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Medical Aid Scheme vs Health Insurance Policy

What is the difference, and which one is right for me?

FSCA

Financial Sector
Conduct Authority

Medical Aid Scheme vs Health Insurance Policy

What is the difference, and which one is right for me?

Whether you choose a medical aid scheme or a health insurance policy, will depend on your lifestyle, your needs and your budget. The costs between the two differ because the products offer different services and benefits. This resource will provide you with information on both options, so that you can make an informed decision on either.

It is important to know which laws apply to these products and which organisations enforce these laws.

- Medical aid schemes are subject only to the Medical Schemes Act (No. 131 of 1998) (the Medical Schemes Act), which is enforced by the Council for Medical Schemes (CMS).
- For Treating Customers Fairly, non-life health insurers are subject to the Short-term Insurance Act (No. 53 of 1998) and life health insurers are subject to the Long-term Insurance Act (No. 52 of 1998), as relevant, which laws are enforced by the Financial Sector Conduct Authority (FSCA).
- Non-life and life health insurers are also subject to the Insurance Act (No. 18 of 2017), which law promotes their financial soundness and is enforced by the Prudential Authority (PA) (part of the South African Reserve Bank (SARB).

***Note:** Short-term insurance is now referred to as non-life insurance, whilst long-term insurance is now known as life insurance.*

By law, medical aid schemes must not unfairly discriminate in the provision of healthcare and medical expenses cover based on race, age, gender, marital status, ethnic or social origin, sexual orientation, pregnancy, disability or state of health. Similar requirements that prevent unfair discrimination apply in respect of health insurance policies.

There are different role players that you should be aware of.

The medical aid scheme (in the case of a medical aid) or the insurer/product supplier (in the case of a health insurance policy) is ultimately responsible to cover you for the medical expenses or pay out the amount agreed to as per the insurance contract.

An authorised financial advisor can assist you in choosing a financial product that suits your medical and health needs and budget – these persons are also regulated by the FSCA, but under a different law, being the Financial Advisory and Intermediary Services Act (No. 37 of 2002). Product suppliers are authorised to sell their financial products and services through financial advisors or directly through tele-sales or the internet.

If you get financial advice, insist that the advisor provides you with details of the fees, cost and what is included/excluded in the cover. For more information on the role of a financial advisor visit www.fscamymoney.co.za

A list of definitions is available at the end of this resource to assist you in understanding the technical terms in relation to medical aid and health insurance.

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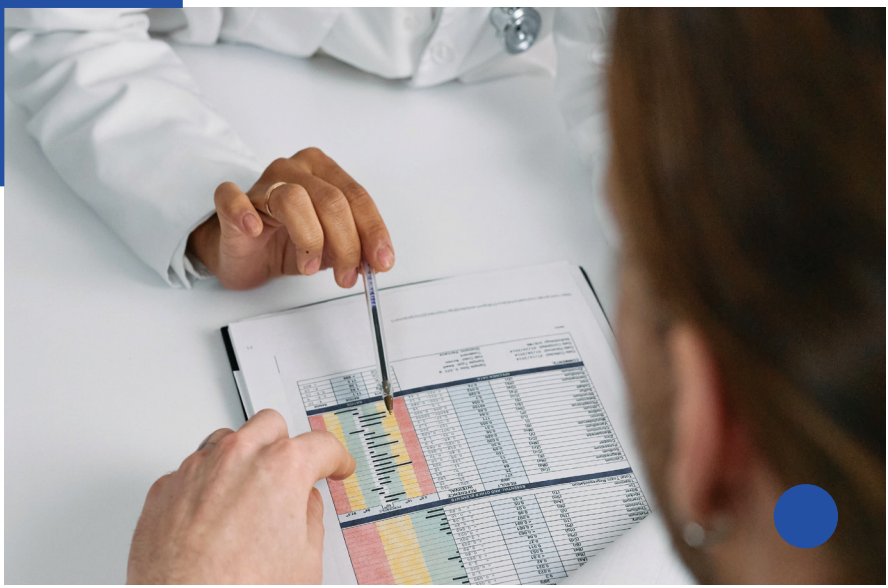


1. What is a medical aid scheme?

A medical aid scheme helps you to pay for your healthcare needs, such as medical expenses related to doctor's visits, nursing, surgery, dental work, optometry, medicine, and hospital accommodation when needed. A medical aid scheme usually provides more benefits than health insurance.

Medical aid schemes are 'not for profit' organisations. They do not have shareholders nor pay dividends from profits made. Medical aid schemes exist for their members as all funds are pooled and safeguarded to be used to pay claims in accordance with the scheme's rules and to ensure that all members are equitably and fairly cared for (relative to their choice of benefit plan). All surpluses (the "profits" from the previous year) are invested on behalf of the members who have joined the medical aid scheme, in accordance with the law.

Members belonging to a medical aid scheme make contributions (monthly payments) and in return receive medical cover according to the rules of the scheme. All medical aid schemes must provide the Prescribed Minimum Benefits (PMB), which are discussed in more detail later in this resource.

There are two kinds of medical aid schemes, namely, open and closed (restricted) schemes. Any person can join an open scheme, but closed schemes are for the employees, specific employer groups, or membership of a specific profession, industry, association or union.

All medical aid schemes in South Africa operate in accordance with the Medical Schemes Act (Act No. 131 of 1998) and are regulated by the Council of Medical Schemes (CMS).

Medical aid schemes are based on three unique principles as stipulated in the Medical Schemes Act as follows:

1.1. Open enrolment

All registered open medical aid schemes must allow any person to join the scheme. They may not discriminate against any person who wants to join a scheme and can pay the monthly membership contributions. A registered medical aid scheme therefore cannot reject an application.

Although medical aid schemes enroll any person, they can impose certain **waiting periods** on new members and/or their dependents when joining a medical aid scheme. Waiting periods depend on the amount of time an applicant has been a member of a medical aid scheme at the time of joining a new scheme. There are typically two kinds of waiting periods:

- A general waiting period of up to three months, imposed when changing between medical aid schemes. During this waiting period, members must pay their normal monthly contributions but are not entitled to claim any benefits during the waiting period, unless in cases where an exception for Prescribed Minimum Benefits applies.

- Condition-specific waiting period of up to 12 months. During this period, members must pay their normal monthly contributions. Any pre-existing health condition(s) (as identified during the application) will be excluded and all associated medical costs during this 12-month period will be for the member's own pocket, unless where an exception of Prescribed Minimum Benefits applies.

Ask your financial advisor what waiting periods apply when choosing a selected medical aid scheme.

Medical aid schemes can also choose to charge a late joiner penalty. A **late joiner penalty** is a penalty fee that the medical aid scheme may impose on any person who joins at age 35 and above, to be fair to existing members, because that person is joining the scheme at a later stage in life when likely to have more expensive medical needs.

1.2. Prescribed Minimum Benefits

Prescribed Minimum Benefits, also known as PMBs, are a set of defined benefits that ensure that all medical aid scheme members have access to certain minimum health services, regardless of the benefit option they have selected. The aim is to provide people with continuous care to improve their health and well-being and to make healthcare more affordable.

For example:

"Felicity has just joined a medical aid scheme for the first time, she requires a consultation with a psychologist. She wants to know how her medical aid will pay for this service. The medical aid scheme will pay for the service after a three-month waiting period is over, if the condition is a PMB."

Prescribed Minimum Benefits are a feature of the Medical Schemes Act, in terms of which medical aid schemes must cover the costs[1] related to the diagnosis, treatment, and care of:

- Any emergency medical condition;
- A limited set of 271 medical conditions; and
- 25 chronic conditions.

Your medical aid scheme will provide you with a list of the medical and chronic conditions that they cover before joining the scheme. You will also be provided with information on designated service providers, listed medication and medicine that will be covered.

A registered medical aid scheme cannot exclude any medical condition that was not diagnosed or treated in the 12 months before applying to join the scheme. For example, if a beneficiary contracts HIV after the three-month general waiting period, the scheme must cover the costs related to the virus.

If the scheme imposed a 12-month exclusion of a specific medical condition and the 12-month period has lapsed, the scheme is liable to cover the condition, in line with the benefit option for the specific benefit option year.

1.3. Community rating

Registered medical aid schemes are not allowed to charge members different contributions for the same plan, unless such contributions are based on the level of income of the applicant and/or the number of dependents. In other words, persons with a lower income may pay a smaller monthly membership contribution relative to those with a higher income, and the scheme may charge the main member less per person if he/she has dependents.

1 All Prescribed Minimum Benefits must be paid by medical aid schemes. However, the amount thereof is subject to scheme rules, listed medication and formularies. If your scheme appoints a designated service provider, and you voluntarily use another provider, your scheme may opt not to pay the difference between the actual cost and what it would have paid if you had used its designated service provider.

2. What is health insurance?

A health insurance policy is a type of insurance contract between an insurer and a policyholder (called an insurance policy). The policyholder promises to pay a premium and the insurer promises to, in return, provide policy benefits if an unplanned or uncertain health event (as referred to in the contract) happens.

An insurance policy may not offer to pay for medical expenses or the costs or services regulated under the Medical Schemes Act, 1998 (Act No. 131 of 1998). Health insurance can take the form of either a short-term (non-life) insurance policy or a long-term (life) insurance policy.

The benefit can either be a fixed sum of money per day, or a maximum lump-sum payment. It is normally paid to the policyholder directly instead of the medical care service provider. However, arrangements can be made in certain instances for payment to be made directly to a healthcare provider. Health insurers are licensed to conduct insurance business and are owned by shareholders and are commercially profit driven.

Types of short-term (non-life) health insurance policies are:

- Non-medical expense cover, as a result of hospitalisation (Hospitalisation policy)
- Medical expense shortfall (Gap cover)
- HIV, Aids, tuberculosis, and malaria testing and treatment
- International travel insurance
- Medical emergency evacuation or transport

Types of long-term (life) health insurance policies are:

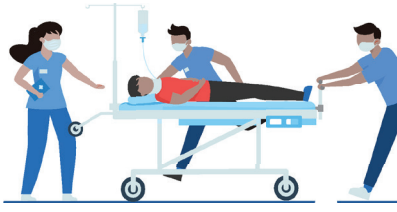
- Non-medical expense cover as a result of hospitalisation, which offers a lump sum cash amount payable for each day the insured is hospitalised, and is intended to pay for, amongst other things, loss of income on account of being in hospital.
- Frail care
- HIV, Aids, tuberculosis and malaria testing and treatment
- Medical emergency evacuation or transport

Health insurance is based on three unique principles as follows:

2.1. Rules for insurers in respect of health insurance policies

Health insurance policies may not pay for medical expenses such as doctors' visits, hospital bills or any of the costs or services regulated under the Medical Schemes Act. There are only a few exceptions to the above rule. These exceptions are applicable to the following types of insurance policies:

- Gap cover (also known as medical expense shortfall cover)
- HIV, Aids, tuberculosis and malaria testing and treatment
- International travel insurance
- Medical emergency evacuation or transport
- Frail Care



The following rules apply to all health insurance policies excluding international travel insurance, medical evacuation and frail care, namely gap cover, non-medical expense cover as result of hospitalisation, or cover in respect of HIV, Aids, tuberculosis, and malaria testing and treatment:

- Must be underwritten on a group basis.
- Must not discriminate against a policyholder on the basis of race, age, gender, marital status, ethnic or social origin, sexual orientation, pregnancy, disability, state of health or any similar grounds.
- An insurer may not refuse to enter into contracts in respect of these policies with potential policyholders, except where that potential policyholder has previously committed a fraudulent act related to insurance.

The following rule applies to all health insurance policies, other than gap cover:

- An insurer may not require the policyholder or insured person to be a member of a medical aid scheme.

2.2. Waiting periods in respect of health insurance

A health insurance policy providing gap cover; non-medical expense cover because of hospitalisation; or cover in respect of HIV, Aids, tuberculosis, and malaria testing and treatment, may provide for a:

- General waiting period of up to 3 months; **and**
- Condition-specific and/or pre-existing condition specific waiting period of up to 12 months.

In respect of these health insurance policies, there are certain requirements in relation to waiting periods to which the insurer must adhere.

An insurer may not impose a condition-specific waiting period on a policyholder's health insurance policy, if that policyholder:

- For 3 months before entering into the 'new' health insurance policy had another health insurance policy with materially similar benefits; and
- had completed the condition-specific waiting period in respect of that health policy.

Furthermore, where a waiting period of a policyholder under a previous health policy in respect of the policies mentioned has not expired at the time the policyholder moves over to a new health policy (with very similar benefits), the insurer of the new health insurance policy may only impose a waiting period equal to that which was remaining on that previous policy.

2.3. Disclosure requirements when taking out a health insurance policy

An insurer must adhere to the following disclosure requirements in respect of all health insurance policies excluding international travel insurance, medical evacuation and frail care, namely gap cover, non-medical expense cover as a result of hospitalisation, or a policy providing cover in respect of HIV, Aids, tuberculosis, and malaria testing and treatment:

- May not create the impression that it is a substitute for medical scheme membership.
- An insurer, in respect of a health insurance policy covering non-medical expense cover as a result of hospitalisation, may not create the impression that it covers you for medical expenses.

3. The difference between a medical aid scheme and health insurance policy

The table below lists the differences between medical aid schemes and health insurance.

MEDICAL AID SCHEME	HEALTH INSURANCE
No maximum entry age (no discrimination).	Some policies have maximum entry ages.
A member of one medical aid scheme cannot be a member of more than one medical scheme.	There is no limit on the number of health insurance policies that a person can have, but there are certain rules about the value of the benefits these policies may provide. If the policyholder is over-insured, she/he may not receive the full pay-out she/he has been contributing toward. This is because risk cover compensates the insured for the loss suffered as a result of the insured event occurring. It is not meant to enrich the insured or the recipient of the proceeds of the policy.
Open enrolment - open medical aid schemes cannot refuse membership.	Membership can be refused based on your risk profile if the insurer chooses to do so.
Community rating: • All members pay the same contribution according to the selected option/plan and the number of members (family size). Premiums are determined in the selected benefit package and can be income based and based on the number of dependants. • Equal premium contribution for high and low risk members.	Premiums are risk-rated, some on an individual basis and some on a group basis. This is dependent on the rules in the law. For gap cover, non-medical expense cover as result of hospitalisation, and HIV, Aids, tuberculosis, and malaria testing and treatment, the premium is determined by the group which the policyholder forms part of. So similar to medical schemes in these types of cover all members (regardless of age, gender, income, etc) pay the same premium for the same benefits.

MEDICAL AID SCHEME	HEALTH INSURANCE
	For products that offer International travel insurance, Medical emergency evacuation or transport or Frail Care, the premium may be determined by the individual risk profile of the policyholder. An insurer may require that a policyholder that enters into a health insurance policy after a specific age pays a higher premium than a policyholder that entered into the contract at a younger age, provided that the same higher premium is payable by all policyholders with the same age.
Accepted by most private hospitals (elective and emergency) depending on the chosen scheme benefit package (pre-authorisation may be required).	Does not cover medical or hospital expenses; usually provides a lump-sum or per day Rand amount (limited to the amounts prescribed in law) for the amount of days that the policyholder is in hospital.
Scheme rules for the specific benefit option will indicate the extent of benefits for non-Prescribed Minimum Benefit conditions. Limitations for specific procedures / devices (e.g. Optometry or Prosthesis benefits) will be stipulated in the scheme rules of the specific benefit package selected for the specific benefit year.	The benefit is either a fixed sum of money calculated per day, or a lump-sum of money which is paid if a specified event takes place (e.g. a specific health condition develops). It is not an amount of money which covers the cost / expenses of a specific medical procedure.
Pays in-hospital benefits, based on registered scheme rules.	Does not pay for the cost of hospitalisation, doctors' bills or other medical expenses. Offers a fixed sum of money to the policyholder calculated per day or lump-sum benefit which is paid if a specified event takes place.
Treatment for dread diseases is subject to what is provided for by the Prescribed Minimum Benefits. Additional treatment (e.g. biological drug treatment or treatments not provided for by the Prescribed Minimum Benefits) will be funded in line with the scheme rules of the chosen medical aid scheme package.	May only cover expenses / cost of testing and treatment for HIV, Aids, tuberculosis, and malaria. All other types of insurance policies do not pay for the medical expense related to dread diseases, but can pay out fixed sums of money to the policyholder or a lump-sum benefit for specific dreaded diseases as per policy schedule.
Hospitalisation limits per annum are high or unlimited, consistent with benefit options stipulated in the scheme rules of a specific benefit year.	The benefits for gap cover and non-medical expense cover as result of hospitalisation are limited in terms of the law. Gap cover is not allowed to pay out more than R172 000 per person per year. Non-medical expense cover as result of hospitalisation may only pay out a maximum of R20 000 per year.

4. Frequently Asked Questions - Medical Aid Schemes

4.1 What is a Medical Savings Account?

Some medical aid scheme options have what is called a medical savings account (MSA). It is usually a percentage of your monthly contribution (maximum 25%), which is used to pay day-to-day and typically out-of-hospital medical expenses. Any unused funds are carried over to the next year, and when you change schemes may be transferred over to the next medical scheme if it has an MSA option, or is payable to you if you are changing to a scheme without a savings account.

5. Frequently Asked Questions - Health Insurance

5.1 Can my family members be covered under my health insurance?

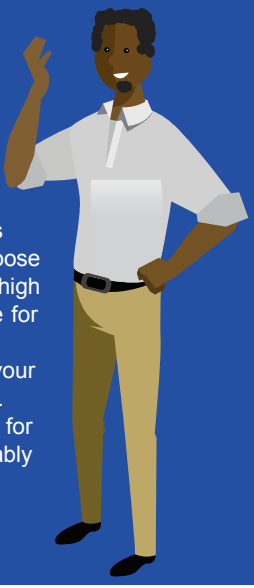
Yes, you can get cover for yourself and any family member you would like to cover, as long as your plan provides for this.

5.2 Is it possible to increase the sum insured (cover amount) if I have an existing health insurance policy?

Yes, it is possible to increase the sum assured to the allowed maximum (if applicable) if you already have an insurance policy. It can be done by contacting your insurer and finding out what the cost of such an increase will be, and the changes that this may require in the insurance contract (policy) between you and the insurer.

6. How do I go about choosing between a medical aid scheme or health insurance policy?

- Identify a few medical aid schemes/health insurance policies and request information about their benefits, contributions/premiums, limitations and exclusions. Compare the information provided to see which one best meets your needs.
- Besides the healthcare benefits, also find out what are the schemes' / health insurers' reserves (solvency ratio), and non-healthcare expenditure, such as administration costs, to ensure that the scheme you choose is in good financial health and offers good value – high administration or other charges mean you may pay more for your cover relative to another scheme with lower charges.
- Finally, choose an appropriate option according to your healthcare needs, your life stage and what you can afford.
- A financial advisor can help you find the right solution for your needs and budget – check that your advisor is suitably authorised by the FSCA.



7. How to lodge a complaint against a medical aid scheme

Medical aid schemes have their own internal complaints procedure process. You have the following options available to you if you are not satisfied with any aspect of your medical aid scheme:

- Notify your medical aid scheme of your complaint in writing.
- If your complaint is not resolved to your satisfaction and within a reasonable time you can refer the complaint to the CMS.

8. How to lodge a complaint against a health insurer

Licensed insurers all have prescribed complaints frameworks and procedures for dispute resolution. You have the following options if you are not satisfied with their financial products or services:

- Notify your health insurer or authorised FSP of your complaint in writing.
- If your problem is not resolved to your satisfaction and within a reasonable time, you can refer the matter for free to the Ombudsman for Short-term Insurance, the Ombudsman for Long-term Insurance or the Ombudsman for Financial Services Providers (otherwise known as the FAIS Ombud).
- If your complaint relates to a possible contravention of the Short-term Insurance Act or the Long-term Insurance Act, you should contact the Financial Sector Conduct Authority (FSCA). If the complaint relates to a possible contravention of the Insurance Act, you should contact the Prudential Authority (PA). If either of these Acts has been contravened, the Ombudsman may hand your complaint over to the FSCA or PA.

Definitions

Limitations and Exclusions

Limitations mean that your medical aid scheme or health insurance policy provides limited cover on certain medical conditions, types of treatments or circumstances. An exclusion describes a medical condition or type of loss that is not covered by a scheme or insurer. Different policies may have different exclusions, as the regulations do not specify what type of risks an insurer must cover. As there are no PMBs applicable to insurers, it remains a business decision of the insurer to decide what type of risks it will cover.

Cooling-off period

If you have recently purchased a health insurance policy with a contact term of more than 31 days and no benefit has been paid or claimed and you decide that it is not suitable or you do not want it for any reason, you may cancel the policy within 14 days of purchasing it. If you purchase a health insurance policy with a contact term of a month or less, you can usually cancel the policy immediately. This period of 14 days is the cooling-off period, and is applicable only to a health insurance policy.

Disclosure

A process where the member and the medical aid scheme, or the policyholder and the insurer, must reveal all material facts to each other before the contract is signed and concluded. If there is key information about your claims history or your medical history, this information should be disclosed upfront to your financial services provider/financial advisor/broker.

Policy terms and conditions / scheme rules

Policy terms and conditions are specific provisions, rules of conduct, duties, and obligations that an insured person must comply with, in order to stay covered by the particular policy. If the policy conditions are not met, then the insurance policy may not pay out for a claim.

The terms and conditions of a medical aid scheme are referred to as the scheme rules. The scheme rules of the specific benefit option for the benefit option year will indicate the terms and conditions of the contract between the member and the medical aid scheme. Similar to policy terms and conditions, these indicate the specific provisions, rules of conduct, duties, and obligations that a member must comply with, in order to stay covered by the medical aid scheme.

Premium / contribution

Is the amount of money that you will pay to a medical aid scheme in return for “healthcare cover” or will pay to an insurer in return for “policy benefits,” as set out in the policy contract or membership documents. Premiums / contributions are paid at regular agreed intervals, usually monthly or annually. These terms may be used interchangeably.

Medical expense shortfall cover - commonly known as Gap cover / gap insurance policy

Gap cover, or a gap insurance policy is a short-term (non-life) insurance policy designed to provide extra protection for those who already have a medical aid scheme. It covers the deficit (short-fall), or part of the deficit, between your medical aid scheme’s tariff (MST), and the actual rates charged by private healthcare professionals. It aims to ensure that you are covered when your medical costs or expenses exceed your medical aid scheme rate, or any related shortfall, so that you do not suffer a financial loss, provided that certain legal limitations, terms and conditions are met. Gap cover is not allowed to pay out more than R172 000 per person per year (as of 2021).

Benefit

The amount payable by the insurer or medical aid scheme to the person who makes a claim, when the insured person suffers a loss that is covered by the health insurance policy or medical aid scheme.

Designated Service Provider

A health care provider or group of health care providers, which are selected by the medical aid scheme as its preferred provider(s) to provide members with diagnosis, treatment, and medical care. If services are provided by a Designated Services Provider in line with the PMB entitlement, then no co-payment (extra costs to you) may apply.

Useful contacts

Financial Sector Conduct Authority (FSCA)

To check if a financial services provider (FSP), in this case the health insurer or financial advisor who is selling you a medical aid scheme or health insurance policy, is licensed and authorised to sell you these financial products and services, contact the FSCA.

FSCA switchboard:	012 428 8000
Call centre:	0800 20 3722 (FSCA)
Fax number:	012 346 6941
E-mail address:	enquiries@fsca.co.za complaints@fsca.co.za
Postal address:	P.O. Box 35655, Menlo Park, Pretoria 0102
Physical address:	Riverwalk Office Park, Block B, 41 Matroosberg Road, Ashlea Gardens, Pretoria, South Africa, 0081
Website:	www.fsca.co.za

For more consumer financial education (CED) information or if you would like the CED to conduct a free financial literacy workshop in your area, community, church, school or workplace contact the **FSCA's CED.**

E-mail:	CED.Consumer@fsca.co.za
Website:	www.fscamymoney.co.za

Prudential Authority (PA)

To find out if an insurer is licensed to do business, contact the PA.

Telephone:	012 313 3911/ 0861 12
SARB:	(0861 12 7272)
Fax:	012 313 3197/ 012 313 3929
E-mail:	PA-Info@resbank.co.za
Postal address:	P.O. Box 8432, Pretoria 0001
Physical Address:	South African Reserve Bank, 370 Helen Joseph Street, Pretoria 0002
Website:	www.resbank.co.za

Ombudsman for Short-term Insurance (OSTI) and Ombudsman for Long-term Insurance (OLTI)

For complaints relating to health insurance policies, contact the Ombudsman for Short-term Insurance or the Ombudsman for Long-term Insurance, depending on the policy classification, being either short-term (non-life) or long-term (life). Please note that your insurer should be given the opportunity to resolve the problem or complaint before it is referred to ombud.

Ombudsman for Short-term Insurance (OSTI)

Telephone:	011 726 8900
Sharecall:	0860 726 890
Fax:	011 726 5501
E-mail:	info@ombud.co.za
Physical address:	1 Sturdee Avenue, 1st Floor, Block A, Rosebank, Johannesburg 2196
Postal address:	Private Bag X45, Claremont, Cape Town 7735
Website:	www.osti.co.za

Ombudsman for Long-term Insurance

Telephone:	021 657 5000
Sharecall:	0860 103 236
Fax:	021 674 0951
E-mail:	info@ombud.co.za
Physical address:	21 Dreyer Street, 3rd Floor, Sunclare Building, Claremont, Cape Town,7700
Postal address:	Private Bag X45, Claremont, Cape Town 7735
Website:	www.ombud.co.za

Not sure which Ombud you should contact? Contact the central contact point for insurance related complaints and enquiries.

Sharecall:	0860 103 236 / 0860 726 890
Telefax:	086 589 0696
E-mail:	info@insuranceombudsman.co.za
Website:	www.insuranceombudsman.co.za

Council for Medical Schemes (CMS)

Contact the CMS to find out more about their role, member rights, Prescribed Minimum Benefits (PMBs), and how to lodge a complaint against a medical scheme.

Telephone:	012 431 0500
Customer Care Centre:	0861 123 CMS (267)
Fax:	086 206 8260
E-mail:	information@medicalschemes.co.za

Complaints

Fax:	086 673 2466
E-mail:	complaints@medicalschemes.co.za
Physical address:	Block A, Eco Glades 2 Office Park, 420 Witch - Haa`1zel Avenue, Eco Park, Centurion, 0157
Postal address:	Private Bag X34, Hatfield, 0028
Website:	www.medicalschemes.co.za

Ombud for Financial Services Providers (FAIS Ombud)

For complaints related to financial advisors and intermediaries contact the FAIS Ombud. Please note that your insurer should be given the opportunity to resolve the problem or complaint before it is referred to the FAIS Ombud.

Telephone:	012 762 5000
Sharecall:	086 066 3274
Fax:	011 348 3447
E-mail:	info@faisombud.co.za
Complaints about our service:	hestie@faisombud.co.za
Enquiries on status of complaints:	enquiries@faisombud.co.za
Physical address:	125 Dallas Avenue, Menlyn, Waterkloof Glen, Pretoria, 0010
Postal address:	P.O Box 74571, Lynnwood Ridge, 0040
Website:	www.faisombud.co.za