This supplement is brought to you by the Council for Medical Schemes (CMS), a statutory body established through the Medical Schemes Act, No. 131 of 1998, to provide regulatory supervision of private healthcare financing through medical schemes.

Protecting your family

means choosing your medical scheme wisely

How to choose a medical scheme

1. Ensure that the scheme you are considering is duly registered in terms of the Medical Schemes Act, No. 131 of 1998. The names, addresses and telephone numbers of all registered schemes are published on the website of the Council for Medical Schemes at www.medicalschemes.com.
2. Identify a few schemes and request information about their benefits, contributions, limitations and exclusions. Compare the information provided to see which one meets your needs.
3. Besides the healthcare benefits, also find out what the schemes' reserves are (solvency ratio), and non-healthcare expenditure, such as administration costs, to ensure that the scheme you choose is in good financial health.
4. Read and get a good understanding of the prescribed minimum benefits (PMBs) that all medical schemes must provide in terms of the Medical Schemes Act. Get a clear understanding regarding the circumstances under which your chosen scheme will provide PMB cover for you. Look at the scheme's list of designated service providers (DSPs), and how close they are to where you stay or normally access medical care. Do the same with all other networks identified by the scheme to provide services to members.

Advice for current medical scheme members

1. If you are already a member of a scheme, read all the information material, such as options to change plans, etc. Ensure that you understand how the benefit options operate, and select an option based on your healthcare needs, and what you can afford. Detailed information regarding benefits and related contributions is provided in the registered rules of medical schemes. It is essential that you obtain the rules of the scheme or a summary thereof, to verify all relevant information, to help you to make an informed choice.
2. Some people choose to make use of an agent or broker (intermediary). The use of a broker is however not compulsory. If you do choose to make use of a broker, ensure that he/she has been accredited by the CMS. Your selection of a scheme must always be based on informed consent.

What is a medical scheme?

Medical Schemes are not for profit organisations.

"[The] 'business of a medical scheme' means the business of undertaking liability in return for a premium or contribution:

(a) to make provision for the obtaining of any relevant health service; *[this means that medical schemes must provide healthcare benefits, including a prescribed package of minimum benefits for healthcare needs.]*

(b) to grant assistance in defraying expenditure incurred in connection with the rendering of any relevant health service; *[this means that monetary contributions are paid in exchange for healthcare benefits.]*

(c) 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." *[this means that medical schemes are allowed to contract with service providers for the provision of comprehensive benefits, including out-of-hospital benefits and PMBs.]*

Medical schemes are based on unique principles stipulated in the Medical Schemes Act. These are:

1. Open enrolment: means that anyone can join a medical scheme and that if you apply for membership, the scheme of your choice cannot turn you away.
2. Community rating: means that all members of a medical scheme pay the same monthly contribution for the same benefits. Variations in contributions may only apply based on the level of income and/or number of dependants.
3. A set of prescribed minimum benefits, commonly referred to as PMBs.

Medical schemes are not for profit entities, and they belong to the members of the scheme. On the other hand, short and long-term insurers providing health insurance products are commercially driven for-profit companies. Unlike medical schemes, health insurance companies are owned by the shareholders.

PMBs ensure that members are fully protected against unforeseen and potentially devastating health events. These principles do not apply to health insurance products. Anyone can buy a short-term or long-term health insurance policy, but the premium you pay will usually depend on the insurer's assessment of your state of health. Older individuals, or individuals with pre-existing health conditions, will pay more for health insurance cover. At the extreme, health insurance companies may refuse to cover you if they consider that there is too high a risk that you are likely to claim.

How does the Medical Schemes Act protect members of medical schemes?

The definition of the business of a medical scheme, as in the Medical Schemes Act No.131 of 1998, was always meant to guide medical schemes on the type of services required to be provided to members in order to operate as a registered medical scheme.

What are medical scheme administrators?

Medical schemes sometimes make use of administrators to handle the administration services for the scheme. Administrators are privately owned companies with the skills, infrastructure, and capacity to render a full range of administration services to schemes in compliance with prevailing legislation. They are accredited by the CMS in

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Postal: Private Bag X34, Hatfield, 0028
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terms of the Medical Schemes Act, on condition that they meet the certain criteria stipulated in the Act. Many medical schemes outsource their functions to administrators.

What is the role of an administrator?
Administrators perform a variety of administration functions in line with written contracts and service level agreements with schemes. They utilise comprehensive and integrated information technology systems that are capable of performing all administration, financial, and management functions.

Medical scheme administrators maintain records of member information. The systems used by the administrators is sophisticated enough to process and provide detailed information on individual members registered with the scheme.

It is the administrator who processes your application for membership and also suspends and terminates it. Administrators collect the monthly members' contributions and manage their allocation as well as the reconciliation of accounts. They ensure that outstanding amounts are collected from members.

How do self administered schemes do it?
Some medical schemes do not make use of the services of administrators. A self-administered scheme undertakes all the administration functions inhouse. Self-administered schemes do not need to be accredited for the administration functions, but they must comply with the stipulated administration standards and are subject to on-site evaluation of compliance, in the same way as third-party administrators.

Your rights as a medical scheme member

You have a right NOT to be unfairly discriminated against on the basis of your Race/Age/Gender/Marital Status/Ethnicity/Sexual orientation/Disability/State of health.

You may join a medical scheme of your choice as long as you can afford it and provided your employer does not require you to join a specific scheme.

Remember that your medical scheme must be registered with the Council for Medical Schemes, or you may not be able to enforce your rights.

Your dependants have the right to be covered by your scheme.

A "dependant" is defined in the Medical Schemes Act as your spouse/partner, dependant children, other members of the main member's immediate family for whom he/she is liable for support, any other person recognised under the rules of the scheme or children under 21 or older if permitted by the rules of the scheme.

Dependants have the right to continue membership of the scheme if the principal member dies, they must be covered until they chose to leave the scheme, join the same scheme in their own right, or join another scheme, as long as they can afford the contributions.

Your medical scheme may NOT charge you more because you are older or sicker. Variations in contribution rates may only be based on income, number of dependants or both.

However, if you are joining a medical scheme later in life for the first time, you may have to pay more, or wait a little longer before you can receive certain benefits.

All Medical Schemes have to provide a basic set of benefits known as prescribed minimum benefits – PMBs.

If your condition is covered by a PMB (e.g. many cancers and HIV/AIDS), the minimum level of care should be equivalent to what is available in the public sector.

Your scheme must pay claims timeously.

Your medical scheme must pay valid claims within 30 days of the claims being received. If a PMB diagnosis is not confirmed, additional clinical information must be sent to the scheme by the treating doctor or healthcare provider to allow the scheme to verify if that claim qualifies for PMB benefits.

You have the right to receive regular statements.

In addition to paying an account, a scheme must furnish you with statements detailing the name of supplier (doctor, hospital, pharmacist etc.), date of service rendered, total amount charged and amount of benefit paid

You have the right to resubmit a claim if the scheme has not paid a valid claim within 60 days.

If a medical scheme believes that an account or claim is incorrect or unacceptable, it must inform you within 30 days, giving the reasons for declining the payment and allow you to resubmit the claim.

You have the right to participate in the scheme's governance.

At least 50% of the members of a scheme's board of trustees must be elected among the scheme members, by members. Annual general meetings must be held, at which members may voice opinions, ask questions and present motions.

You have the right to information about your scheme.

A scheme must give you information upon request about scheme rules and benefits, the latest annual financial statements, management accounts and accompanying annual financial statements and the list of protocols and formularies.

You have the right to advance notice of change in contributions, benefits, or any other changes affecting membership.

You have the right to confidentiality of your medical information.

Your scheme must keep information strictly confidential regarding the diagnosis, treatment and health status of you and your dependants.

You have the right to obtain proof of membership. A scheme must issue to each member with a written proof of membership including the date of entitlement of benefits and details of any waiting periods or any other conditions applicable e.g. late joiner penalties.

You have the right to complain to your medical scheme if any of these rights are not respected or if the service is deficient in some way or other.

If you have exhausted all avenues of complaint at your scheme and its dispute committees, you may take it up with the complaints department of the Council for Medical Schemes, or appeal directly to Council if you are unhappy with the findings.

Your obligations as a medical scheme member

Be honest and open with your scheme or when joining a medical scheme. If you are found to have provided false information, you may lose your membership or have it suspended. If you act illegally, criminal charges may be laid against you.

Do not submit fraudulent claims e.g. boosting the amount claimed for, or claiming for sunglasses and toiletries or other items which are strictly not allowed by your scheme.

You must disclose any material information about your health, that is asked on application to the scheme.

Pay contributions (timeously).

Contributions must be paid directly to your medical scheme on time, unless payment arrangements are made with your employer.

Limitations on member rights

Some rights can be limited in the rules of your scheme.

Scheme rules may restrict benefits covered and limit amounts payable on items not covered by the Medical Schemes Act, its Regulations and the PMBs. Some schemes, for instance have a limit on dental or optometry benefits. It is important to read and understand your scheme rules. Some options within schemes cover 100% of all benefits; while other options within the same scheme may cover less benefits.

Some schemes may require you to get pre-authorisation before certain procedures may be covered or performed.

This and other cost-saving interventions are known as "managed care" and may be applied – but must be contained in the rules of your scheme.

*If your scheme has entered into contracts with certain hospital groups, doctors or pharmacists for services, this must be contained in the rules of your scheme.

A scheme may refuse to pay a claim that is submitted four months after:
- The last date of service rendered, as stated on the account, or
- The date on which the account was returned for correction.

Members and their dependants are not allowed to belong to more than one scheme at anytime. Members may not transfer benefits to persons not registered on their medical scheme.

No person may be a dependant of more than one medical scheme, or claim against more than one scheme. This can be regarded as fraud.

Schemes may restrict changes between options to the beginning of a year. Schemes may also ask for sufficient notice before changes are made.

Waiting periods and late joiner penalties may be imposed under certain strictly limited circumstances. These conditions must comply with the Medical Schemes Act.

On admission to membership a scheme may impose a three month general waiting period, a12 months condition-specific waiting periods (CSWP) for pre-existing conditions, a waiting period on PMBs or a late joiner penalty

Exceptions apply in cases where termination of membership due to employment or employer changing schemes, a child born to a member, or there is a change between benefit options.

Category	3 Month General waiting period	12 Month condition-specific waiting period	Application to PMB
New applicants, or persons who were not members for the past three months or more.	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 benefit option.	No	No	No
Child-dependant born during period of membership.	No	No	N/A
Involuntary transfers due to change of employment or employer changing scheme.	No	No	N/A

What should you ask your doctor before and after treatment?

- Does the condition form part of the prescribed minimum benefits (PMBs)?
- Is the doctor or service provider part of my medical scheme's designated service providers (DSPs)?
- Do I need authorisation from my medical scheme before receiving the treatment or service?
- Do you charge at my medical scheme's tariff?
- Is there a co-payment or levy?
- Is this medication on my medical scheme's formulary list?

The Complaints Procedure

Who can complain?
Any beneficiary of a medical scheme, or any person who is aggrieved with the conduct of a medical scheme, broker, managed healthcare organisation, and administrator of a medical scheme, can submit a complaint to the Registrar of Medical Schemes' office.

It is however important to note that complainants should always first seek to resolve any complaint through the scheme's complaints processes, before approaching the Council for Medical Schemes for assistance.

1. You can contact your scheme by phone or writing to the Principal Officer of the scheme, giving her/him full details of your complaint.
2. If you are not satisfied with the response from your medical scheme's Principal Officer, you can ask the matter to be referred to the Disputes Committee of the scheme.
3. If you are not satisfied with the decision of the Disputes Committee, you can appeal against the decision within 3 months of the date of the decision, to the Council. The appeal should be in the form of an affidavit directed to the Council.

Complaints can be submitted by any reasonable means such as a letter, fax, e-mail or in person at the Registrar of Medical Schemes' offices from Mondays to Fridays, 08:00 – 16:30. The complaint form is available on the Council for Medical Schemes' website: www.medicalschemes.com.

Your complaints should be in writing, detailing the following:
Full names, membership number, benefit option, contact details and full details of the complaint with any documents or information that supports the complaint.

The Council for Medical Schemes' Complaints Adjudication Unit also provides telephonic advice and personal consultations, where necessary.

Who can you complain about?
The Council for Medical Schemes governs the medical schemes industry and therefore your complaint should be related to your medical scheme.

If your complaint is related to any other aspect of the health industry, please visit the relevant websites:
- For complaints against Health Professionals (doctors) and allied health professional such as physiotherapists, occupational therapists etc – visit www.hpcsa.co.za or call 012 338 9300.
- For complaints against Private Hospitals – visit www.hasa.co.za or call 011 784 6828.
- For complaints against Nurses – visit www.sanc.co.za or call 012 420 1000.
- For complaints against Brokers – visit www.faisombud.co.za or call 012 762 5000.
- For complaints in respect of other health insurance products – visit www.osti.co.za (short term insurance ombudsman) or call 012 762 5000 or www.ombud.co.za (long term insurance ombudsman) or call 021 657 5000.

Time limits for dealing with Complaints
Our aim is to provide a transparent, equitable, accessible, efficient as well as a reasonable and procedurally fair dispute resolution process.

The Registrar's office will send a written acknowledgement of a complaint within 3 working days of receipt, providing the name, reference number and contact details of the person who will be dealing with the complaint.

In terms of Section 47 of the Medical Schemes Act, a written complaint received in relation to any matter provided for in this Act, will be referred to the entity complained against for a written response to the Registrar's office within 30 days.

Upon receipt of the response, the Registrar's office will analyse the response in order to make a decision or ruling. Decisions/rulings will be made within an estimated period of 120 working days of the date of referral of a complaint, and communicated to the parties.

The Registrar's ruling and appeals process
Section 48 of the Medical Schemes Act makes provision for any party who is aggrieved by any decision relating to the settlement of a complaint or dispute (including the Registrar's decision on complaints) to appeal such a decision to the Council. This appeal is at no cost to either of the parties.

An appeal must be submitted within three months or later period condoned by the Council, upon good cause shown, and should be in the form of an affidavit directed to the Council. The operation of the decision shall be suspended pending review of the matter by the Council's Appeals Committee.

The secretary of the Appeals Committee will inform all parties concerned of the date, time and venue of the hearing. This notice should be provided no less than 14 days before the date of the hearing.

The parties may appear before the Committee and tender evidence or submit written arguments or explanations in person or through a representative. The Appeals

Committee may after the hearing confirm or vary the decision concerned or rescind it and give another decision they deem to be just.

The Section 50 appeals process
Any party that is aggrieved with the decision of the Appeals Committee may appeal to the Appeal Board. The aggrieved party has 60 days within which to appeal the decision and must submit written arguments or explanation of the grounds of his or her appeal.

The Appeal Board shall determine the date, time and venue for the hearing and all parties will be notified in writing.

The Appeal Board shall be heard in public unless the chairperson decides otherwise.

The Appeal Board shall have the powers which the High Court has, to summon witnesses, to cause an oath or affirmation to be administered by them, to examine them, and to call for the production of books, documents and objects.

The decisions of the Appeal Board are in writing and a copy thereof shall be furnished to parties. The prescribed fee of R2000.00 is payable for Section 50 Appeals.

Pro Bono Legal Services
The CMS, together with ProBono.Org have set-up a Pro Bono Panel for medical scheme members. Legal representatives will render free services to members of medical schemes who are in dispute with their medical schemes and have suffered hardship, or cannot afford their own legal representation in cases serving before the CMS Appeals Board.

Not all cases will be referred to the Pro Bono Panel. The CMS Legal Services Unit together with ProBono.Org will use their discretion to refer matters where members have clearly suffered hardship. Some of the considerations will include the monetary value involved as well as the condition the member suffers from.

How to avoid having to lodge a complaint against a scheme:
1. Make sure you have read and understood your scheme rules.
2. Study your benefit guide and make sure that you understand benefits offered by the option that you have chosen.
3. Read all correspondence from your medical scheme, e.g. newsletters and statements.
4. Make sure your contributions are paid in full and on time each month.
5. Make sure that you are well informed about how your scheme operates.

Fraud, Waste and Abuse

Some of the fraudulent and wasteful activities by medical scheme members involve the following:

- Collusion between members and healthcare providers in order to get illegal financial gain from a medical aid scheme.
- Cash back claims, this is when members are admitted to hospital for procedures that could have been avoided in order to claim through hospital insurance products.
- Non-disclosure of prior ailments is the most common fraud reasons cited for member fraud. This occurs when a member fails to inform the medical scheme about previous health conditions.
- Card farming occurs when members share their medical scheme benefits with non-members. This type of fraud is reported to be prevalent with female members, who cover only one child on the medical scheme, but all the children then share the benefits of that one child who has cover.
- Fraud, waste and abuse have cost medical schemes billions of Rands each year, and are contributory to price increases.

Training Programmes

The Training programmes listed below are offered by the Education and Training services at the Council for Medical Schemes. Details regarding training dates are published on the CMS website: www.medicalschemes.com.

The Accredited Skills Programme
This training is aimed at trustees and principal officers. Training takes place over two sessions of two days each. The programme is made up of unit standards which are quality assured by the Insurance Seta (INSETA), and are registered on the National Qualifications Framework (NQF) carrying 30 South African Qualifications Authority (SAQA) credits. Information on the cost for the programme is available on request.

Trustee Induction
Is a two-day training session aimed mainly at newly appointed board of trustees members from open and restricted schemes. Participation in the training is open to all schemes. This training programme is a pre–requisite for registering for the Accredited Skills Programme. The training is offered at no cost.

Introductory Broker Training Programme
Is a one day introductory broker training which bears Continuing Professional Development (CPD) points approved by the Financial Planning Institute (FPI). The CMS is an approved CPD provider for the FPI. Information on the cost for the programme is available on request.

Advanced Broker Training Programme
Is a one day advanced broker training which bears 6.5 Ethics and Practice Standards CPD points approved by the FPI for the Financial Sector Conduct Authority's (FSCA) health services business class. Information on the cost for the programme is available on request.

Prescribed Minimum Benefits Training
Is a scheme specific training programme offered to schemes upon request.

Consumer Education
The CMS offers various member education and training interventions such as exhibitions, capacity building workshops, as well as other outreach activities for members of medical schemes.

The CMS has also produced different information booklets which provide important information for members of medical schemes. These are currently available in five different languages. The booklets are available upon request for different organisations. This includes request for reproduction by schemes and employer groups.