Medical scheme terms and what they mean

If you're joining a medical scheme for the first time and you're trying to understand the terminology, you will be forgiven for thinking that you've landed on another planet.

Some of the terms below are relatively self-explanatory, but others are not. Here's a quick definition of each of them. For more information, visit the website of the Council for Medical Schemes.

1. Principal member
This is the main member on the fund. It can be a single person, or someone who has registered one or more dependants on the scheme. The principal member often pays a larger contribution than the dependants do. If the main member dies, the dependants can usually stay on the fund, but one of them will have to become the new principal member.

2. Open and closed funds
An open fund is open to everyone who wants to join. A closed fund is usually just for certain groups of people, such as the employees of a specific company, for whom membership of the fund is often a condition of employment. Members of the public cannot join these medical schemes.

3. Medical scheme tariff
This is the specified tariff in rand that the medical scheme will pay for certain procedures or consultations. Your specialist may charge R750, but if the medical fund tariff on your option is only R500 for that particular type of consultation, you will have to pay the difference. This is called a co-payment.

4. Waiting period
When you join a medical scheme you cannot claim for day-to-day expenses during the first three months, unless you have come straight from another medical scheme. But you are covered for medical emergencies from the day you join. You can be excluded for no more than 12 months for the treatment of a pre-existing condition.

5. Prescribed minimum benefit (PMB)
There are 270 conditions for which all members have to be treated, according to the Medical Schemes Act. All medical schemes and hospital plans are bound by this law. But hospital cash-back plans and health insurance products are not, as they are not governed by the act.

6. Day-to-day benefits
These are out-of-hospital benefits, which differ greatly from scheme to scheme and from option to option. The bigger your contribution, generally the bigger your cover. These benefits can cover things such as GP visits, prescription medication, dental treatment and visits to the optician. Check your benefit schedule for your particular option.

7. Hospital plan
This is usually cheaper than a comprehensive plan and covers you for hospitalisation only, and not for out-of-hospital treatment. All hospital plans, however, have to pay for chronic medication prescribed for one of the 27 chronic conditions named in the act.

8. Medical savings account (MSA)

A percentage of your contribution (usually 15% to 25%) is paid into this savings account, from which your day-to-day claims are paid. If you do not use this money in a given year, it is transferred into your MSA for the following year. If you leave the fund and you have money in your MSA, it will be paid out to you.

9. Chronic illness benefit
There are 27 chronic conditions specified by the act. Your medical scheme must pay for this medication on an ongoing basis. You can be required to use generics. Once you have registered your condition as a chronic one with your scheme, this medication will not be paid for from your MSA, but from your overall limit.

10. Acute medicine benefit
These are once-off prescriptions, such as an antibiotic for an ear infection. When the infection clears up, you no longer need to take the medication, unlike medication for something such as high blood pressure, which usually has to be taken for life.

11. Network doctors/network hospitals/designated service providers
A scheme might have a working agreement with certain doctors, hospitals or service providers to treat its members at the medical scheme tariff. A scheme may require its members to use these services, and can expect them to make co-payments, should they choose to use out-of-network services.

12. Pre-authorisations
Unless there is a medical emergency, you will have to get pre-authorisation from your fund before you will be admitted to a hospital for specific procedures. If you do not have pre-authorisation, the scheme can refuse to pay. Pre-authorisations are obtained by contacting your scheme administrator at least three days before admission.

13. Self-payment gap
If you have R5 000 for the year in your MSA and it is depleted, you go into the self-payment gap where you have to fund day-to-day medical costs yourself. If that is R3 000, for example, once you have reached it, you could claim what is called above-threshold benefits. This is usually also limited to a rand amount.

14. Clinical protocols
These are considered to be medically appropriate claims for certain conditions and procedures put together by teams of medical professionals. Your cover is subject to the scheme's rules and funding guidelines.

15. Overall annual limit
This is often a set amount (but not always) which includes a combined limit of in- and out-of-hospital expenses.

16. Ex-gratia payment
If your benefits for certain things have run out, you can put in a request for payment of further treatment. Each case is carefully considered and judged according to certain guidelines. No scheme is obliged to grant all requests for ex-gratia payments.

References: council for Medical Schemes and Nasmed Benefit Brochure

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