BIZCOMMUNITY

10 tricky terms - Know your medical aid speak

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Medical aid terms can be as difficult to decipher as your doctor's handwriting. That's why knowing medical aid speak is essential if you are going to understand your medical cover says Gerhard Van Emmenis, Principal Officer of Bonitas Medical Fund.

1. Medical schemes
Medical schemes are not-for-profit and owned by the members of the scheme. In turn the scheme appoints a Board of Trustees to manage the affairs of the scheme to ensure that they are in the member's best interests. This may also be known as medical aids or funds.

2. Medical scheme administrators
Medical scheme administrators are separate entities to the actual medical scheme and operate on a for-profit basis. The medical scheme may go out to tender for an administrator but an existing contract with the administrator may also exist for a certain number of years. The administrator is responsible for managed the administration of the scheme such as processing claims.

3. Medical scheme plans
There are usually a number of plans from which to choose. In general, more comprehensive plans are usually more expensive. The cover you need will vary according to your age, family size, dependents and income. It is important to look at your benefits holistically to ensure they offer you real value for money. Plans that offer more benefits in addition to your savings or benefits from risk generally offer more value.

4. Waiting periods when joining a medical aid scheme
If you have not been on a medical aid scheme or a hospital plan, there may be a waiting period, which means you will continue to pay premiums but are not covered for a period that is outlined by the scheme. The Medical Schemes Act outlines that medical aid schemes are entitled to impose waiting periods: These vary from a 3-month general waiting period or a condition-specific of up to 12 months.

5. What is a late-joiner penalty?
In South Africa, schemes can impose late-joiner penalties on individuals who join after the age of 35, who have never been medical aid members, or those who have not belonged to a medical aid for a specified period of time since April 2001. The reasoning for this is to ensure fairness (whereby members who have been part of a scheme for years are not subsidising newer members who have not contributed to the scheme).

6. Generics
These are 'cost effective copycats' of the original drug. The pharmaceutical company that develops the original drug spends millions on research and development and so take out a patent to protect themselves for a period of time. After the patent has expired other drug companies can make the generic equivalent without the initial clinical research costs. They have exactly the same dosage, intended use, effects, side effects, route of administration, risks, safety and strength as the original drug.

7. Gap cover
At times there may be a shortfall between what the medical scheme pays and what the hospital or specialist charges. As a member you are responsible for paying the difference. Even if you are on a top range medical aid plan, it doesn't mean there will not be 'gaps' between the tariffs your scheme is prepared to pay and the amount your specialist charges.

There is an insurance policy called Gap Cover which you can take out to pay for this shortfall.

8. Prescribed Minimum Benefits (PMBs)
PMBs are a mandatory set of defined benefits that medical schemes must provide cover for all medical scheme members. These ensure members have access to a certain minimum level of health services, regardless of the benefit option chosen. It currently covers medical emergencies, 25 chronic and 270 medical conditions. PMBs are being reviewed by the Council of Medical Schemes (CMS) with a view to aligning them with the proposed National Health Insurance.

9. Designated Service Providers (DSP)
A DSP is a healthcare provider (doctor, pharmacist, hospital etc) that is the medical schemes' choice for members to use. If you don't use the DSP you may have to pay a portion of the bill as a co-payment. You can avoid co-payments and get more value for money by using preferred suppliers and DSPs.

10. Tariffs and rates of payment
Each Medical Schemes has a Rate of Payment ie the amount the medical scheme will pay for that service. Providers charge different rates known as the Scheme Tariff. Members often misunderstand that 100% of the Scheme tariff/rate doesn't necessarily mean 100% of the account or what you will be charged. However, as a patient you can negotiate the best possible rate with your healthcare provider.

"Too often members do not understand what their medical aid option offers and are not familiar with the terminology," says Van Emmenis. "The best advice I can offer is to be informed. Take the time to read all the information supplied, including the fine print, and compare plans. If you are unsure phone the scheme and ask questions, or check with your broker. Your health and that of your family is important so it is vital that you are comfortable with the choice you make and are confident your healthcare needs will be taken care of."

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