gross contribution may be made towards a medical savings account. This account is used to fund largely general day-to-day claims, such as GP visits. Medical Schemes are allowed to indicate any amounts not exceeding the 25% prescribed in their rules. Should the funds in the medical savings account be depleted, members become liable for all outstanding balances that, as per the scheme rules, would have been paid from the medical savings account.

Some options within Medical Schemes have a self-payment gap of a threshold amount, which is a specified amount of money that members need to pay from their pocket first before accessing benefits again. Once this amount was reached/"paid in", an above threshold benefit (ATB) cover kicks in and all further claims will be paid by the scheme. It is however important to check with your scheme if this above threshold benefit applies to the option you belong to.

PMB accounts may never be funded from the medical savings account and even if the medical savings account and all annual benefits are depleted the PMB accounts must still be funded, but note that protocols, formularies and DSPs apply.

**You want treatment for which your scheme excludes cover.** In cases where the specific treatment you need is excluded by the scheme and stipulated as such in the scheme rules, you will need to pay the accounts from your own pocket. Medical Schemes can only pay for services/benefits defined as relevant health services.

If the condition is a PMB and the treatment is available in the state sector the Medical Scheme may not exclude the specific treatment. Most Medical Schemes will exclude treatment that is not available in South Africa, as well as cosmetic surgery.

**You get what you pay for** – the trade off between contributions and choice and level of cover. If you choose cover that is not adequate set your own savings aside for future medical needs. Medical Schemes fund accounts as per the limits and sub-limits, but there is cross-subsidisation – this means that the pool of money available in the day-to-day benefits are contributed by all members. Healthy members who do not claim or use all their benefits will as such subsidise the older and more sick members.





**For more information visit**

[www.medicalschemes.com/benefitseason2015](http://www.medicalschemes.com/benefitseason2015)

Click [here](#) to subscribe to our Newsletters