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Medical aid members love to complain, but often get it wrong

Medical aid members often do not understand the terms and conditions of the scheme, and so are quick to complain when faced with unexpected medical bills for treatment for which they thought they were covered.

The Council for Medical Schemes (CMS) released its annual report, in which it showed that of 3,527 complaints regarding open medical plans, 1,172 were resolved in favour of the plan, in 260 instances both parties were said to be in the right and only 971 complaints were ruled to be valid.

People love to complain about their medical aid scheme's premiums but most of them have got it wrong, t schemes' regulator complaints manager, Thembekile Phaswane says.

Although schemes are obliged to pay in full for the treatment of 270 diseases and 26 common chronic conditions classified as prescribed minimum benefits, they have the discretion to determine which doctors or hospitals a member must use if he wants full financial cover.

When medical aid schemes can prove that a member did not use the specified doctor or hospital, the member must pay the shortfall. In addition, Phaswane says, doctors do not always disclose that they were not among a medical aid scheme's designated service providers.

The schemes with the highest rate of complaints per member were Spectra Med, Resolution Health, Genesis, Suremed and Keyhealth. "It's not the first time we have seen these same schemes in the top 10 with respect to complaints," says Phaswane.

Most medical aids schemes ran at a loss this year, including Bonitas and the Government Employee Medi Scheme (GEMS) - they paid out more than they earned in premiums. This is partly explained by an ailing population and the average age of medical aid scheme members increasing every year. GEMS hit the headlines recently because of its financial losses, but it is now said to be stable and will pay claims for the next year.

Source: I-Net Bridge