Your health. Your rights.

Your rights and duties as a member of a Medical Scheme in line with the Medical Schemes Act 131 (1998)

CMS
Council for Medical Schemes

For you. For health. For life

The Council for Medical Schemes is a statutory body established by the Medical Schemes Act (131 of 1998) to provide regulatory supervision of private health financing through medical schemes.

VISION

To promote vibrant and affordable healthcare cover for all

MISSION

The CMS regulates the medical schemes industry in a fair and transparent manner and achieves this by:

- protecting the public and informing them about their rights, obligations and other matters, in respect of medical schemes;
- ensuring that complaints raised by members of the public are handled appropriately and speedily;
- ensuring that all entities conducting the business of medical schemes, and other regulated entities, comply with the Medical Schemes Act;
- ensuring the improved management and governance of medical schemes;
- advising the Minister of Health of appropriate regulatory and policy interventions that will assist in attaining national health policy objectives; and
- ensuring collaboration with other entities in executing our regulatory mandate

**This is a guide to the Medical Schemes Act and its regulations and does not deal comprehensively with all situations. Your medical scheme rules or the Council of Medical Schemes will have detailed answers to your questions.*

MEDICAL SCHEME MEMBERS HAVE RIGHTS

You have a right NOT to be unfairly discriminated against on the basis of your:

- Race
- Age
- Gender
- Marital Status
- Ethnic or social origin
- Sexual orientation
- Disability
- State of health

You may join a medical scheme of your choice… as long as you can afford it and provided your employer does not require you to join a specific scheme.

But remember: The scheme must be registered with the Council for Medical Schemes – or you may not be able to enforce your rights.

Your dependants have the right to be covered by your scheme.

A "dependant" is defined in the Medical Schemes Act as your:

- Spouse / partner
- Dependant children
- Other members of the member's immediate family for whom he is liable for support
- Any other person recognised under the rules of the scheme
- Children under 21 or older if permitted by the rules of the scheme

Dependants have the right to continue membership of the scheme.

If the principal member dies, dependants must be covered until they chose to leave the scheme, join the same scheme in their own right, or join another scheme, as long as they can afford the contributions.

Your medical scheme may NOT charge you more because you are older or sicker. Variations in contribution rates may only be based on:

- income, and
- number of dependants
- or both

However, if you are joining a medical scheme later in life for the first time, you may have to pay more, or wait a little longer before you can receive certain benefits.

All Medical Schemes have to provide a basic set of benefits known as Prescribed Minimum Benefits – PMBs.

If your condition is covered by a PMB (e.g. many cancers and HIV/AIDS), the minimum level of care should be the equivalent of what is available in the public sector.

Your scheme must pay claims timeously.

Your medical scheme must pay valid claims within 30 days of the claims being received. If a PMB diagnosis is not confirmed, additional clinical information must be sent to the Scheme by the treating doctor / provider to allow the Scheme to verify if that claim qualifies for PMB benefits.

You have the right to receive regular statements.

In addition to paying an account, a scheme must furnish you with statements detailing –

- Name of supplier (doctor, hospital, pharmacist etc).
- Date of service rendered.
- Total amount charged.
- Amount of benefit paid.

You have the right to resubmit a claim if the scheme has not paid a valid claim within 60 days.

If a medical scheme believes that an account or claim is incorrect or unacceptable, it must –

- Inform you within 30 days, giving the reasons for declining the payment and allow you to resubmit the claim.

You have the right to participate in the schemes governance.

- At least 50% of the members of a scheme's board of trustees must be elected among the scheme members by members.
- Annual general meetings must be held, at which members may voice opinions, ask questions and present motions.

You have the right to information about your scheme.

A scheme must give you information upon request about:

- Scheme rules and benefits
- Latest annual financial statements
- Management accounts and accompanying annual financial statements
- List of protocols and formularies

You have the right to advance notice of change in:

- Contributions
- Benefits, or
- Any other changes affecting membership.

You have the right to confidentiality of your medical information.

Your scheme must keep information strictly confidential about the diagnosis, treatment and health status of you and your dependants.

You have the right to obtain proof of membership.

A scheme must issue to each member written proof of membership including:

- Date of entitlement of benefits
- Details of any waiting periods or any other conditions applicable e.g. Late Joiner Penalties

You have the right to complain to your medical scheme if any of these rights are not respected or if the service is deficient in some way or other.

If you have exhausted all avenues of complaint at your scheme and its dispute committees – you may take it up with the complaints department of the Council for Medical Schemes or appeal directly to Council if you are unhappy with the findings.

YOU HAVE A DUTY TO…

Be honest and open with your scheme or when joining a medical scheme. If you are found to have provided false information, you may lose your membership or have it suspended. If you act illegally, criminal charges may be laid against you.

- Do not submit fraudulent claims e.g. boosting the amount claimed for, or claiming for sunglasses and toiletries or other items not strictly allowed by your scheme.
- You must disclose any material information about your health asked on application to the scheme.

Pay contributions (timeously).

- Contributions must be paid directly to your medical scheme on time, unless payment arrangements are made with you employer.

LIMITATIONS ON MEMBERS' RIGHTS

Some rights can be limited in the rules of your scheme.

Scheme rules may restrict benefits covered and limit amounts payable on items not covered by the Medical Schemes Act, its regulations and the Prescribed Minimum Benefits. Some schemes, for instance, limit dental or optometry benefits. It is important to familiarise yourself with your scheme rules. Some options within schemes cover 100% of all benefits; while other options within the same scheme may cover less.

Some schemes may require you to get pre-authorisation before certain procedures may be covered or performed.

This and other cost-saving interventions are known as "managed care" and may be applied – but must be contained in the rules of your scheme.

**If your scheme has contracted with certain hospital groups, doctors or pharmacists for services, it must be contained in the rules of your scheme.*

A scheme may refuse to pay a claim that is submitted four months after:

- The last date of service rendered, as stated on the account, or
- The date on which the account was returned for correction.

Neither members, nor their dependants, may belong to more than one scheme at anytime. Members may not transfer benefits to persons not registered on their medical scheme.

No person may:

- Be a dependant of more than one scheme, e.g. a child cannot be registered on both parents' medical schemes.
- Claim against more than one scheme. This can be regarded as fraud.

Schemes may restrict changes between options to the beginning of a year. Schemes may ask for adequate notice before changes are made.

Waiting periods and late joiner penalties may be imposed under certain strictly limited circumstances. These conditions must comply with the Medical Schemes Act.

On admission to membership a scheme may impose a:

- 3 month general waiting period
- 12 months condition-specific waiting periods (CSWP) for pre-existing conditions
- Waiting period on PMBs
- Late Joiner Penalty

Except:

- Termination of membership due to employment or employer changing schemes
- A child born to a member
- Change between benefit options

PROVISIONS APPLICABLE TO WAITING PERIODS

CATEGORY	3 Month General W/P	12 Month Condition Specific W/P	Application to PMB
New applicants, or persons not members for preceding 90 days	Yes	Yes	Yes
Applicants who were members for less than 2 years	No	Yes	No
Applicants who were members for more than 2 years	Yes	No	No
Change of benefit option	No	No	No
Child-dependant born during period of membership	No	No	N/A
Involuntary transfers due to change of employment or employer changing scheme	No	No	N/A

THE COMPLAINTS PROCEDURE

Who can complain to the Registrar's Office?

Any beneficiary or any person who is aggrieved with the conduct of a medical scheme can submit a complaint.

It is however very important to note that a prospective complainant should always first seek to resolve complaints through the complaints mechanisms in place at the respective medical scheme before approaching the Council for assistance.

You can contact your scheme by phone or writing to the Principal Officer of the scheme, giving her/him full details of your complaint.

If you are not satisfied with the response from your Principal Officer, you can ask the matter to be referred to the Disputes Committee of your scheme.

If you are not satisfied with the decision of the Disputes Committee, you can appeal against the decision within 3 months of the date of the decision to the Council. The appeal should be in the form of an affidavit directed to the Council.

Complaints can be submitted by any reasonable means such as a letter, fax, e-mail or in person at our Offices from Mondays to Fridays during 08:00 – 17:00. The complaint form is available on www.medicalschemes.com.

Your complaints should be in writing, detailing the following:
Full names, membership number, benefit option, contact details and full details of the complaint with any documents or information that substantiates the complaint.

The Council for Medical Scheme's Complaints Adjudication Unit also provides telephonic advice and personal consultations, when necessary.

Who can you complain about?

The Council for Medical Schemes governs the medical schemes industry and therefore your complaint should be related to your medical scheme.

If your complaint is related to any other aspect of the health industry, please visit the relevant websites:

- For complaints against Health Professionals (doctors) and allied health professional such as physiotherapists, occupational therapists etc – www.hpcsa.co.za or call 012 338 9300

- For complaints against Private Hospitals – www.hasa.co.za or call 011 784 6828
- For complaints against Nurses – www.sanc.co.za or call 012 420 1000
- For complaints against Brokers – www.faisombud.co.za or call 012 762 5000
- For complaints in respect of other health insurance products – www.osti.co.za (short term insurance ombudsman) or call 012 762 5000 or www.ombud.co.za (long term insurance ombudsman) or call 021 657 5000

Time limits for dealing with complaints

Our aim is to provide a transparent, equitable, accessible, expeditious as well as a reasonable and procedurally fair dispute resolution process.

The Registrar's Office will send a written acknowledgement of a complaint within 3 working days of its receipt, providing the name, reference number and contact details of the person who will be dealing with a complaint.

In terms of Section 47 of the Medical Schemes Act 131 of 1998 a written complaint received in relation to any matter provided for in this Act will be referred to the medical scheme. The medical scheme is obliged to provide a written response to the Registrar's Office within 30 days.

The Registrar's Office shall within 4 days of receiving the complaint from the administrator, analyse the complaint and refer a complaint to a medical scheme for comments.

Upon receipt of the response from the medical scheme, the Registrar's Office will analyse the response in order to make a decision or ruling. Decisions/rulings will be made within 120 working days of the date of referral of a complaint and communicated to the parties.

The Registrar's Ruling and appeal to Council

Section 48 of the Act makes provision for any party who is aggrieved with the decision of the Registrar to appeal such a decision.

This appeal is at no cost to either of the parties.

An appeal must be submitted within three months and should be in the form of an affidavit directed to the Council. The operation of the decision shall be suspended pending review of the matter by the Council's Appeal Committee.

The secretariat of the Appeals Committee will inform all parties involved of the date and time of the hearing. This notice should be provided no less than 14 days before the date of the hearing. The parties may appear before the Committee and tender evidence or submit written arguments or explanations in person or through a representative.

The Appeals Committee may after the hearing confirm or vary the decision concerned or rescind it and give another decision they deem to be just.

The Section 50 Appeal's process

Any party that is aggrieved with the decision of the Appeals Committee may appeal to the Appeal Board. The aggrieved party has 60 days within which to appeal the decision and must submit written arguments or explanation of the grounds of his or her appeal.

The Appeal Board shall determine the date, time and venue for the hearing and all parties will be notified in writing.

The Appeal Board shall be heard in public unless the chairperson decides otherwise.

The Appeal Board shall have the powers which the High Court has to summon witnesses, to cause an oath or affirmation to be administered by them, to examine them, and to call for the production of books, documents and objects.
The decisions of the Appeal Board are in writing and a copy thereof shall be furnished to parties. The prescribed fee of R2000.00 is payable for Section 50 Appeals.

Pro Bono Legal Services

The CMS, together with ProBono.Org have set-up a Pro Bono Panel for medical scheme members. Legal representatives will render free services to members of medical schemes who are in dispute with their funds and have suffered hardship or cannot afford their own legal representation in cases serving before the CMS Appeals Committee or Appeal Board.

Not all cases will be referred to the Pro Bono Panel. The CMS Legal Services Unit together with ProBono.Org will use their discretion to refer matters where members have clearly suffered hardship. Some of the considerations will include the monetary value involved as well as the condition the member suffers from.

How to avoid complaints

- Make sure you have read and understood your scheme rules.
- Study your benefit guide and familiarise yourself with the benefit option you have chosen.
- Read all correspondence from your scheme, e.g. newsletters and statements.
- Make sure your contributions are paid in full and on time each month.
- Remember: Avoid complaints by informing yourself!

Contact the CMS

Customer Care Centre
0861 123 267
0861 123 CMS

Reception
Tel: 012 431 0500
Fax: 012 430 7644

www.medicalschemes.com

General enquiries
E-mail enquiries:
information@medicalschemes.com

Complaints
Fax: (086) 673 2466
E-mail:
complaints@medicalschemes.com

Postal address
Private Bag X34
Hatfield
0028

Physical address
Block A, Eco Glades 2 Office Park
420 Witch-Hazel Avenue
Eco Park, Centurion
0157

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