CHOOSING THE RIGHT MEDICAL SCHEME – GO FOR THE OPTION THAT SUITS YOUR LIFESTYLE

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Once you have compiled a shortlist of schemes that are financially stable, have a good membership profile and are governed soundly, you need to look at the options available on those schemes.

Consider your healthcare needs and those of your family, if you have one, in light of your medical history and lifestyle.

Look at what you have spent on health care over the past five years. Add up what you have spent on medicines and treatment. If you are already a member of a scheme, obtain a history of your claims.

Then consider your future needs - for example, whether you plan to start a family, engage in hazardous activities, or have hereditary illnesses that might affect you or a member of your family.

Remember that you are more likely to need expensive benefits as you get older, and changing circumstances, such as having more dependants, can affect your healthcare needs dramatically.

List the medical expenses for which you will need cover. For example, hospitalisation for specific conditions, such as a back operation or child birth, or treatment for specific conditions such as diabetes.

Now scrutinise each of the shortlisted medical scheme's benefits and compare them with each family member's needs.

Benefits Offered

Does the scheme have a traditional option with listed and, usually in some way limited, benefits for all kinds of medical needs, or does it offer a new-generation option with a medical savings account?

If it has a savings account, look at how much of your claims must be paid from that account; it may be all the day-to-day benefits or only certain ones not covered by the scheme. Establish whether the contributions to the savings account will be enough to cover all these expenses.

If there is a network option, consider whether you are happy with the limited choice of healthcare providers and whether facilities or practitioners in the network are located conveniently.

Examine the benefits, paying particular attention to the following:

Annual Limits and Sub-Limits

Ascertain whether a scheme has an overall annual limit - for example, R750 000 - or "unlimited" benefits.

Remember that the cost of a serious injury with a long stay in a private hospital can run into hundreds of thousands of rands for just one person. If you have a family, consider what your bills may be if all of you were involved in a serious motor accident. Would the limit be enough?

Benefits may be "unlimited", limited to a rand value or limited to a certain number of consultations.

Watch out for combinations of benefits, because this is a way of limiting your cover.

Common combinations are:

* Consultations with general practitioners and specialists;
* Basic and advanced dentistry; and
* Radiology and pathology.

When you consider the benefits offered, particularly on a low-cost scheme, it is vital to check what treatments are excluded - especially expensive ones such as transplants and chemotherapy. If there are limits or exclusions, you need to make sure you have enough money to pay for such eventualities.

Check whether the hospital cover gives you access to care in private or public hospitals. Be clear on whether the hospital limits are per beneficiary (member and each dependant) or whether there is an overall family limit.

The Rate at Which Your Medical Costs Are Covered
Check whether the scheme pays claims at the rates in the National Health Reference Price List (NHRPL) or at the actual rates charged by the service providers. If it pays at the NHRPL rates and your pro-vider charges more, you will have to pay the difference. Top specialists usually charge far more than - up to three times - the NHRPL rate.

Co-Payments or Levies
Schemes use co-payments or levies to manage costs. You may be required to pay R10 a script, or 10 percent of the cost of a visit to a doctor. By making you pay part of the cost, schemes hope you will use only the services you really need.

Restrictions on Access
Check whether or not the cover offered by the scheme is conditional on your using certain doctors or networks. Examples are schemes that:

* Use networks, such as Prime Cure, for day-to-day, out-of-hospital cover;
* Cover you only if you use particular hospitals or a particular hospital group;
* Cover medication from certain pharmacies only;
* Have formularies, or lists of medicines that you must use; and
* Offer certain services only in public, or government, hospitals.

If the scheme does specify the provider and you use a different one, you will either pay an additional levy or penalty, or receive no benefits for that service.

Usually a scheme restricts providers to give you access to more affordable benefits. It is up to you to decide whether or not the inconvenience of having to use certain healthcare providers is worth the saving offered, and if it suits your needs.

Prescribed Minimum Benefits

Find out how the scheme provides these benefits. For example, do you have to get these benefits from a particular provider or from state hospitals? Do you have to use certain medicines to have cover?

Check Costs and Regulations

The final step is to work out what you will pay for cover under a certain option.

Also find out if the scheme will impose a waiting period when you join. There are also late-joiner penalties applicable in certain cases to people over 35.

Calculate the contribution you will pay for a particular option, depending on whether you will be joining the scheme as a single member or with dependants.

If your employer pays a subsidy for you to be a member of a scheme, remember to deduct that subsidy from the overall contribution and to establish whether any portion of the subsidy will be taxed.

The final question is, are you prepared to pay the contributions for the benefits offered? If you cannot afford it, you will have to reduce the level of cover until an affordable contribution level is reached.

The Range Of Options Available

There are a number of different types of medical scheme options. Before you look at them, you need to be aware of some of the terms used.

Schemes often distinguish between major medical benefits or hospital benefits and day-to-day benefits.

- Day-to-day benefits are those covering out-of-hospital consultations with doctors, dentists and other medical professionals, the treatment they prescribe, medicines, spectacles and so on.
- Hospital benefits are those covering your stay in hospital and the cost of your treatment in hospital, including the cost of doctors who treat you while you are there.
- Major medical benefits are those covering hospital treatment as well as some higher-cost out-of-hospital treatments such as high-cost scans or oncology treatments.

The prescribed minimum benefits (PMBs) are those your scheme must by law provide. They cover more than 300 life-threatening conditions - mostly for in-hospital treatment - as well 25 common chronic conditions.

Schemes often refer to insured benefits or risk benefits. These are benefits paid from your contributions, excluding the portion which goes into your medical savings account, if you have one.

Traditional Options

Traditional options generally provide only insured benefits, covering both major medical and day-to-day expenses. They range from being highly comprehensive - and usually expensive - to low-cost options that offer limited benefits.

Often the option will have an overall annual limit on cover provided and various sub-limits within that. Other options have hospital or major medical limits and sub-limits for categories of day-to-day expenses.

Some schemes offer a medical savings account with a traditional option so that you can use the savings to supplement the insured benefits.

Hospital Plans

These typically offer cover only for major medical or hospital expenses, and emergency services such as ambulances. No day-to-day expenses are covered. However, schemes no longer offer pure hospital plans because they all have to provide cover for the treatment of 25 common chronic conditions, which mostly involves out-of-hospital benefits.

New-Generation Options with Savings Accounts

These options offer certain insured benefits - usually those covering hospital and major medical expenses. You fund other benefits yourself by contributing to a medical savings account. The amount you can spend on benefits not covered by the scheme depends on how much you have in your account.

These options usually allow you to spend your savings as you wish on any medical expenses. But in some cases the scheme will limit transactions from these accounts to, for example, payments at National Health Reference Price List (NHRPL) rates.

Savings accounts transfer the risk of not having enough to cover claims to you, the member. You need to manage your medical expenses to ensure there is enough in the account to cover you for the year.

Medical schemes use savings accounts to prevent you using more than you need on day-to-day expenses.

Savings accounts are also used in other options as a means to top up the limited benefits the scheme offers.

Medical savings accounts have to comply with regulations under the Medical Schemes Act. These stipulate that:

- You cannot put more than 25 percent of your total contribution into a medical savings account. The aim is to ensure that you are not funding a substantial portion of your benefits.
- Money in your savings account can't be used to offset contributions or debts you owe the scheme, except when you leave it.
- If you have a credit balance in your medical savings account it must be transferred to another medical scheme or benefit option with a medical savings account when you change schemes or benefit options.
- If you change to a scheme or benefit option without a medical savings account or stop being a member of a medical scheme, the credit balance in your existing account must be taken as cash.

- Money in your medical savings account cannot be used to pay for the costs of a PMB.

Many options with savings accounts offer you access up front to the amount you will contribute to that account over the year. In other words, the amount you have not yet contributed for the year is available to you on credit. If you leave a scheme before contributing what you have used on credit, you will owe the scheme the balance.

Some medical schemes offer credit or debit cards for medical expenses and this credit may become accessible when savings account benefits are exhausted. However, payments to these cards are not regarded as medical scheme contributions for tax purposes and they are essentially banking products that operate outside the scheme.

Above-Threshold Benefits

Some schemes offer above-threshold benefits on options with medical savings accounts. These benefits can be accessed once you have exhausted your savings.

These benefits usually cost more. Paying for them is like insuring yourself against high medical expenses.

The claims that count towards this threshold are usually what are regarded as essential claims. You cannot, for example, spend all your benefits on cosmetic surgery and then claim above-threshold benefits.

Some schemes have what is known as a self-payment gap - in other words, the threshold is higher than the savings account benefit and you must pay some of your claims out of your own pocket before reaching it.

Network Options

Network options usually offer lower contributions in return for your agreeing to use a particular network of healthcare providers.

In the past these were often lower-cost options, but increasingly medical schemes are introducing networks in an attempt to contain costs and prevent your being faced with a gap between what the scheme pays and what healthcare providers charge.

Discovery Health, for example, has set up its own hospital network and offers lower rates to members prepared to use it.

Discovery Health has also set up direct payment arrangements with practitioners. Members who use these practitioners are assured that the scheme will pay their medical bills in full. However, you don't pay lower contributions for using these practitioners. You only ensure that you don't face paying their bills out of your own pocket.

Lower-cost network options typically restrict members to using certain medicines and visiting certain doctors and hospitals. One of the bigger networks, Prime Cure, has medical centres in certain areas as well as contracted practitioners. Another large network, CareCross Health, is a network of private practitioners.

CareCross also operates a private practitioner network, OneCare, aimed at the middle-income market.

There are also smaller networks of general practitioners, including Faranani, which serves previously disadvantaged areas.

Members are given a list of doctors, dentists, pharmacists and optometrists in the network. Usually visits to these healthcare providers are unlimited.

Certain schemes also limit hospitalisation benefits to certain hospital groups. However, if there is an emergency, you are covered by the PMBs for immediate treatment at any hospital. Once stabilised, you can be moved to a hospital within the network.

Certain schemes combine network and traditional option features in one scheme.

The lower-cost networks often do not cover things such as advanced dentistry, visits to specialists, advanced pathology or radiology. Certain schemes offer cover for visits to a specialist, but only if you are referred by a network doctor.

Lower-cost network options often limit optometry benefits and have formularies - lists of low-cost medicines, which can be used to treat certain conditions and which may include generic rather than brand-name medicines.