10 gaps in your medical scheme cover

January 23 2012 at 06:11pm
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If there was ever a time when medical scheme members believed that their schemes covered all, or virtually all, their expenses, it was a long time ago.

More recently, we, as medical scheme members, have been facing both rapidly rising contributions and increasing gaps in our cover.

Medical schemes, in turn, are facing rising costs as a result of new medicines, medical practices, technologies and research that is more complex.

In addition, we are living longer but with more illnesses that are chronic and this has resulted in schemes facing higher, and increasingly expensive, claims.

The medicines and medical practices that are used to treat us have become a lot more sophisticated and a lot more expensive, and there are better ways of diagnosing what is wrong with us. While the merits of medical schemes funding these treatments for their members collectively and individually can be debated, you may be confronted with a significant shortfall in your benefits if you want or need a therapy other than what your scheme provides.

Cost pressures typically result in one of three things: increases in your contributions, or cuts in your benefits, or both.

To make members' benefits go further, schemes have implemented a number of different measures that involve controls on the healthcare services you access or negotiations with the providers you consult. These measures can have cost implications for you, particularly if you do not follow your scheme's increasingly complex rules.

To avoid incurring medical bills that your scheme does not cover in full, you should understand how these gaps can occur and the ways in which you can minimise them within your scheme. Here are 10 common gaps and some ways you can avoid them:

1. YOUR BILLS EXCEED YOUR BENEFIT LIMITS

One of the most irritating lines on a medical scheme statement is the one that states you have exceeded your benefit limit. It means that your claim amounts to more than the benefit provided by your scheme.

Schemes have two kinds of limits: an overall limit on the benefits paid during the course of a year and annual sub-limits on different kinds of benefits.

If your medical scheme has an overall limit on benefits, you could find yourself paying out of pocket if your medical expenses in that year are very high and exceed the limit. For example, Bonitas Medical Fund's Primary option has an overall limit of R750 000 per family a year. The limit may seem high, but you could reach that limit if a member of your family became critically ill or if two or more family members were involved in a car accident.

The cost of a serious trauma event with a subsequent lengthy stay in a private hospital for just one person can run into hundreds of thousands of rands.

For example, Discovery Health's Benefit Tracker for July 2011 records that between August last year and July this year the average cost of a heart transplant for Discovery Health members was R768 639, while the average cost of having a premature baby weighing less than one kilogram and needing major operations was R614 561.

Most schemes have sub-limits on certain benefits, and you will find yourself paying out of your own funds if you exceed these limits. The sub-limits may confine the benefits to a rand value or they may be restricted to a certain number of consultations or services, such as 12 general practitioner (GP) consultations or one pair of glasses every two years.

While some sub-limits may appear reasonable, one expensive incident can result in your exceeding the limit. For example, an annual limit of R3 000 for dentistry may seem reasonable, but the benefit would be inadequate should you require, say, a dental implant, which can cost between R4 000 and R7 000.

Schemes also limit benefits by combining them, and this could result in your quickly exceeding the limits. Common combinations are:

* A set number of consultations with GPs and specialists;

* A rand amount for basic and advanced dentistry; and

* A rand amount for radiology and pathology.

To avoid the problems that come with exceeding your benefits, make sure you choose a suitable option for your medical needs. A good medical scheme broker should be able to help you analyse your needs and the limits on the available options to find one that may be suitable for you.

Although the more you pay in contributions, the better your cover is likely to be, some schemes have succeeded in offering good benefits on lower-cost options, mainly by limiting your choice of healthcare providers to certain hospitals, pharmacists or doctors.

Once you are on a suitable option, make sure you are well acquainted with the benefits provided by your scheme and keep a tally of medical bills where benefit limits apply.

2. DOCTOR'S RATE IS HIGHER THAN SCHEME'S RATE

The number of specialists who practise in South Africa has declined rapidly in recent years, while the demand for their services has increased.

The law of supply and demand has enabled specialists to charge higher fees, and medical schemes cannot meet many of these tariffs. At the same time, medical schemes have reduced the rates at which they are willing to reimburse specialists. The result has been a widening gap between what schemes pay and what specialists charge.

In the past, many medical schemes paid benefits based on the guideline tariffs, which were known as the Reference Price List (RPL). Typically, higher-end options paid up to 300 percent of the RPL rates, while lower-end options paid at the RPL rate (100 percent).

To address its inability to meet every specialist's individual rate and the inability to predict when members may be out of pocket, in 2007 Discovery Health Medical Scheme cut the rate at which it reimburses doctors on all but its high-cost top option, to fund a direct payment arrangement for providers who charge the scheme rate (see below).

The rate of reimbursement on Discovery Health's higher options was cut from 300 to 200 percent of the RPL and on the lower ones from 150 to 100 percent of the RPL.

Many other schemes also cut their rates of reimbursement, and scheme options that reimburse doctors at 300 percent of the RPL are now a rare find.

However, not all of these schemes have introduced direct payment arrangements and not all specialists have bought into these arrangements. As a result, you may well find consultations with, and procedures performed by, specialists whose fees are not covered by your scheme give rise to a gap in your cover.

Further to this development, the RPL has been struck down by a court, adding to the confusion over rates of reimbursement. The Council for Medical Schemes began publishing the RPL after the Competition Commission in 2003 put a stop to what it said were anti-competitive negotiations between schemes and providers over the rates that schemes would pay for healthcare services.

In 2007, responsibility for the publication of the RPL was passed on to the Department of Health. Until 2008, the Health Professions Council of South Africa (HPCSA) regarded 300 percent of the RPL as the highest tariff that practitioners could charge ethically without obtaining your written consent.

In November 2008, the HPCSA abandoned its "ethical tariff", saying doctors should obtain your written consent if they wanted to charge medical scheme members more than their scheme pays.

In 2010, a number of healthcare providers challenged the legality of the process used by the Department of Health to determine the RPL. They succeeded in having the RPL struck down by the North Gauteng High Court after the judge found that the process by which the RPL was determined was indeed flawed.

There are now no guideline tariffs and the ethical tariffs are also problematic.

Medical schemes have developed their own scheme rates, which are usually based on previous versions of the RPL adjusted for inflation or adjusted in line with input on tariffs obtained by the scheme. Some schemes have adjusted the 2009 RPL rates for the average rate of inflation in 2010 and 2011, while some have gone back to the 2006 RPL – the last one published by the Council for Medical Schemes before the Department of Health took over publishing the RPL – and have adjusted it for inflation. Also, schemes have used different assumptions in adjusting the RPL rates for inflation.

As a result, there is a wide range of rates at which medical schemes reimburse doctors, so there is a higher probability of a difference between what your scheme pays and what your doctor charges. This makes it more difficult for you to know if your scheme's rate will cover what the practitioner charges.

In addition, practitioners in high demand may charge rates that are even higher than 300 percent – frequently 400 percent but even up to 600 percent of your scheme's rate.

The shortfall between what your specialist charges (the private rate) and what your medical scheme refunds you (the medical scheme rate) is known as the tariff shortfall.

There are two ways to close the gaps in cover that result because your doctor charges more than your scheme reimburses. One way is to use a gap cover policy, and the next issue of Personal Finance magazine will take a closer look at these and other policies that can help you with shortfalls in your medical scheme cover.

The other way is to use doctors who charge within the scheme's rate.

To minimise the tariff gaps in your cover, some medical schemes have entered into direct payment arrangements with specialists. These contracts typically involve a direct payment to doctors who agree to charge at the scheme rate. To avoid the problems of collecting on bills and bad debts, doctors are willing to accept these rates of reimbursement.

If your doctor charges more than your scheme’s rate, the scheme usually pays you the benefit it is obliged to pay and leaves you to settle the bill in full. But sometimes members use the money paid to them by schemes for other purposes, and the doctor does not get paid.

Some schemes induce doctors to enter into direct payment arrangements by paying better rates to doctors who join than to those who do not.

Discovery Health, Momentum Health and Resolution Health have direct payment arrangements with a range of specialists, and Fedhealth is in the process of setting them up.

It is not compulsory for you to use a specialist who has entered into a direct payment arrangement with your medical scheme, but if you use a specialist who is contracted in, you can minimise the chances of a nasty surprise when the specialist’s bill arrives.

Schemes also offer options with cheaper contribution rates if you agree to forgo using the healthcare provider of your choice and use one within a provider network. These options typically offer hospital cover via a network of hospitals and day-to-day cover through a doctor network.

More recently, schemes have started to use networks in ways that are more flexible. For example, you can choose an option that gives you the freedom to choose your doctor but you must use a hospital network to enjoy hospital cover and a pharmacy network for your chronic medication.

Discovery Health, Momentum Health and Resolution Health have been granted exemptions under the Medical Schemes Act that allow them to introduce discounted contributions for members who use provider networks within certain options. Members of these options are obliged to use providers who are part of the networks or they will incur an out-of-pocket expense.

You may face a co-payment for using a provider outside of the network or, worse, your claim may not be paid at all.

Katy Caldis, the chief executive officer of Fedhealth, says what your scheme will pay for out-of-network benefits depends on the rules of the option to which you belong.

Out-of-network benefits are typically non-existent on lower-cost options, with the result that your scheme will not pay at all if you use a non-network doctor or provider, Caldis says.

Michael Settas, the managing director of Xelus Specialised Insurance Solutions, says using a specialist within a network can eliminate tariff gaps.

However, he says, you need to watch out for a situation in which a surgeon who may be part of a network chooses to work with an anaesthetist who may not be.

It is also important to note that a contracted specialist may not always be available in your area or may have a long waiting list, or the speciality you require may not have a contracted specialist.

Andre Jacobs, the business unit head for healthcare operations at insurance brokers and consultants Aon, says networks generally work for people in metropolitan areas but can be a problem if you live in a remote area and have to drive long distances to see a doctor who is part of the network.

Caldis says another problem that you can face is if your specialist practices at a hospital that is not within your scheme option's hospital network.

Dr James Arens, the clinical operations executive of Pro Sano Medical Scheme, says if your scheme does not have a specialist network or you do not use a specialist within its network, you should find out upfront what your scheme will pay and whether that amount will cover the bill.

It is not unreasonable to discuss the cost of your treatment with your doctor, and members need to get into the habit of negotiating discounts with their service providers, Arens says.

Caldis says in some cases healthcare professionals will charge less if you pay them after the consultation and then claim back from the scheme. This is because the healthcare professional receives his or her money quicker and avoids the administration of claiming from your medical scheme.

3. UNPAID PMB CLAIMS

The Medical Schemes Act lists almost 300 conditions that schemes are obliged to cover as prescribed minimum benefits (PMBs). The PMBs include all medical emergencies, some 270 conditions that if left untreated would severely affect your quality of life and 27 common chronic conditions.

If your condition is a PMB, your medical scheme must cover the cost of the diagnosis, treatment and care of the condition in full, without a co-payment, and the bill may not be paid from your medical savings account.

The PMBs should ensure that you do not have gaps in essential cover. However, many members have PMB claims that are not paid by their schemes or are paid illegally from their medical savings accounts.

To ensure that your scheme will pay your PMB claims, make sure that you:

* Can prove that your medical condition is a PMB;

* Know your rights in terms of the PMB regulations issued under the Medical Schemes Act;

* Know whether your scheme expects you to access treatment for a PMB in a particular way; and

* Know how your scheme expects you to claim for services related to a PMB condition.

Medical schemes are entitled to limit the services for which they pay for a PMB to those that are provided in state facilities, or to any alternative treatment as long as it is not less than that provided in state facilities. You may therefore find that, even if you have a PMB condition, your scheme will not pay for the latest treatment, which is too expensive to be used in state facilities.

Schemes are also entitled to control the cost of providing the PMBs by appointing designated service providers (DSPs), which you must use to access the PMBs. The DSP may be a chain of pharmacies or pathologists, or a network of doctors or hospitals.

Failure to use the DSP, unless the DSP was not reasonably close to where you live or was not available within a reasonable period of time, or because it was an emergency, can result in a gap in your cover, even though your condition is a PMB.

Schemes are entitled to apply co-payments if you choose not to use the DSP. These co-payments must be stipulated in the rules of the scheme. They can be a set percentage of the bill or the difference between what the DSP would have charged and what the service provider that you used charged.

Schemes may also apply managed care principles to PMB services (see point four) as long as these do not result in your receiving a level of treatment that is lower than that in state facilities.

Managed care for PMB conditions, such as the common chronic conditions, may involve a list of medicines or following a treatment protocol for the condition. Failure to use the listed medicines could result in a gap in your cover.

Before it will pay your claim as a PMB, your scheme may, for example, expect you to obtain pre-authorisation, join its disease management programme, or complete a chronic medication application form annually or whenever your doctor recommends a change in medication.

Your medical scheme is supposed to identify and pay PMB claims where possible. Schemes rely on the diagnostic and service codes on your claims to identify PMB claims. If these codes are incorrect, the scheme may not pay the claim.

In some cases, schemes do not regard the codes as adequate to confirm your condition as a PMB, while other schemes expect you to register your condition or apply for authorisation for its treatment.

Your claim could be rejected if the scheme is of the view that it does not have enough information about your condition or if you were expected to apply for authorisation and failed to do so.

If you know your condition is a PMB, you will be in a position to question why your scheme rejected a claim or why it was paid from your medical savings account when the scheme should have paid it.

You should also try to establish from your doctor what the diagnostic code, or ICD-10 code, for your condition is. This is because an incorrect diagnostic code on a claim can result in it not being regarded as a PMB.

Most schemes identify and pay hospital admission PMB claims automatically. But if you have one of the 27 common chronic conditions, many but not all schemes expect you to register your condition with them. Registering your chronic condition will typically entitle you to a set of standard benefits.

There may be a second tier of treatment above the standard benefits, and you are entitled to this care if you need it, but your doctor may have to provide clinical motivation to the scheme before you can claim for it as a PMB.

If you or your doctor is not aware that you need to apply for approval for second-tier treatment, you may find that your PMB claims are rejected. If you become aware that you had to seek approval after you have begun treatment, ask your scheme to approve the claims that you have already incurred.

In the process of convincing your scheme to pay your PMB claim, you may need to find out what treatment is available to state patients.

Last year, LA Health medical scheme, which is administered by Discovery Health, rejected claims that a member with multiple sclerosis, a PMB condition, submitted for the physiotherapy he needed.

The regulations under the Medical Schemes Act state that the minimum treatment for multiple sclerosis includes “supportive care”, but there are no further details in the regulations.

The member complained to the Council for Medical Schemes. The council found that state hospitals provide physiotherapy to multiple sclerosis patients and instructed LA Health to pay the member's claims for physiotherapy.

Schemes have different policies for what you need to do to have a claim paid for a once-off acute out-of-hospital PMB, such as acute otitis media (middle ear infection), and out-of-hospital PMB conditions that involve ongoing chronic medication. The latter are not among the 27 common chronic conditions, but, because they involve ongoing chronic medication, you may still have to register on the scheme’s chronic medication programme to get your claims for this medication paid.

The medicines include post-transplant medication, hormone replacement therapy, medication for metabolic and endocrine conditions (such as hyperthyroidism), anti-coagulative therapy, medication after cardiac surgery, and medication required by quadriplegics and people with valvular heart disease.

Medical schemes have agreed to abide by a code of conduct on the PMBs. The code commits schemes to reassessing a PMB claim up to three years after the scheme processed it if you later establish that the condition for which you claimed is a PMB but your scheme did not have sufficient information to identify it as such.

4. MANAGED CARE LIMITS ON TREATMENT

In order to contain the costs of providing you with benefits, medical schemes may engage with healthcare providers and decide on the most cost-effective, best-practice treatment or procedure for a particular condition. These decisions are referred to as managed care protocols.

If your doctor recommends a treatment that differs from the scheme's protocols, you may find your claim for the treatment denied or only partly paid.

One of the longest-standing managed care techniques is pre-authorisation, but schemes now use a number of measures and a range of disease management programmes that set out the most cost-effective management of diseases such as HIV/Aids, diabetes, high blood pressure, asthma, heart disease, hypertension and even cancer.

If you have one of these conditions, you may be expected to register on your scheme’s disease management programme, and failing to do so will result in your claims being rejected.

These programmes may include protocols on how your disease should be managed, including stipulating the number of consultations and diagnostic tests you need and even listing the cost-effective medicines that can be used, known as a formulary.

Typically, the formulary will list cheaper generic medicines and will exclude newer, more expensive ones that have yet to be proved cost-effective for treating a particular condition.

Managed care protocols are usually developed by a managed care entity, which may be separate from or housed within the scheme's administrator and must be accredited by the Council for Medical Schemes.

Medical schemes' managed care protocols are usually based on what is accepted as the best practice by the association or society that represents the relevant medical discipline, and your doctor should be aware of that best practice, schemes say.

However, there are often differences of opinion between the doctors who treat you and the doctors who sit on the teams that are appointed to manage a scheme's costs, and this can expose you to gaps in your medical cover.

You should therefore ask your doctor if the treatment that he or she has recommended is in line with best practice and, if it is not, what the doctor's experience of typical medical scheme cover for the treatment has been, Alain Peddle, the head of research and development at Discovery Health, says.

One of the best ways to determine whether or not you will have cover for the treatment is to obtain a "quote letter" from your doctor that outlines the treatment or procedure using the relevant ICD-10 codes. Then contact your scheme and ask it to check if all the services listed are covered, he says.

Telephoning your medical scheme for pre-authorisation for an in-hospital procedure or chronic medication will also help you to establish what your benefits are and whether or not the scheme is likely to cover the procedure or medication.

Arens says you should telephone your scheme to obtain pre-authorisation so that you obtain first-hand information about any disclaimers and exclusions that can result in an out-of-pocket payment.

You can also ask for a written copy of the managed care protocol, but it is likely to have been written by doctors for doctors, so you may need some help interpreting what it means.

Before you start a course of medication, find out whether or not your scheme has a formulary. If your doctor prescribes a medicine that is not on the formulary, check with him or her whether you can use one that is.

If your doctor has sound medical reasons for prescribing a medicine that is not on the formulary, or if you have already tried the formulary medicine and it has not worked, your doctor should provide a motivation to the scheme for alternative treatment. The scheme will be obliged to consider this or tell you what alternative it will cover.

If the scheme's clinical experts and your doctor cannot agree on a suitable treatment that the scheme will cover, you should be aware that the regulations under the Medical Schemes Act state that there must be a way in which you can appeal against a decision made by a managed care entity.

Managed care entities are also expected to review their decisions regularly to ensure that they are still appropriate.

Unless your scheme provides you with a complaint process to follow, take your complaint to the office of the principal officer of the scheme. If you do not resolve your complaint there, you can take the matter to the Council for Medical Schemes.

If you do not agree with the Council for Medical Schemes's ruling, you can appeal to its Appeal Committee and from there to the Appeal Board – an independent board of legal experts appointed by the Minister of Health.

5. CO-PAYMENTS AND DEDUCTIBLES

Besides the co-payments that schemes are entitled to apply if you do not use the scheme's DSP or formulary medication for PMBs, schemes also use co-payments or deductibles to control other costs.

By applying co-payments or deductibles to certain procedures or to medicines, schemes make you responsible for part of the bill and ensure that you and your doctor will use only those procedures and medicines that are absolutely necessary.

Caldis says schemes may use co-payments for procedures that are not considered effective or have doubtful outcomes. Procedures that typically attract co-payments are gastroscopies, laparoscopies, the removal of wisdom teeth, colonoscopies and joint replacements that schemes regard as recommended without being essential.

However, even if the procedure is absolutely necessary, you will still pay the co-payment.

Settas says co-payments may also be applied to specialised diagnostic procedures – such as magnetic resonance imaging (MRI) and computed tomography (CT) scans – and some schemes impose a flat amount for every non-emergency hospital admission regardless of the type of procedure. These co-payments range from about R1 000 to as much as R8 000 per procedure, depending on your scheme and benefit option. The advantage of belonging to a scheme or an option with co-payments on defined procedures is that you generally pay a lower monthly contribution, Settas says.

Schemes cannot impose co-payments on any procedure classified as a PMB unless the scheme has appointed a DSP and you choose not to use the DSP. If, for example, your scheme has a co-payment for a hip replacement operation, it cannot impose this co-payment when the hip replacement is required as a result of fracture, because in this case the procedure is covered by the PMBs.

6. GAPS IN CANCER BENEFITS

The treatment of cancer is developing fast, but the cost of the chemotherapy or radiotherapy involved is climbing. Specialised medicines, such as biologics, monoclonal antibodies or tyrosine kinase inhibitors, which target the cancer cells, may advance your chances of survival or prolong your life but they will increase the cost of treating you.

Medical schemes have limited their oncology benefits in the face of the rising costs of treating cancer and the increasing prevalence of the disease.

Many schemes have an annual limit on the amount that you can spend on oncology and/or exclude cover for more expensive treatments. As a result, there may be gaps in your oncology cover.

On Medshield's Mediplus option, for example, the oncology benefit is limited to R230 000 per family a year. Discovery Health pays for cancer treatment in full up to R200 000 per 12-month cycle per beneficiary on its Saver and Priority plans and up to R400 000 per 12-month cycle per beneficiary on its Comprehensive plans. Thereafter cancer benefits are unlimited, but there is a co-payment of 20 percent.

Caldis says if the scheme and its managed healthcare company have done their job properly, the annual limits should be set at an appropriate level for a particular treatment protocol.

However, the benefit can be exhausted quickly if your treatment involves expensive chemotherapy, which can be as much as R30 000 a month, that the benefit was not intended to cover.

The treatment of some, but not all, cancers is covered by the PMBs, so your scheme is obliged to pay for your treatment beyond any scheme limits but only to the extent that the treatment is the same you would enjoy in a state facility.

In addition, your scheme may control the cost of treating a PMB cancer by expecting you to use the scheme's DSP, following its managed care protocols or taking medicines listed on its formulary.

But beware: the PMBs do not offer everyone the safety net of benefits that you may think they do.

Leading oncologists say the PMBs do not cover the treatment of all curable cancers and, in the case of incurable cancers, offer insufficient palliative care.

For example, the PMBs define treatable cancers of the organs as those that have not spread to other organs, whereas many cancers that have spread to other organs are in fact still curable.

Oncologists say that even when it is clear that a cancer is covered by the PMBs, medical schemes are using the vagueness of the PMB regulations to deny benefits to members, particularly for more expensive treatments. For example, in considering the level of treatment in state facilities, schemes will typically exclude treatment that is provided free of charge in state facilities by pharmaceutical companies.

This approach may result in a scheme paying only for what oncologists argue are old-fashioned therapies that are no longer appropriate, while your scheme argues that the old therapy is not out of date and is much cheaper than the new ones on offer.

Work has begun to define the cancer PMBs properly and to detail the minimum treatments for each of them, but progress is slow because this is a complex task.

Some schemes offer only PMB cover for cancer, or their cancer benefits are so limited that they stretch only as far as PMB cover. The South African Oncology Consortium (SAOC) says these benefits are the first of three tiers of cancer benefits that schemes typically offer on their options.

The SAOC is an organisation to which all accredited South African oncologists belong, and most medical schemes draw on its guidelines and expertise to manage their oncology benefits.

Medical scheme options that provide cover at the SAOC's second tier offer reasonably good oncology cover, including a number of biologics, but exclude some very costly treatments.

The most expensive medical scheme options use the SAOC's third tier of benefits, which provide you with cover for the latest treatments. Typically, these options have high overall oncology limits and/or additional limits for expensive chemotherapy.

7. INADEQUATE MEDICAL SAVINGS ACCOUNTS

If you are on a traditional medical scheme – one that does not use a medical savings account – your day-to-day benefits are usually limited per benefit category. These limits could, for example, be R2 000 a year for optical benefits or R3 000 a year for dentistry, Settas says.

Once the limits on your day-to-day benefits are exhausted, you have to pay future accounts out-of-pocket unless you have a medical savings account to top up the limited benefits.

Many medical schemes expect you to fund your day-to-day benefits exclusively from your medical savings account.

If the amount that you will contribute to your medical savings account during the year is inadequate for your usual annual medical needs, or if you have a particularly bad year health-

wise, you may find that the balance in your savings account is depleted and you may then incur high out-of-hospital costs.

When paying your day-to-day medical expenses out of a medical savings account, you may also face a gap in your cover if your scheme reimburses providers at the scheme rate only.

When you join an option in which your day-to-day medical expenses are paid from a medical savings account, you are in effect self-funding these expenses.

The Medical Schemes Act limits the amount that you can contribute to a medical savings account to 25 percent of the contribution.

The limit on how much you can contribute to a savings account means that cheaper options tend to have lower savings account contributions.

Watch out for options that appear cheaper because they set contributions to a medical savings account at much less than 25 percent of contributions, unless the savings account is intended only to top up the day-to-day benefits provided by the scheme.

If you have to fund your day-to-day healthcare needs through a medical savings account, you must determine how much you will contribute to the account in a year and compare this with the potential cost of the benefits that you will have to fund from the account.

For example, multiply the monthly amount you contribute to your medical savings account by 12 and see what you will accumulate in the account over the year. Then compare that with the typical costs you may incur, as provided by Neels Barendrecht, the chief executive of Agility Health Solutions. These costs could include a visit to the dentist for an uncomplicated filling (R300 to R600), an eye test (about R350), a pair of single-focus glasses with the most basic frame (about R750), at least three visits to a GP (about R265 a visit) and a standard antibiotic (anything from R13 to R700 but averaging about R150). Now it is easier to see how long the funds in your savings account are likely to last.

Take a look at what you spent on optometry, dentistry, GP visits, prescription medicines, pathology tests and X-rays over the past three years and work out the annual average. Pay particular attention to your chronic medication expenses that are not covered by the PMBs – for example, depression (R37 to R500 a month) and hay fever (R45 to R250 a month).

Once you have an idea of your average day-to-day medical costs, assess whether the level at which you are contributing to your savings account is sufficient.

Remember that you should also have room in your savings account or in your budget for some out-of-the-ordinary medical expenses that you may have to cover – for example, complications after the flu, such as a lung infection that requires X-rays (about R200) and visits to a specialist (about R650 to R800).

Also, check whether radiology benefits for MRI and CT scans, wheelchairs and artificial limbs, which can cost thousands of rands, must be paid from your savings account.

You should also be aware that expenses you may have expected your scheme to cover but that it does not will be paid from your medical savings account and can quickly deplete it.

The surgical removal of wisdom teeth and basic dentistry under anaesthetic for young children are not covered by all scheme options.

Another example is the medicines you are prescribed after being in hospital. Some schemes pay for these take-home medicines for seven days after you have been in hospital, whereas others do not.

If you join an option with insufficient cover for your day-to-day needs because the medical savings account contributions are too low, you must accept that you will have to pay for some of your medical expenses yourself. You may be able to take this risk if you are healthy and have enough discretionary savings to tap into when you need them.

You can, at additional cost, minimise the risk of running out of funds in your medical savings account by choosing an option with above-threshold or safety benefits. These insured benefits ensure that if you exhaust your savings account, you are not left without essential cover.

You reach the threshold once you have spent the amount that you will contribute to your medical savings account for the year, or the threshold may be set higher than the savings account balance.

If the threshold is higher than the savings account balance, a self-payment gap will arise, and you have to pay your claims while you are in that gap.

The scheme will start to pay your claims again only once your claims reach the threshold.

Barendrecht says you should be aware that the scheme determines whether you have reached the threshold by adding up your claims as if they had been paid at the scheme rate, rather than the rate charged by the service provider, so you may have to spend a lot more than the threshold to get out of the self-payment gap.

In addition, the scheme may have rules that specify that only certain claims contribute to the amount you need before you reach the threshold.

For example, the scheme may allow you to pay for over-the-counter medicines from your savings account, but these claims may not be included for the purposes of determining whether you have reached the threshold.

Similarly, for the purposes of determining the threshold, there may be a limit on what you can spend on spectacles.

In other words, your claims may appear to reach the threshold, but the scheme will say you have not reached it because certain claims or portions of them do not count towards the threshold.

Settas says that in many cases the self-payment gap can be as much as R10 000 or even R12 000 for a family of four.

Wynand Venter, a financial planner and medical scheme adviser who practises in the Durban and Pietermaritzburg area, says he advises his clients to buy an option with an above-threshold benefit only if they have ongoing health problems and are likely to access these benefits, otherwise the difficulty in reaching the threshold typically does not justify the cost of the above-threshold benefit.

Whether you have a medical savings account or day-to-day benefit sub-limits, you can try to make your benefits last longer by choosing your provider, negotiating the tariffs you will pay, choosing the setting in which services will be provided, seeking cheaper alternative treatments to the one proposed for you and using generic medicines.

If you are well disciplined, you can pay an extra amount into a savings account or debit card and set it aside for medical expenses only.

Even in years of good health, use your savings account prudently so that you can build up funds for years when your expenses are high.

Some medical schemes, such as Discovery Health, Fedhealth and Resolution Health, offer on certain options an extension for, or unlimited, consultations with a GP if you agree to use a GP

who is part of a network. While your medicines are not covered, at least you know you will always have cover for some of your expenses when you have exceeded your savings account balance.

It will be worthwhile to switch to a GP within a network if this also results in lower amounts being charged to your savings account, and you will have established a relationship with that doctor should you exhaust your savings account and have to access the extended GP consultation benefit.

8. LIMITS ON BODY PARTS AND APPLIANCES

There is a huge variation in the cost of artificial body parts, such as an artificial arm or eye, or an internal prosthesis, such as the rods and screws used in back operations and the stents in cardiac operations, and hip, knee or shoulder replacements.

Similarly, external appliances and devices, such as wheelchairs, walking frames, hearing aids and crutches, are available from the most basic to the top of the range. Medical schemes tend to limit their benefits for these items to the cost of the functional necessities, and your and your doctor's desire to fit you with the deluxe model may come at cost.

While some schemes will entertain good reasons in a clinical motivation for cover for artificial body parts that exceed the limits set by the scheme, your doctor's motivation may not be enough to sway your scheme's clinical team.

9. EXCLUSIONS ON COVER

Most medical schemes have exclusions on cosmetic surgery, healthcare services related to infertility and injuries sustained from wilful violations of the law or during wilful participation in a war or participation in high-risk activities or professional sport.

When joining a scheme, you may also face exclusions from cover if either of the waiting periods (a three-month general waiting period on all benefits or a 12-month waiting period on benefits for a pre-existing condition) are imposed. Be aware of these exclusions, because they could result in gaps in your cover.

Other exclusions may be less obvious. Some schemes offer PMB cover for costly procedures, such as organ transplants and renal dialysis, in public hospitals only. Cover for these procedures in a private hospital is excluded. Should you require one of these transplants and wish to have the operation performed in a private hospital, you should be aware of the costs you could incur.

Besides heart transplants (average cost: R768 639), Discovery Health's Benefit Tracker for March 2011 records the highest costs of three other organ transplants in private facilities for Discovery Health members. In the year to July 2011, the average lung transplant cost more than R513 000, a liver transplant cost in excess of R518 000, and a kidney and pancrea transplant more than R327 000.

If in order to keep your contributions affordable, you join an option in which private hospital cover for organ transplants is excluded, make sure that you can move to a higher option on the same scheme should you need such a procedure. Although your scheme may allow you to upgrade only at the end of the year, you will then at least be able to access the appropriate cover. If you try to move to another scheme, you may face a waiting period when you are ill and need cover.

You should also be aware that most schemes do not cover the costs of the search for an organ or the hospitalisation and services that the organ donor requires, regardless of whether or not the donor is a member of your scheme.

10. LONG-TERM REHABILITATION

Good medical schemes offer rehabilitation benefits if you are temporarily disabled as a result of injury – for example, after being involved in a car accident – or after surgery or a stroke. These benefits are intended to cover your needs after “acute events” for a short period of time, such as three weeks. But you may need treatment for many months or even years, and so your scheme’s rehabilitation benefit may be insufficient.

* This article was first published in the fourth-quarter 2011 edition of Personal Finance magazine.