CMS
Council for Medical Schemes

CMScript

Member of a medical scheme?
Know your guaranteed benefits!

Issue 5 of 2014

Disclosure of information and waiting periods:
This issue focuses on the rights and responsibilities of members with regards to disclosure of medical information on application of membership and waiting periods for new members

NOTE: The Clinical Review Committee of the Council for Medical Schemes (CMS) noticed that members of medical schemes are not fully aware of their membership rights and responsibilities. The word member/s in this article refers to both the main member and any dependent/beneficiary of the medical scheme.

Membership application and termination

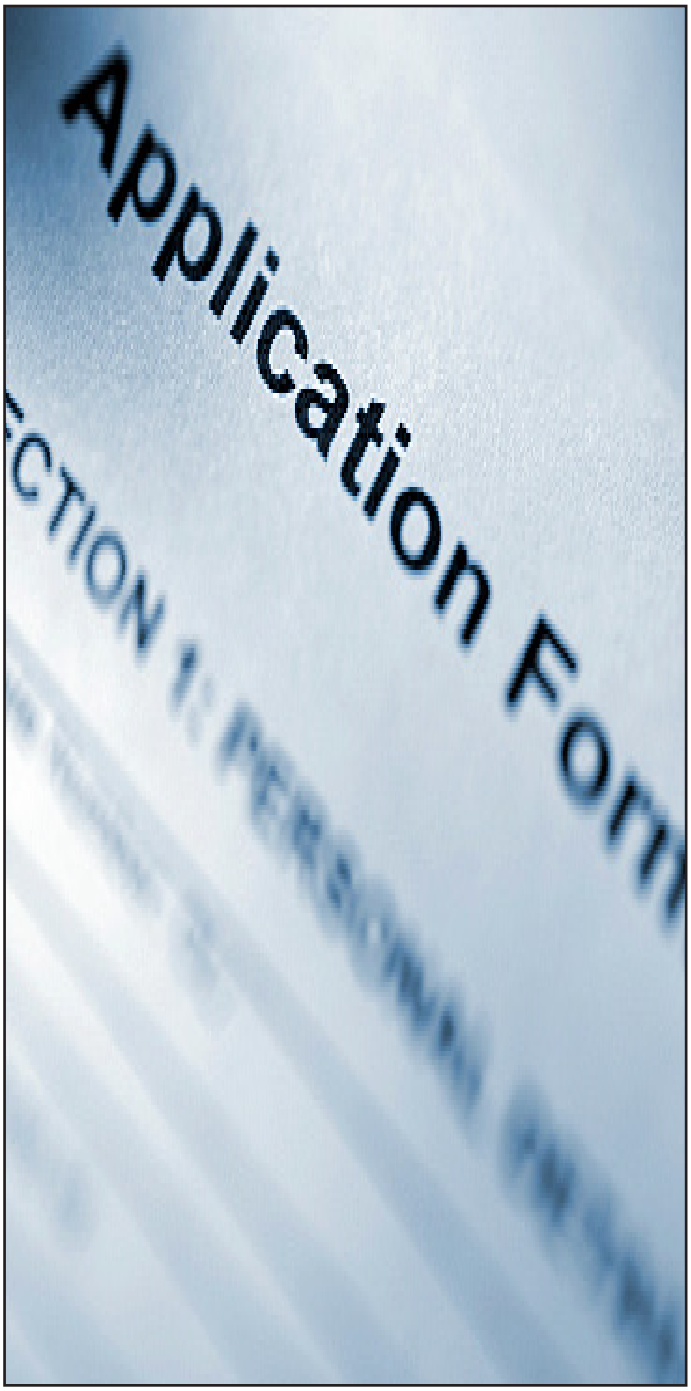
Applicants and members of medical schemes have certain rights but also certain responsibilities.

Section 29 (1) (n) of the Medical Schemes Act specifies that membership applications may not be influenced by an applicant's age, sex and past or present state of health. This means that you have the right not to be unfairly discriminated against or charged a higher membership fee on the basis of:

- Race
- Age
- Gender
- Marital status
- Ethnic or social origin
- Sexual orientation
- Pregnancy
- Disability
- State of health

Section 29 (2) further states that your membership may not be cancelled or suspended except on the grounds of:

- failure to pay, within the time allowed in the medical scheme's rules, the membership fees required in such rules
- failure to repay any debt due to the medical scheme
- submission of fraudulent claims
- committing any fraudulent act
- non-disclosure of material information



2

Non-disclosure of material information

Section 29A (7) state that a medical scheme may require an applicant to provide the medical scheme with a report in respect of a condition for which medical advice, diagnosis, care or treatment was recommended or received in the 12 month period ending on the date on which an application for membership was made.

The above section indicates that the applicant has the responsibility to disclose information about previous medical treatment. As already mentioned, non-disclosure of any material information may lead to termination of the membership of either the main member or the dependent/beneficiary.

Each scheme has its own application form that contains a medical questionnaire in which members must generally disclose all conditions/diseases that:

- A member or dependent suffer from on the date of application
- Was diagnosed with in the past 12 months – this includes conditions that were diagnosed but managed with lifestyle changes e.g. high cholesterol
- Was treated for in the past 12 months
- Obtained medical advice for – even if medical advice was not obtained from a doctor but another provider such as a pharmacist

Please note that most of the application forms also include a question where the member should indicate if he/she or any of the dependents had any symptoms or illnesses that was not specifically diagnosed by a doctor or for which no specific treatment was provided.

Section 29(2) indicates that membership can be terminated for the non-disclosure of material information but what exactly is meant with the word material?

According to the Black's Law Dictionary Free Online Legal Dictionary 2nd Ed, material information means important; more or less necessary; having influence or effect; going to the merits; having to do with the matter.

According to the Oxford legal dictionary material information is (Of evidence or a fact) significant or relevant, especially to the extent of determining a cause or affecting a judgement.

CMS has received a lot of enquiries from prospective members who were requested to provide a medical report from their treating doctor. Is this allowed and who should pay the doctor for writing this report?

Regulation 12 determines that if a medical scheme requires a medical report to be provided to it by an applicant, the medical scheme shall pay to the applicant or relevant health care provider the costs of any medical tests or examinations required by the medical scheme for the purposes of compilation of this report.

Break between medical schemes **90 days or more**	**Break between medical schemes** **LESS than 90 days (0 to 89 days)**		
PERIOD OF PREVIOUS MEMBERSHIP **Regardless of previous membership**	**PERIOD OF PREVIOUS MEMBERSHIP** **24 Months and longer**	**PERIOD OF PREVIOUS MEMBERSHIP** **Shorter than 24 months** **(previous waiting periods may still be in place)**	**PERIOD OF PREVIOUS MEMBERSHIP** **Regardless of previous membership in cases of:** ***Change of employment** ***Employer changing / terminating medical scheme**
▪ **3 month general waiting period** ▪ **12 month condition specific waiting period** ▪ **Waiting period may include PMB conditions**	▪ **3 month general waiting period** ▪ **Waiting period may not apply to PMB conditions**	▪ **12 month condition specific waiting period** ▪ **Waiting period may not apply to PMB conditions**	▪ **No general or condition specific waiting periods may be imposed**

Waiting Periods

The Medical Schemes Act provide for waiting periods to be imposed on new applicants to a medical scheme and members who move from one scheme to another. The waiting periods that may be implemented is determined by the following factors:

- Did the applicant previously belong to a medical scheme?
- If yes, how long before the application was the termination of the previous?
- Did the applicant belong to a previous medical scheme for more than two years?
- Is the application a result of involuntary transfer due to a change in employment?

The act allows for two different waiting periods i.e.:

- 3-months General Waiting Period – during this general waiting period no claims will be funded by the scheme
- 12-months Condition Specific Waiting Period – this is a period during which a member is not entitled to claim benefits in respect of a condition for which medical advice, diagnosis, care or treatment was recommended or received within the 12 month period ending on the date on which an application for membership was made.

Condition specific waiting periods may therefore not be imposed on related conditions, unless a direct link can be demonstrated between the relevant conditions. In cases where an applicant never belonged to a medical scheme in the past or where the member had a break in coverage exceeding 90 days, the waiting periods may also include prescribed minimum benefit (PMB) conditions.

Example

A member suffers from high blood pressure (hypertension) and in the 12 months preceding his application treatment for this was received. The condition is declared and the scheme informed of the medicine that is used for this condition.

The medical scheme imposed a 12 month condition specific waiting period on the hypertension. The medical scheme however also indicated that the waiting period includes all related conditions /conditions that may be caused by hypertension. These conditions included stroke, heart attacks, other cardiac problems and kidney failure.

The medical scheme acted within their rights by imposing the waiting period on the hypertension but it is incorrect to extend this waiting period to the related conditions.

The act specifically indicates that only conditions for which medical advice, diagnosis, care or treatment was recommended or received within the 12 month period ending on the date of application may be included in a condition specific waiting period.

The table on the left indicates which one of the two waiting periods (or both) may be imposed in different circumstances.

References:

http://thelawdictionary.org/material/
Oxford Law Dictionary

PMBs

Prescribed minimum benefits (PMBs) are defined by law. They are the minimum level of diagnosis,treatment, and care that your medical scheme must cover – and it must pay for your PMB condition/s from its risk pool and in full. There are medical interventions available over and above those prescribed for PMB conditions but your scheme may choose not to pay for them. A designated service provider (DSP) is a healthcare provider (e.g. doctor, pharmacist, hospital) that is your medical scheme's first choice when you need treatment or care for a PMB condition. You can use a non-DSP voluntarily or involuntarily but be aware that when you choose to use a non-DSP, you may have to pay a portion of the bill as a co-payment. PMBs include 270 serious health conditions, any emergency condition, and 25 chronic diseases; they can be found on our website by accessing the link provided (www.medicalschemes.com/medical_schemes_pmb/index.htm).

The Communications Unit would like to thank Ronelle Smit for assisting with this edition of CMScript.

information@medicalschemes.com

Hotline: 0861 123 267
Fax: 012 430 7644