Auto & General Park, 1 Telesure Lane
Riverglen, Dainfern 2191
PO Box 11250, Johannesburg 2000

Tel 011 428 1400
Fax 0860 10 51 97
Web www.1life.co.za

Know your medical aid terms

Alternatives to hospitalisation
While hospital plans cover hospital and in-hospital costs only, medical aids are very aware of how expensive a hospital stay can be. As a result, some offer out-of-hospital benefits on hospital plans that cover the costs of certain procedures and care at a doctor's rooms or at a day hospital as an alternative to a hospital stay.

Authorisation
When you are undergoing treatment such as surgery you need to apply for authorisation so your scheme will cover you at the agreed rate. If you don't apply for authorisation some schemes won't cover the full amount. When you apply for authorisation don't assume it means every cost is covered – ask exactly what procedure and treatment is covered and what is not.

Chronic disease list, formularies and protocols
The chronic disease list is a list of approved medications for PMBs (see later). These medications are sometimes referred to as formularies. Protocols are treatment guidelines. Some medical aid plans will only cover the costs if treatment protocols are followed and approved medications used.

Co-payments
Medical aids might not cover the cost of a procedure or treatment in full and require a co-payment - where you pay a portion of the cost - or be limited to a set amount. Scans and scopes often have co-payments, but if a scan or scope is for a PMB it should be covered in full.

Disease management programmes
Most medical aids have disease management programmes where you have to register for certain benefits if you have a specific condition such as HIV, diabetes or cancer. If you are diagnosed with a chronic illness, schemes are more likely to cover costs of certain treatments in full if you register on these programmes. Some schemes also offer maternity and baby programmes that offer extra benefits such as discounts on baby products.

DSPs
(See Networks below)

Formulary
A formulary is a list of approved medicines that schemes usually pay in full. Non-formulary medicines may require a co-payment or may not be covered at all.

Hospital costs and in-hospital costs
Private hospitals in South Africa don't employ specialists or doctors so when you stay in hospital you will have an account from the hospital for their fees, including ward and theatre fees, and an account from specialists and doctors who consult while you are in hospital, such as anaesthetists and surgeons. It is a good idea to check with your medical aid how they cover both these costs. Hospital plans usually cover them all, but often have additional requirements that you use certain hospitals, doctors and surgeons to qualify for full cover.

Medical aid, medical insurance, gap cover and dread disease cover
Medical aid is offered by registered medical schemes and offers options with different benefits. These benefits include hospital cover, PMB cover (explained below), general healthcare and sometimes preventative screening. Medical aid pays for costs actually incurred either in full or at an agreed rate.

Medical insurance, offered by registered insurance companies, offers a set amount of cover in Rands such as R150 000 in total, or R500 a day in hospital. Medical aids tend to pay doctors and hospitals, medical insurance products pay the life insured.

Gap cover is a type of medical insurance that can pay for treatments your medical aid may not cover.

Dread disease cover is an insurance policy that pays out a lump sum on diagnosis, according to the diagnosis and the amount insured. You can use dread disease lump sum payments to pay for treatment or any other costs.

Medical savings accounts (MSA)
On certain plans, a portion of your contribution goes towards risk benefits and a portion goes to an MSA account. Your risk benefits cover things such as hospital stays and chronic care. Risk benefits are often unlimited (on certain plans) if certain providers are used. Savings accounts are used to pay for day to day benefits such as GPs and over the counter medicines. When your savings are used up you either have to pay for these costs yourself or wait until you reach a threshold (see below).

Networks and DSPs
If you want to save on your medical costs and medical aid contributions use network options and DSPs - designated service providers.

Medical aids negotiate favourable rates with certain doctors, hospitals and other healthcare providers, which usually means you won't pay anything out of your own pocket when you consult these doctors and use hospitals in this network. DSPs work in a similar way – they agree on rates and services and medical aid members don't incur extra costs when using them.

PMBs
Prescribed minimum benefits (PMBs) are benefits all medical aids must cover on all options, including hospital plans. They cover 25 chronic conditions such as asthma and diabetes, 270 medical conditions such as HIV and some cancers, and any emergency medical condition.
An emergency is when immediate treatment is needed, and if it is not received there may be serious and lasting damage or loss of life or limb.

Primary care plans
Primary care or primary health care plans offer cover for day to day medical costs such as GP visits, dentistry and medication. They do not cover hospital or in-hospital costs.

Scheme rates
You'll notice the term "100% of scheme rate" quite a lot when looking at medical aid brochures. This is the rate the medical aid has agreed to pay certain healthcare providers such as doctors and hospitals. Medical

aids will cover costs at a percentage of this rate for example 100% or 200%, depending on which plan you are on. While these rates are not publicly available, they don't differ too much across schemes and hospital costs are usually covered in full. However, 100% of the scheme rate is not always 100% of the cost so if you are having a procedure ask your doctor and medical aid what they charge and cover.

Terminal care benefits
These are for end of life care such as home nursing. Medical aids are starting to offer these as an alternative to hospitalisation.

Threshold
Many plans have a threshold limit which is the point at which your excess costs are covered. For example, a threshold may be R10 000. If you spend more than R10 000 on medicines a medical scheme may cover the costs you incur after you reach this amount - subject to certain conditions such as using a DSP.

Wellness screening and preventative care
Most schemes offer these to all their members at no cost. They include testing for HIV, cholesterol, blood pressure and blood glucose tests, and vaccines and immunisation such as the flu vaccine. Many hospital plans offer these, but some are limited to a Rand amount, number of tests per family or number of tests over a number of years at certain ages.