5 tips on choosing a medical aid

By Craig Comrie

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Medical aid is one of the biggest cost centres on many family budgets, then there is the tricky business of understanding what is covered and what is not. It's therefore important to choose one that is right for you and your health needs and will potentially not leave you financially ruined?

Image source: Getty/Gallo

Tip 1: Find a medical aid you can trust

All official medical schemes should be registered with the Council for Medical Schemes (CMS). If you are worried that a certain provider is not legitimate, you can go to the CMS website to verify their validity.

No one knows your needs better than you. It's up to you to do your own research. Luckily, schemes provide smart internet capabilities which can compare a wealth of information of their products in the market. Easy to access member feedback portals also provide first-hand accounts on how schemes treat their members.

You can also speak to a broker. With so many schemes out there, it can feel impossible to properly weigh up the pros and cons of them all. A reputable broker has knowledge of the different schemes and can provide a personalised answer based on your needs.

Tip 2: Know the difference between a medical scheme and health insurance

Confusion tends to set in when deliberating the difference between medical schemes and health insurance. In the end it comes down to cost versus benefits and remember cheap usually means fewer benefits.

If you need peace of mind or more generous care, then you definitely need a medical scheme. If you are looking for affordable basic cover under R500 a month, then you can look at health insurance. However health insurance products typically pay a larger proportion of your premium to marketing, distribution and administration costs.

When belonging to a scheme, remember you effectively are a shareholder of the business and with any remaining profit or “surplus” at the end of the year is then saved for future years claims. Medical schemes even the lowest cover sometimes refer to as “hospital plans” must offer what is known as Prescribed Minimum Benefits. According to CMS, these are benefits that ensure that all medical scheme members - regardless of the provider and the benefit option - must have access to certain minimum health services.

Prescribed Minimum Benefits are defined in the Medical Schemes Act, and all medical schemes have to cover the costs related to the diagnosis, treatment and care of:

Any emergency medical condition
- A limited set of 270 medical conditions (defined in the Diagnosis Treatment Pairs);
- 25 chronic conditions (defined in the Chronic Disease List)

Medical insurance sits on the other end of the value scale, paying a set amount for your stay in hospital. This cost is often not nearly enough considering the high costs of medical care in a general, high care or intensive care unit.

Tip 3: Understand the limits of a hospital plan

To cut costs, many people choose to downgrade their medical aid cover to a hospital plan. If you’re with a CMS accredited medical scheme, then you can rest assured that even the lowest level hospital plan should comply with the above mentioned Prescribed Minimum Benefits. You also need to be aware that every visit to the hospital emergency rooms does not count as hospitalisation. Even if you think it was a medical emergency, there is a difference between getting treated as an out-patient and being admitted and so some visits to emergency rooms may in fact come from your day-to-day or savings benefits unless you are admitted.

It is critical to understand that that many schemes have a limit on their hospital cover. They will require you to attend only certain hospitals and may have a hospital limit on what is covered depending on your scheme and plan.

Tip 4: When first becoming a member of a scheme, prepare to wait

If you are looking to sign up for medical aid, you can almost certainly expect a waiting period. There are two types of waiting periods or underwriting conditions.

The first is the general waiting period. If you are healthy, under 35 and haven’t been on a medical scheme before, you will generally only have to wait three months before full cover takes effect.

The second is called condition specific waiting period. This applies if you have a pre-existing condition or injury prior to joining the scheme. In these cases, the standard practice is that schemes apply a 12-month condition-specific waiting period before you can access benefits relating to these pre-existing conditions, which is standard practice.

It is best to disclose your pre-existing conditions as three or 12 months is not a long time to wait. This is a contractual relationship at the end of the day and by not disclosing your condition after signing the contract, the scheme has full rights to terminate you from the scheme and refuse cover.

An additional matter to be aware of is if you are delaying becoming a member of a medical scheme, you may be required to pay late joiner penalties for the rest of your life. This is applied by all schemes to encourage younger members to join early rather when its too late. These penalties will follow you regardless if you move medical schemes at a later stage and can cost you up to 50% more than the scheme premium. This is depending on your age.

Tip 5: Be careful of loyalty frills

It's easy to get caught up in the excitement of loyalty benefits. The reality is that promoting healthy behaviour improves your lifestyle but things such as discounted flights or free movie tickets won't help you when you have a car accident and are taken to the ICU. Too many people mistake frills and loyalty-based products as core healthcare benefits they are buying only to discover that they don't have the proper cover they need when the time comes.

Don't be fooled by big brands that market frills because you will literally pay the price when it is too late. Ultimately, it's important to understand the pros and cons of choosing a medical aid especially based on your needs and affordability.

ABOUT THE AUTHOR

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