PSG

MAY 2015

HEALTH NEWSFLASH

News you need to know

How to maximise bang for your buck from your medical scheme in 2015

As we approach mid-year, we often hear complaints from medical scheme members that they are running out of their benefits. Here are a few reminders about what you can do to ensure you are extracting full value from your cover!

Getting the best out of your hospital cover:

- If your scheme has appointed a Designated Service Provider (DSP) network for hospitals, you will usually pay a lower monthly contribution in exchange for using a hospital from a defined network for planned procedures.
- If your scheme has an arrangement in place for doctors and specialists, there will usually be an incentive (full cover by the scheme) for using 'their' providers.
- If you are going to be admitted to hospital for a planned procedure, always check with your scheme at authorisation stage if there are any co-payments or sub-limits that will apply. An example here is for joint replacements, where most schemes have specified sub-limits if you do not use their DSP.
- Also talk to your doctor before a planned procedure. Check what they are going to charge and what your scheme will cover. If there is a large difference, don't be afraid to ask if your doctor is prepared to adjust the fee, especially if you can afford to pay upfront.
- Medical schemes are obliged to meet the cost of 270 in-hospital Prescribed Minimum Benefit (PMB) procedures at cost, in full. So if you have been or are going to be admitted to hospital, check with your doctor if it's for one of these procedures. If so, as a general rule, you shouldn't be saddled with any shortfalls – so ask for your adviser for assistance if you are!

Cover for In-hospital shortfalls:

If your option applies co-payments for defined procedures or covers you for only 100% of the medical scheme's rate (and not the rate actually charged by the doctor), it is worth your while to investigate gap cover. This is a separate insurance policy you can take out to cover (for you and your family) the difference between the medical scheme rate and what the provider has charged you (up to a maximum defined level). On some gap cover products the co-payments are also included. The monthly premium for gap over products varies depending on the level of cover taken, but for individual families (not part of a corporate group) the ballpark is around R200 per family per month.

Chronic illness benefits:

In terms of the Medical Schemes Act, there are 27 chronic illnesses (best known as PMBs) which all options on all schemes are required to cover for medication and treatment. However, schemes can apply measures designed to contain costs.

- Almost all options on all medical schemes apply a medicine formulary. This is a list of drugs which the scheme will cover in full. If you use medication that is not on the scheme's formulary, you will be liable for the difference. So it is best to discuss the formulary medication with your doctor to see if it is appropriate for you.
- Schemes can also specify that you obtain your medication from DSP pharmacies. Check to see if you are able to use the scheme's DSP pharmacy – if there are none close to you, most schemes also designate a courier pharmacy which will deliver the medication to you at a preferred address.

Day-to-day benefits:

Investigate or consider the following;

- Does your scheme contract with doctors and specialists and, if so, are you willing to use them? Using contracted or network doctors usually means obtaining full or improved cover levels, while using doctors outside of the network usually results in restricted benefits or co-payments.
- Must you be referred to a specialist by your GP?
- Does your scheme offer additional GP consultations, which they will pay for, after you have exhausted your day-to-day benefits?
- Does you scheme/option cover emergency treatment in a casualty facility from risk?
- Use generic medication wherever possible – get into the habit of asking your doctor and pharmacist about this.
- Try to keep your claims within any specified sub-limits e.g. optometry.
- Find out if your option has any day-to-day benefits that are not paid out of your day-to-day sub-limits or savings. Two examples where this sometimes applies are dentistry and optometry. Remember, though, that if this does apply, you usually still need to get pre-authorisation from your scheme.
- Try to pay for non-critical items (such as schedule 0.1 and 2 drugs) from your pocket to stretch your day-to-day benefits.

Supplementary benefits:

Many schemes offer supplementary benefits that members are often unaware of. These could potentially save you significant day-to-day expenses. Examples include:

- Preventative care benefits, ranging from basic screenings (blood pressure, cholesterol, blood sugar and body mass index measurements) through to mammograms, pap smears and prostrate testing. In some cases this extends to maternity programs, dental check-ups, flu vaccinations and more. These usually require authorisation from the scheme. A mammogram costs in the region of R1 000, so don't look a gift horse in the mouth!
- Loyalty programmes offered by schemes usually incentivise healthy lifestyles by offering discounts for gym membership. If this lifestyle is something that appeals to you, take advantage of the discount. There are often other incentives such as discounts from retail and travel partners, and cash back rewards. The savings you obtain here will go some way to offsetting the increases in the medical scheme contribution.

Talk to us!

From the enquiries our healthcare consultants receive on a daily basis, it is clear that with better understanding of benefits, members would be able to significantly stretch their medical scheme benefits – so start talking to your adviser today.