WCMAS

Our members Our passion

Witbank Coalfields Medical Aid Scheme

FREQUENTLY ASKED QUESTIONS

Ntsika option

Universal Care

These are the abbreviated benefits; a copy of the Scheme Rules is available from the Scheme Office or on the Scheme website.

Benefits are subject to the approval by the CMS

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ABBREVIATIONS USED IN THESE FAQ'S

M	= member
M+	= member with dependants
pbpa	= per beneficiary per annum
pfpa	= per family per annum
PMB	= prescribed minimum benefits
Financial year	= 1st January – 31st December
DSP	= Designated Service Provider
SR	= Scheme Rates = NHRPL (National Health Reference Price List)
PPO	= Preferred provider pharmacies
CDL	= Chronic Disease List
TTO	= To Take Out i.e. medicines taken home from hospital

IMPORTANT CONTACT INFORMATION

Universal call centre:	086 148 6472
WCMAS office telephone:	013 656 1407
WCMAS facsimile:	086 627 7795
Hospital pre-authorisation:	086 148 6472
Disease management programme:	086 148 6472
Chronic medicine:	086 011 1900 (Swiftauth)
ER24	084 124 (Ambulance)
Oncology programme:	086 148 6472
Call back option:	SMS membership number to 47977

MEMBERSHIP

1) Can anyone join WCMAS?

WCMAS is a restricted Scheme providing medical aid cover to participating employers only.

2) What is the process to follow to become a participating employer?

Employers in the coal mining industry, with more than 100 employees wanting to join the scheme can contact the Principal Officer for further information.

3) Who is eligible for membership?

Subject to approval by the Board of Trustees, members may apply to register the following as their dependants: -

- the spouse of a member irrespective of the gender of either party, married in terms of any law or custom who is not a member or registered dependant of another medical scheme and cannot include a divorced spouse or former partner of the member,
- the partner of a member with whom the member has a committed relationship based on objective criteria of mutual dependency irrespective of the gender of either party and shall include the spouse of a member to whom he/she is married in terms of custom or tradition and must provide satisfactory proof to the Board of the committed relationship or marriage,
- a child, stepchild or legally adopted child of a member under the age of 21 or a child who has attained the age of 21 years but not yet 26, who is unmarried and a student at an institution recognized by the Board of Trustees. Should a member elect to cancel the registration of a child between the ages of 21 and 25 years as a dependant of the fund, such child will not be eligible for re-registration as a dependant on the fund at a later date,
- a dependent child who due to a mental or physical disability, remains dependent upon the member after the age of 21.

4) What is the process of applying for membership?

Prospective members must be employed by employer groups associated with the scheme and can apply for membership through their respective HR or time offices. The person with whom the application form is completed will submit the form and supporting documents to the scheme.

5) How do I register my dependents?

A member may apply for the registration of his or her dependants at the time that he applies for membership or as follows: -

- a member must register a new-born or newly adopted child within 30 days of the date of birth or adoption of the child, and increased contributions shall then be due as from the first day of the month following the month of birth or adoption and benefits will accrue as from the date of birth or adoption,
- a member who marries subsequent to joining the Scheme must within 30 days of such marriage register his or her spouse as a dependant. Increased contributions shall then be due as from the date of marriage and benefits will accrue as from the date of marriage.
- Students that are accepted as child dependants shall be recognised as such for periods of not more than twelve (12) months at a time.

6) What documents should I submit with applications, amendments or resignations?

Applications & Amendments – all types of members:

☐ Copies of identity documents of the principal member and his / her spouse (if applicable)

☐ Copies of marriage certificate (if applicable)

☐ Copies of identity documents or unabridged birth certificates of child dependants

☐ Copies of the membership certificates of previous medical schemes to which the principal member / dependant belonged

☐ Proof of banking details (either a bank stamped statement, confirmation from the bank confirming banking details or a cancelled cheque none of which should be older than 3 months.)

Applications & Amendments – Pensioner or Widow Members:

In addition to the above, the following will also be required:

☐ Copies of the signed records of service

☐ Proof from the pension fund confirming monthly income (if applicable)

☐ Proof of being declared totally unfit for all work on the mines (ill-health or disabled applicants) (if applicable)

☐ Copy of death certificate (only Widow / widower members)

☐ Letter from the employer confirming the payment subsidy (if applicable)

Applications & Amendments – Special dependants:

In addition to the above, the following will also be required:

☐ In the case of Common law wives: Signed affidavit confirming the relationship with the principal member, as well as a completed medical history form signed by a doctor as well as a copy of the membership certificate of the previous medical aid.

☐ In the case of children over the age of 21: Proof of registration as a full-time student at a recognised tertiary institution.

Resignations:

☐ Proof of banking details (either a bank stamped statement, confirmation from the bank confirming banking details or a cancelled cheque none of which should be older than 3 months.)

7) How long will it take to register me or to make amendments on my membership?

The scheme endeavours to maintain a 5-day turnaround time, subject to receipt of all supporting documentation.

8) How will I know when I have been registered or my requested amendment made?

You will receive a membership certificate via e-mail or it will be sent to your time office. You will also receive an SMS on the day of registration taking effect. Your new membership card will be posted to you. Alternatively, you can phone the scheme's call centre on (013) 656 1407.

9) Can my divorced spouse be registered as a dependent if the divorce settlement decrees that I am liable for cover?

The Scheme does not provide cover for divorced spouses even if the divorce settlement decrees that the member is liable for cover.

10) How much time do I have to inform the scheme of changes in my personal details?

A member must inform the Scheme within 30 days of the occurrence of any event which results in any one of his or her dependants no longer satisfying the conditions in terms of which he may be a dependant e.g. divorce or child dependant full time employed (this is not the complete list).

11) May my dependents or I be a beneficiary of more than one medical scheme?

No person may be a member of more than one medical scheme or a dependant of more than one member of a particular scheme. The membership will terminate if he or she becomes a member or a dependant of a member of another medical scheme.

12) Can my membership be cancelled?

Membership may be cancelled by the scheme as per section 29(2) of the Act which provides that a member's membership will be terminated or suspended in the case of:

- Failure to pay contributions, within the time allocated in the scheme rules (rule 12.4);
- Submission of fraudulent claims (rule 12.5);
- Committing of any fraudulent act (rule 12.5);
- The non-disclosure of material information.

13) Do I have to provide notice when resigning from membership?

Members are allowed to resign from the scheme at any time during the year when submitting a written notice to the scheme which must not be less than 1 month (rule 12.2.1).

14) How do I change benefit options?

Members are allowed to change benefit options with effect from 1 January every year only. The change may be effected by completing and submitting a resignation form for the option currently registered on and completing and submitting an application for the option that you wish to change to. All supporting documents will be required in the event of changing benefit options. You are required to provide the scheme with 30 days' prior notification of any intended changes.

WAITING PERIODS

1) What is a waiting period?

The Scheme may impose upon a person in respect of whom an application is made for membership or admission as a dependant, and who was not a beneficiary of a medical scheme for a period of at least 90 days preceding the date of application a general waiting period of up to three months and a condition-specific waiting period of up to 12 months.

Penalty Bands	Maximum penalty
1 – 4 years	0.05 x contribution

5 – 14 years	0.25 x contribution
15 – 24 years	0.50 x contribution
25+ years	0.75 x contribution

2) What are the different types of waiting periods?

i. General waiting periods

This is a period of 3 months in which a beneficiary is not entitled to claim any benefits.

ii. Condition specific waiting periods

This is a period of up to 12 months in which a beneficiary 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 twelve-month period ending on the date on which an application for membership was made.

This waiting period can be applied to members who were not previously on a medical aid for a period of at least 90 days preceding the date of application.

3) What is a late joiner penalty?

The law provides that a penalty may be imposed on a member or his/her adult dependant in certain circumstances when the applicant joins the scheme for the first time from the age of 35 years.

4) How are late joiner penalties calculated?

The penalty to be applied depends on the number of uncovered years and is calculated as a percentage of the monthly contribution applicable to the late joiner.

Example:

Member applied to join the Scheme on the 1st June 2011. He had previous medical cover 1971-1981 and again 1981–1990.

Total monthly contribution = R2 500.

Member's age = 65 years old. Creditable coverage is 19 years (number of years covered by medical aid).

65 years – (35 + 19) = 11 years not covered. Therefore, penalty band 5-14 years applies which = 25%.

Member premium = Risk Penalty = R2 500 + (25% x R2 500) = R3 125 contribution payable.

CONTRIBUTIONS

1) What are my monthly contributions?

The contributions are listed in the benefit guide and are also available on the scheme's website.

2) Whose responsibility is it for the payment of my contributions?

You remain liable at all times for payment of contributions to the scheme, irrespective whether you receive assistance from your employer towards a subsidy.

CLAIMS, BENEFITS AND ENTITLEMENTS

1) Are any benefits pro-rated if I only join the scheme after January?

Yes, all the scheme's benefits are pro-rated, unless the benefit is quoted per day.

2) How do I apply for managed care programmes?

Please refer to the scheme for details on specific programmes offered. Please call 0861 486 472 or 013 656 1407.

3) What happens when an annual limit on non-PMB medication benefit has been exhausted?

You will be liable for any balance once benefits are exhausted.

CHRONIC MEDICATION

1) **Why is it important for a beneficiary to be registered for chronic medication?**

It is important that you apply for chronic medication benefits as soon as your doctor has diagnosed you with a chronic condition and provided you with a prescription for on-going medication. WCMAS may require additional information from your doctor before authorising your medicine.

2) **What happens when a beneficiary is not registered for chronic medication?**

The member will not be able to access his chronic medicine benefit.

3) **Who should be registered for chronic medicine?**

Any beneficiary who is diagnosed with a chronic condition should be registered.

4) **Does each dependant need to apply separately for chronic medication?**

Yes

5) **How many times does a beneficiary have to apply for the medication?**

Every time when a new condition is diagnosed the beneficiary should apply. Beneficiaries will also be required to renew their script every 6 months. Once a year general check-ups may also be required.

6) **In addition to the beneficiary, who else must complete and sign the registration form when applying for chronic medication?**

WCMAS does not have registration forms. All registrations must be done by contacting SwiftAuth Online on the toll free no 0860 111 900. The doctor must phone Swiftauth for registrations, and members will not be able to do this.

7) **What additional documents are required to support the application?**

SwiftAuth will request the supplier for any additional documentation it may require to register the condition.

8) **Where do I have to send the completed registration form?**

No manual forms. Please call the toll free number 0860 111 900 at SwiftAuth Online.

9) **How will I know that my application has been approved?**

There will be an immediate answer when the supplier or his/her receptionist phones Swiftauth for authorisation.

10) **What process should I follow to update any modification to the chronic authorisation?**

Contacting SwiftAuth Online on the toll free number 0860 111 900 where all updates are made.

11) **Can I get my chronic medication at any pharmacy and / or dispensing doctor?**

No. Only pharmacies and doctors on the Universal network.

12) **What happens if a doctor changes a beneficiary's medication in the middle of the month?**

The supplier contacts SwiftAuth Online on the toll free number 0860 111 900 to make any changes.

13) **What happens if a beneficiary uses a provider of their choice instead of the Universal Network Provider?**

If member does not make use of a Universal Network Provider, the member will have a co-payment of 30%.

14) **What happens when a beneficiary uses medication that is not on the formulary list?**

Please refer to formularies to Medikredit. WCMAS does not have a formulary list but we apply MMAP reference pricing and have limits on certain medication e.g. sleeping medication, anxiety medication and pain medication.

15) **Can a beneficiary receive benefits for more than one month's supply of medication? And how do I apply for it?**

Medication can only be claimed every 25 to 30 days depending on the product, except where a member goes overseas then they can apply for an early refill.

UNIVERSAL PROVIDER NETWORK

1) **Where can I find the list of Universal network providers and contact details?**

You can contact Universal health on 080 362 8677 or e-mail them on network@universal.co.za. You can also send you membership number to 47977 for an agent to call you back within 24 hours.

2) **What will be covered on the claims in the event that a member does not make use of a network provider or baskets of care?**

Members will be liable for a co-payment.

HOSPITALISATION

1) **What process should I follow if there are no available services or beds within the network at the time of request?**

The case managers will load the case as an involuntary admission and the service will be paid accordingly.

2) **What are the scheme's obligations to ensure that I am facilitated in obtaining those services from an alternative service provider in cases as described in question 18?**

The member and hospital will still receive an authorisation number which will ensure that the claim will be paid.

PRE-AUTHORISATION

1) **What is meant by pre-authorisation?**

The pre-authorisation process and Special Care Programmes (managed care) ensure that members get the most cost-effective and appropriate care for their illness. This also allows the cost of hospitalisation, medicine and treatment to be managed to the benefit of our members.

Even though pre-authorisation is obtained, it does not guarantee payment of subsequent claims.

2) **Which benefits require pre-authorisation?**

Pre-authorisation is required for planned hospital admissions, MRI/CT/PET scans, radio-isotope scans, ICON program, chronic medication and other major medical expenses where specified in the Benefit and Contribution Schedule for various plans.

Pre-authorisation is also required for frail care and nursing homes.

3) **What is the process that should be followed to obtain pre-authorisation?**

Authorisation must be obtained at least 72 hours before hospitalisation except for emergency or involuntary admission.

Pre-authorisation can be obtained by one of the following:

- Print and complete the hospital authorisation form from our website – **www.wcmas.co.za**, and email or fax to Universal pre-authorisations at **preauthorisation@universal.co.za**
- Phone Universal Hospital pre-authorisation on **0861 486 472**
- HIV Program **diseasemanagement@universal.co.za**
- Oncology Program **oncology@universal.co.za**

For frail care and nursing homes, please forward a medical motivation, treatment plan and quotation for approval to preauthorisation@universal.co.za or phone 0861 486 472.

4) What information should I have on hand when obtaining pre-authorisation?

Before phoning for a hospital pre-authorisation, you will need to have the following information available:

- Name and contact details of principal member
- Initials, surname and date of birth of the patient
- WCMAS membership number
- Name and practice number of treating doctor
- Name and practice number of hospital where you are to be admitted
- Proposed duration of hospitalization
- Date and time of admissions
- CPT4 (procedure) code - remember to ask your doctor for this
- ICD-10 (diagnosis) code - remember to ask your doctor for this

5) Are there processes to be followed once I am admitted?

Member must note that certain disposable appliances that may be used in a hospital procedure may not be paid by the Scheme and will be regarded as exclusion. The member will be liable for any expenses not covered by the Scheme. Members are advised to discuss this with their supplier before the procedure is done. Universal will send confirmation of the items excluded with their authorisation codes to the member and service provider.

COMPLAINTS AND DISPUTE RESOLUTION

1) How do I lodge a complaint with the scheme

Members are encouraged to explore the Scheme's dispute resolution process prior to lodging any complaints with the CMS.

- A complaint can be lodged in terms of the medical scheme rules to the Scheme Principal Officer in writing either via facsimile on 086 627 7795 or via e-mail to wcmas@wcmas.co.za.
- Should the member's complaint warrant further investigation then the member may address the complaint to the Board of Trustees in writing either via facsimile 086 627 7795 or via e-mail to wcmas@wcmas.co.za and marked for the attention of the Chairperson.
- Final submission can be sent to the Schemes Disputes Committee in writing either via facsimile 086 627 7795 and via e-mail at wcmas@wcmas.co.za and marked for the attention of the Disputes Committee.

2) How do I lodge a complaint with CMS

The Medical Schemes Act allows members to lodge their complaint directly to CMS. However, members are encouraged to explore the scheme's dispute resolution process prior to lodging their complaints with CMS.

Written complaints can be addressed to the CMS complaints division and sent to: Fax: (012) 431 0608

CONTACT DETAILS OF REGULATOR

Council for Medical Schemes
Private Bag X34
HATFIELD
0028

Telephone: 086 112 3267
www.medicalschemes.com
support@medicalschemes.com
complaints@medicalschemes.com

GLOSSARY OF TERMS

Glossary of terms as produced by the CMS in its communication guidelines

Acute medication

Medicine prescribed for an acute illness or condition to relief symptoms for example antibiotics and pain killers for headache.

Adult dependant

A dependant who is 21 years or older.

Agreed tariff

Sometimes a fund has agreements with preferred providers, such as doctors and/or hospitals, where specific tariffs have been negotiated.

Ambulance services

This includes all medically equipped transport types like ambulances or helicopters utilised for medical emergencies.

AT (Agreed Tariff)

A particular medical scheme might have agreements with DSP's (Designated Service Providers) / Preferred Service Providers. The Agreed tariff is the tariff that the involved parties agreed upon.

Beneficiary

A principal member or a person registered as a dependant of the member.

Benefits

The amount payable for medical services provided in terms of the rules to a member, whether for himself or in respect of his dependant.

Benefit limits

The maximum treatment/amount payable for a specific benefit.

Capitated services

Clinical and/or administrative services provided by preferred providers which are paid for on a member per month basis and delivered up to limits specified in contracts with the preferred provider concerned

Chronic Disease List (CDL)

Chronic conditions listed in terms of Annexure B of the regulations to the Medical Schemes Act. The regulations list consist of 27 chronic conditions that makes up the chronic disease list. Medical schemes may add on top of the 27 CDL.

Chronic diseases

These are illnesses or diseases requiring medicine for prolonged periods of time. The Medical Schemes Act provides a PMB (Prescribed Minimum Benefit) listing the minimum chronic conditions your medical scheme should cover under law. With reference to this list, your medical scheme compiles its own list of approved chronic diseases that it will cover – for example high blood pressure, diabetes or cholesterol. [See "Chronic medicine" and "Chronic medicine benefit"].

Chronic medicine

Medicine prescribed by a medical practitioner for an uninterrupted prolonged period of time. This medicine is used for a medical condition that appears on your scheme's list of approved chronic conditions. [See "Chronic diseases" and "Chronic medicine benefit"]. It should however be noted that not all conditions necessitating treatment for more than three months can be termed chronic conditions, some acute conditions may also last a few months.

Chronic medication programme

A programme adopted by the scheme for the management of claims in respect of medicine used by beneficiary on an ongoing basis or for an incurable /life-threatening disease, by applying principles for clinical appropriateness and cost-effectiveness.

Claim

After a member received medical treatment, he / she or the service provider (the doctor or hospital) submits a claim to your medical scheme to request payment of the bill. Usually members can wait for their scheme to pay out the claim, or you can pay the bill from their own pocket and then claim the amount back from your scheme.

Consultation

This refers to member's visit for treatment to a service provider, like a doctor, specialist, physiotherapist, etc.

Contribution

The fixed amount payable on a monthly basis to a medical scheme in exchange for benefits. Members pay a fixed amount for each adult dependant and each minor dependant that is registered under your membership.

Co-payment

A percentage of an admitted claim by a member or a specific amount in relation to such a claim, that the member concerned shall be liable to pay in other words out-of-pocket, partial payment by a health insurance member for health services used in addition to the amount paid by the insurance: the aim is to place some cost burden on members and thereby discourage them from excessive use of health services.

Creditable coverage

any period during which a late joiner was –

A member or dependant of a medical scheme

A member or dependant of any entity doing the business of a medical scheme which, at the time of membership of such entity, was exempt from the provisions of the Act;

A uniformed employee of the National Defence Force, or a dependant of such an employee, who received medical benefits from the National Defence Force: or

A member or dependant of the Permanent Force Continuation Fund, but excluding any period of coverage as a dependant under the age of 21 years;

CT and MRI scans

Special x-rays taken of the inside of your body to try to find the diagnosis and/or treatment.

Day-to-day benefits

Principal members and their dependants can spend a certain maximum amount of money in a particular year for out-of-hospital expenses. These day-to-day limits can be calculated for overall expenses or expenses that fall into certain categories. [See "Threshold"]

Deductible

The amount that one must pay (upfront), form a member's own pocket to the service providers.

Dental benefits

Depending on the medical scheme option you chose, you can have dental benefits, which can include a wide range of different dental treatments and procedures.

Dependant

As defined in the Act and includes;

A members spouse or partner who is not a registered member of a medical scheme;

A dependent child;

The intermediate family of a member in respect of whom the member is liable for family care and support;

In relation to a dependant other than the member's spouse or partner, a dependant who, due a mental or physical disability, is dependent upon the member; and

Any other person who is recognised by the Board as a dependant for the purpose of these rules

Disease management

It is a holistic approach that focuses on the patient's disease or condition, using all the cost elements involved. It can include patient counselling and education, behaviour modification, therapeutic guidelines, incentives and penalties and case management. The beneficiary usually has to co-operate with the program in order to receive the benefits.

Designated service provider (DSP)

A health care provider or a group of providers selected by the scheme as a preferred provider to the beneficiaries, diagnoses, treatment and care in respect of or more PMB conditions or any other relevant health service covered by the scheme. This includes selected hospitals, pharmacies, doctors, physiotherapists, pathology and radiology services.

Emergency medical condition

[See "Inception date"] The sudden and at the time unexpected onset of a health condition that requires immediate medical or surgical treatment, where failure to provide medical or surgical treatment would result in serious impairment to bodily functions or serious dysfunctions of a bodily organ or part or would place the person's life in serious jeopardy in accordance with the scheme's protocols

Exclusions

Medical treatment and/or care not covered by the scheme [Also See "Waiting period (condition specific)"]

Family

This is a medical scheme member and his/her dependants.

Formal sector

The official sector of the economy, regulated by society's institutions, recognised by the government and recorded in official statistics

Formulary

A defined preferred list of medicine used to treat specific diseases.

Generic medicine

Generic medicines are medicines that contain exactly the same active ingredients, strength and formulation as their branded equivalents. The same or another company manufactures these medicines when the patent on the branded product expires. As a result, these medicines are usually much cheaper.

HIV/AIDS

The Human Immunodeficiency Virus is a retrovirus that breaks down the human body's immune system and can cause Acquired Immunodeficiency Syndrome (AIDS).

AIDS is a condition where the immune system begins to fail, leading to life-threatening opportunistic infections.

ICD codes

Inclusion of ICD 10 codes on claims from health care providers to medical schemes is a mandatory requirement since 1 January 2005. Every medical condition and diagnosis has a specific code, called the ICD 10 code. These codes are used primarily to enable medical schemes to accurately identify the conditions for which a member sought health care services. This coding system then ensures that member's claims for specific illnesses are paid out of the correct benefit and that healthcare providers are appropriately reimbursed for the services they rendered. It stands for "International Classification of Diseases and related problems".

Inception date

The date on which a member becomes a member of a scheme and his / her dependants' membership is registered. The member's premiums are payable from this date.

Late joiner penalty (LJP)

A penalty which is imposed on an applicant or adult dependant who, at the date of application for membership or admission as a dependant, as the case may be, is 35 years of age or older but excludes any beneficiary who enjoyed coverage with one or more medical schemes as from a date preceding 1 April 2001, without break in coverage exceeding 3 consecutive months since 1 April 2001;

Manage health care

This is any effort to promote the rational, cost-effective and appropriate use of health care resources. Usually members only qualify for benefits if they have followed the guidelines and protocols the medical scheme has set out to manage the illness. Example: In the case of oncology treatment, managed health care would probably mean that a member has to join a case management programme. The doctors and the specialists from the medical scheme will work together to decide on the most cost effective treatment programme. [Link to "History of managed healthcare"].
Managed health care may assist in appropriate management of conditions with chronic medication including HIV.

Medicine class

Medicine with similar chemical structures or similar therapeutic effects.

Medical formulary

This is a list of cost-effective medicines that guides the doctor in the treatment of specific medical conditions. Medicine formularies are continuously checked and updated by medical experts to ensure that they are consistent with the latest treatment guidelines.

Medicine exclusion list (MEL)

This list is specific to a scheme that excludes payment for certain medicines from the acute or chronic benefit for various reasons, unless a PMB.

Medicine price list (MPL)

Is a reference pricing system whereby a ceiling price has been allocated to a group of drugs, which are similar in terms of composition, clinical efficacy, safety and quality.

Member

Any person who is eligible to be a member of the scheme in terms of scheme rules, and who is registered as such by the scheme.

Minor

A dependant who is not yet 21 years old. Some schemes also include older students as "minors".

MMAP (Maximum Medical Aid Price)

This is the maximum medical aid price that a member's scheme will pay for the cost of generic medicine, where a generic alternative for branded medicine does exist. Only the cost of the generic equivalent is covered.

National health insurance

A mandatory health insurance scheme that covers all or most of the population, whether or not individuals have contributed to the scheme.

Network

An institution or an individual service provider with which the scheme has contracted to obtain specific services according to the to a defined reimbursement structure or when a scheme has negotiated preferential rates with a specific service provider in offering benefits. The list of preferred providers is called the "network". There will most probably be limited to use the suppliers (like doctors, pharmacies, hospitals) that are registered with this network of providers. [See "Designated Service Provider (DSP)"].

Oncology

This field of medicine is included in the treatment of cancer. It can consist of chemotherapy and radiation therapy. If you're a member of a medical scheme, the member will probably have to join a disease management programme, of which the oncology treatment will form a part.

Benefit Options

The different products registered by medical schemes, offering members sets of specific benefits.

Out-of-pocket payment

Payment made by an individual patient directly to a health care provider, as distinct from payments made by a health insurance scheme or taken from government revenue.

Overall annual limit (OAL)

The overall maximum benefit which a member and registered dependants are entitled in terms of the scheme rules, which are calculated annually to coincide with the financial year of the scheme.

Over the Counter Drugs (OTC)

Medication obtained without a prescription at a pharmacy. This includes S0, S1 and S2 medicines ("S" stands for schedule).

Pharmacy Advise Therapy (PAT)

Most common ailments can be treated effectively by medicines available from a pharmacy without a doctor's prescription. If a member's medical scheme option offers you a PAT benefit, it means that some of these costs will be paid for by the medical scheme

Pre-authorisation

The process of informing a scheme of a procedure, prior to the event, in order for approval to be obtained.

Pre-existing condition

A condition which medical advice, diagnosis, care or treatment was recommended or received within the twelve month period ending on the date on which an application for membership was made.

Preferred Provider Network (PPN)

A provider of service or a group of provider of services contracted to the scheme to deliver quality health care services and to participate in the managed health care process of beneficiaries.

Prescribed Minimum Benefit (PMB)

The benefits contemplated in Section 29(1)(o) of the Act which consists of the provision of the diagnosis, treatment and care costs of:

- Conditions listed in Annexure A of the regulations specified therein; and
- Any emergency medical condition.

Primary Health care Provider

A primary healthcare provider deals with members' and members' family's day-to-day healthcare needs – like treating a minor burn. These can include general practitioners (GP's), nurses, oral hygienist, dentist and Allied Health Workers.

Private hospital

Unlike state hospitals, private hospital groups are run as businesses and cost a whole lot more. Although some state facilities are excellent, private hospitals usually offer more luxury and better aftercare. As a member of a medical scheme, the member will probably receive health care in a private hospital.

Principal Officer

A person appointed by the board of trustees (BOT) who is fit and proper to hold office for the scheme.

Professional dispensing fee

A legislated maximum fee that a pharmacist or dispensing doctor may charge for services rendered to dispense medicine.

Pro-rated benefits

Some of the medical scheme benefits are provided on a calendar year basis, which means that members have an annual limit on them. If a member join a scheme on a date other than 1 January, his / her benefits are calculated pro-rata, which means that he / she receive a year's benefits in advance. If the member exceed his / her annual limit, he / she will have to pay excess costs out of his / her own pocket.

Prosthesis

A fabricated artificial substitute for a disease or missing part of the body, surgically implanted and shall be deemed to include all components, forming an integral and necessary part of part of the device so implanted and shall be changed as a single unit. This also include the urinary, cardiac and vascular stents and graft, as well as all electronic implantable devices, spinal instrumentation and fixators (including external fixators)

Restricted medical scheme

A medical scheme that only employees from a particular or affiliate organisation may belong to.

Rejection codes

A list of codes normally reflecting on the remittance advice indicating reason for payment discrepancies.

Related account

Any account / claim related to an approved in-hospital admission other than the hospital account.

Risk

In some cases, members' monthly contributions to their medical scheme will be split into two portions – a risk and a savings portion. The risk portion reflects your contribution to benefits that are being paid by the scheme and not from a savings component.

Risk underwriting

When a scheme looks at the application of a group, they will require certain information from the company in order to see what the risk to the scheme will be. Risk factors include the average age of the employees, the pensioner ratio as well as the number of chronic medicine users within the group. Once this information has been established, the scheme can decide what underwriting will be applied to the group with regards to new applicants. [See "Underwriting"].

SAMA rates (South African Medical Association)

This is the tariff structure that the South African Medical Association deems to be appropriate for their members (doctors and specialists). It is a guideline for doctors in private practice regarding what fees they may charge for their services. [See "BHF rates" and "NHRPL]

Scheme rate / tariff

The rate that the scheme sets for paying health care professionals.

Self-payment Gap

The gap (monetary) between the maximum benefits reach and the starting point of the threshold benefits.

Single exit price (SEP)

The price set by the manufacturer or importer of a medicine or scheduled substance, combined with the logistics fee and VAT, as regulated in terms of the Medicine and Related Substances Act, 1965 (Act no 101 of 1965) as amended.

Spouse

The person a member is are married to under any law or custom that is recognised by South African law.

Supplier-induced demand

Where more services are provided than are 'clinically necessary', such as more than necessary diagnostic tests or more frequent than necessary repeat 'checkups' visits where these services are initiated by the health care provider; frequently linked to fee-for-service payment mechanism, which provides an incentive for providers to deliver as many services as possible to generate more income.

Termination of membership

The cancellation / end of being a member of the scheme

The Bill

It refers to the Medical Schemes Act of 1998. This Act stipulates members' rights as a medical scheme member. The Act and the regulations there under are amended or replaced from time to time. During the time of amendment these changes are referred to as a Bill.

Threshold

On some medical scheme options, members pay for their day-to-day medical expenses from their medical savings account or from their own pocket, until your claims reach a certain limit. Once your day-to-day expenses have reached that fixed

rand amount, for example, R5 000, (your "threshold"), their medical scheme kicks in and will pay further claims up to a certain limit.

Treatment taken out-Medication (TTO)

The medication that is required to take home but is prescribed to the beneficiary whilst in hospital.

Voluntary health insurance:

A health insurance, to which an individual or group can subscribe without a legal requirement to do so.

Voluntary use of DSP

When a member/ beneficiary choose to utilise service providers other than what the scheme proposed.

Underwriting

Depending on members' previous medical scheme history, members' new medical scheme can apply underwriting on your new membership. This means that according to regulation, they are allowed to impose a three-month general waiting period and/or a twelve-month waiting period on an existing illness condition. A Late Joiner Penalty can also be placed. [See "Waiting period (condition specific)", "Waiting period (general)" and "Late joiner"].

Waiting period (condition specific)

Depending on members' previous medical scheme history, a scheme may impose a waiting period of up to 12 months from the inception date of their membership, for any pre-existing conditions. No benefits will be paid for any costs involved in this condition.

Waiting period (general)

A scheme will probably have a three-month general waiting period on benefits for new members. No benefits are paid during this period except for some procedures that are covered within the PMB (Prescribed Minimum Benefit) as prescribed by the Medical Schemes Act.