

AON



FAQ'S

Contents Page

1. How to determine what benefit option would best suit you.....	3
2. How does a medical scheme calculate the cost of Medical Scheme benefit options?.....	4
3. What does hospital reimbursement rates mean?.....	4
4. What is meant by unlimited in hospital cover?.....	5
5. What is an ICD-10 Code?.....	6
6. What is a NAPPI Code?.....	7
7. What is Take-home medication?.....	7
8. What is a chronic disease and what is an 'extended chronic disease list'?.....	7
9. What is meant by a Managed Care benefit option and Managed Care?.....	8
10. Network Hospitals, doctors and other service providers - will they save me money?.....	10
11. What is a 'co-payment' and why would I have to pay this?.....	11
12. What is a new generation benefit option?.....	12
13. What is a Personal Medical Savings Account and how does it work?.....	12
14. What is a self payment gap (SPG)?.....	12
15. What are over the counter medications?.....	15
16. What are waiting periods and how are they applied?.....	15
17. What is a Late Joiner Penalty (LJP)?.....	17
18. When can I upgrade or Downgrade my plan?.....	18
19. What is a solvency ratio of a medical scheme?.....	18
20. How do I submit a claim?.....	19
21. What are my rights as a medical scheme member?.....	20
22. 20 Tips to Remember.....	21
23. Medical Scheme word usage & Definitions to Assist You.....	22
24. What is Gap Cover?.....	27
25. What is Gap Cover not?.....	29
26. Serious Illness Protection Plan	29
27. What is National Health Insurance?.....	29
28. What is South Africa's vaccination strategy?.....	30
29. Why do I have to register on the EVD system?.....	31
30. What are the steps to my vaccination?.....	31



Medical Scheme Questions

1. How to determine what benefit option would best suit you:

We all need private medical scheme cover. There are options that range from 'affordable to the extreme', depending on what we need, want, and can afford.

There are a couple of things to consider when choosing a medical scheme and benefit options that are best suited to you and your family, these include but are not limited to the following:

1. What have your medical expenses been over the past two to three years? How much have you spent on 'out of hospital expenses'? This will help determine your future 'out of hospital' requirements, such as any planned medical procedure/s that you or your family may need to have. Are you planning on starting a family or having any more children? What are your optometry and dentistry requirements likely to be over this period?
2. What in-hospital reimbursement rates do you require? This rate can vary from 100% to 300% depending on the benefit option that you choose. Your in-hospital reimbursement rate will impact on how medical specialists and other providers are paid by your medical scheme. If you choose a benefit option that reimburses at 100% your medical scheme will reimburse you at the medical scheme rate, whereas if you select 200% or 300% reimbursement rate the medical scheme will reimburse you at 2 or 3 times the medical scheme rate. You can also choose to take a Gap or Top Up policy to provide you with higher in hospital cover.
3. Do you need a plan that has unlimited cover in hospital? It is always advisable to select a plan with unlimited in hospital cover. This means that no matter how long you stay in hospital, or what the cost, it will be covered by your medical scheme, provided it has been authorised by them. Selecting a benefit option with limited in hospital cover could result in you being held responsible for unquantifiable bills once your cover has been exhausted.
4. Do you or any member of your family suffer from a chronic condition? 'A chronic condition describes a medical condition which is persistent and long-lasting. A chronic condition is consistently present and requires managed care. Diabetes, Hypertension or Heart disease are examples of a chronic condition. Please refer to our Question on Prescribed Minimum Benefits
5. Are you expecting to undergo any specialist treatment/s or in-hospital procedures in the next year? The reason that this is important is because you need to know if your medical scheme covers this procedure. It may also be excluded if the medical scheme has imposed any waiting periods on you. Remember that with a condition specific exclusion, which is twelve months in duration, it is only the confirmed condition that will be excluded. You will still have cover for all other ailments. Please refer to the Question on waiting periods for further information.
6. Have you been on a medical scheme before, or are you currently a member of an existing registered medical scheme? This is important to help determine if you will be subjected to a Late Joiner Penalty, which can increase your monthly contribution by up to 75%, depending on your age and previous medical scheme history. (Please see Question on Late Joiner Penalties for more detail.)
7. Is your current situation likely to change significantly in the near future? If this is the case, you will need a benefit option that can keep pace with your changing lifestyle. Things to consider would be the following:
 - a. Are you planning to get married?
 - b. Planning a family; or extending your current family?
 - c. Are you close to retirement?
 - d. Are you or any member of your family going to require medical treatment for an ailment or medical condition in the near future?
 - e. What are you and your family's potential dentistry requirements going to be in the next 2 to 3 years?
 - f. What are your optometry needs?
 - g. What is your current and potential future affordability?
 - h. Would a network provider and hospital network suit the needs of you and your family?



2. How does a medical scheme calculate the cost of Medical Scheme benefit options?

The process of calculating the contribution for each benefit option is complex and dealt with by each medical scheme's team of actuaries, the Principal Officer, and the trustees of the medical schemes.

Simply put, medical schemes calculate the expected costs for the upcoming financial year and divide this total by the number of members on the medical scheme. This figure then determines each member's contribution to the medical scheme. It is for this reason that it is important to look at the overall demographics of the medical scheme to establish their potential risk profile before deciding on which medical scheme is best suited to your needs.

It is important to note that the lowest contribution isn't always the cheapest one. Most of the lower priced plans are 'entry level' plans and offer only basic cover. You will find that most of these benefit options utilise fixed networks of providers and hospitals with access to only basic - dentistry, radiology, optometry and pathology. Although your monthly contribution is low, you may face huge out of pocket expenses if the service is not covered, or if you don't make use of the prescribed networks.

- If the chronic condition that you require cover for is a listed Prescribed Minimum Benefit (PMB) (see list of these conditions on page?), then the medical scheme is obliged to cover the medication and treatment of this chronic condition within certain parameters, and guidelines, as set out by the Medical Schemes Act. (Please see Question 14 for more information on PMB's).
- If the chronic condition that you require cover for is not a listed PMB, then you will need to look at a benefit option that provides cover for an extended list of chronic conditions over and above the listed 27 PMB's.

For example, if you have been diagnosed with high cholesterol, you will have cover for this particular condition via the PMBs. The treatment and care of this condition is defined in the Regulations attached to the Medical Scheme Act – under Hyperlipidaemia.

There are certain algorithms (rule by which a chronic condition should be treated in terms of the most appropriate treatment) in place which dictate the level of severity of a chronic condition, at which point, benefits would be payable by the medical scheme to members who meet the criteria. This means that if you are diagnosed with a PMB condition, e.g. high cholesterol, that does not yet meet the severity level in terms of the description within the algorithm, then the medical scheme is not obliged to pay for your treatment, and there would be no cover in such instances.

There are no standard benefit options across the medical scheme industry; each medical scheme designs their options differently. It is important to do a comprehensive comparison of the various medical schemes before deciding which one best suit the needs of you and your family. The best way to do this is to consult someone who is well equipped to assist you with this comparison, such as an accredited healthcare intermediary. All Aon Consultants are accredited healthcare intermediaries. You can phone our Aon Resolution Centre on 0860 100 404 option 3 for further assistance.

3. What does hospital reimbursement rates mean?

A reimbursement rate is the rate at which medical schemes reimburse members or Healthcare Providers for medical goods and services rendered.

Each medical scheme has its own reimbursement rate or medical scheme rate. This is determined in accordance with the National Health Reference Price List (NHRPL), recommended by the Department of Health. This is just a guideline, and medical schemes can reimburse at any rate they choose. It is important that the rate of reimbursement chosen by medical schemes does not negatively impact on the financial stability of the medical scheme.

Each medical scheme's rate is different. It will cost a member more to be on a medical scheme that reimburses healthcare providers at 300% of the medical scheme rate, than a medical scheme that reimburses at 100% of the medical scheme's rate. Medical schemes can reimburse members at a rate varying anywhere between 100% – 300%



This means the following:

100% cover = 1 x the medical scheme rate
200% cover = 2 x the medical scheme rate

Just as medical schemes are not bound by the NHRPL, neither are healthcare providers, this means that healthcare providers are able to charge more than the NHRPL rate.

If your chosen healthcare provider charges more than the medical scheme's reimbursement rate, then you will have to pay the difference out of your own pocket.

Example:

A Doctor charges R2000 for an in hospital procedure, and the medical scheme rate is R1000 then the following will apply:

- If you have chosen a plan that covers you at 100% of the scheme rate, then the scheme will pay R1000 to you and you will have to pay the full R2000 over to the Doctor (The member will be liable for the R1000 difference)
- If you have chosen a plan that covers you at 200% cover, and the medical scheme rate is R1000 then it will be 2 x R1000 = R2000. This R2000 will be paid directly to the doctor or service provider.
- If you have chosen 300% or higher, then the full amount will also be paid to the service provider.

Hospitals in South Africa in most cases, have already negotiated with the medical schemes to charge only medical scheme rates (or as close to this as possible), for medical scheme members.

The associated costs that can be charged at a rate stipulated by the healthcare provider are the costs which are of most concern to the members. Doctors working from a hospital are not bound by the agreement that the hospital group has with the medical scheme, they are a separate entity to the hospital, and as such they are permitted to stipulate and charge their own rates. The same applies to other providers such as radiologists and pathology labs.

It is important to find out from your doctor what rate he charges, to determine what your potential liability may be, if there is one. It is your responsibility to negotiate rates with your provider prior to any treatment.

Always remember there are other doctors you can choose, so shop around to ensure that you are receiving the best possible rates. There are different ways in which you can do this:

- Speak to other specialists or providers to establish what rate they would charge you for the same procedure.
- Speak to your medical scheme; most medical schemes have a panel of accredited doctors and providers who will charge patients a predetermined rate agreeable to both the scheme and provider.
- Speak to your existing specialists about what rate they charge and ensure that this is the best possible rate they are able to give you.
- Always negotiate with all the various providers that you are going to obtain care from, this not only includes the specialist but other providers such as anaesthetists, physiotherapists, paediatricians etc ...

4. What is meant by unlimited in hospital cover?

Often people get very confused by this; if a member is on a plan that has unlimited in hospital cover, the assumption is that if they are in hospital for 3 months and the bill comes to R500,000 then the entire bill should be paid.

This is technically correct when applied to the hospital account. It is, however, important to note that certain specialists, and other healthcare providers, may be charging more than your medical schemes reimbursement rate, and this will leave you with a co-payment (your medical scheme will only pay at your chosen reimbursement rate), and you will have to pay the difference.



Some medical schemes apply limits for certain procedures or appliances in hospital, such as internal prosthesis. In this case, the medical scheme may, for example, have a prosthesis limit of R 35 000, if however, the provider charges R 45 000. Then the R 10 000 shortfall will be payable by you, the member.

This amount can only be funded from a personal medical savings account if funds have been accumulated for this cost from the previous financial year. Or alternatively if you do not have a personal medical savings account, or do not have accumulated funds in your personal medical savings account, then you will have to pay this from your pocket. Some of these costs can be managed better if you use your medical scheme's designated service provider.

There are also limits applied by certain medical schemes on some in-hospital procedures, for example, but not limited to:

- Specialised dentistry and internal prosthesis. or
- In-hospital treatment for mental health disorders.

Each medical scheme and each plan are different, so always enquire about what limits are imposed for what!!!

The unlimited part refers to the stay in hospital and the 'hospital account only'. This includes the ward fees for a general ward only, the medication you receive whilst in hospital, the nursing care, food etc.

Private wards are not included in this. Should you elect to have a private room, you will have to fund the cost difference between a general award and a private ward.

The specialists, the laboratories, and the radiologists are not part of the hospital and can charge their own stipulated rates. Your medical scheme will pay according to your benefit option.

Due to the nature of a hospital visit, bills are sent through to the medical scheme by each separate service provider. It can at times take a couple of months to have all bills from a hospital event paid and fully reconciled. In some instances, the service providers may send the accounts to you, and to your medical scheme, it is, therefore, important that you check with your medical scheme before settling any accounts.

As a patient you are entitled to request a full quotation from your doctor before he performs a procedure, either in or out of hospital. This quotation can be submitted to the medical scheme. This will assist you in determining if you will be liable for any co-payments, if you are going to be liable for a co-payment, then it is wise to negotiate a better rate with your provider. It will also help if you check with your medical scheme and see if they have a list of preferred providers who charge a pre-negotiated rate, to avoid any potential co-payments. If you are unsure, or have any additional questions, please call the Aon Resolution Centre on 0860 100 404 option 3.

Private wards are not included in this. Should you elect to have a private room, you will have to fund the cost difference between a general ward and a private ward.

5. What is an ICD-10 Code?

This is known as the 'International classification of disease code'. These are primarily used by hospitals and doctors, to identify and clarify health issues and hospital procedures. This code is recognised all over the world.

There is a numeric identifier and a description for each issue and procedure, and there are thousands of ICD-10 codes that can be used to classify a diagnosis.

Doctors and hospitals use this ICD-10 code to determine how they will be reimbursed.

It is very difficult to determine how much a procedure actually costs before you have the procedure.



This is the reason why:

Example:

John goes into hospital for open-heart bypass surgery, which is also referred to as 'Coronary Artery Bypass Graft.' There are 28 possible ICD-10 procedure codes that can be used to convey this health issue.

It is important to note that each member's situation is different; each patient has different needs, i.e., 'patient A' may require less blood in theatre than 'patient B', or fewer days in hospital before or after the operation, so from this example one can see how difficult it is to obtain the cost of a procedure, until each doctor, specialist or service provider has submitted their bills with the relevant ICD-10 codes for payment.

Each medical scheme pays different amounts for different procedures, because each medical scheme's rate of reimbursement is different.

6. What is a NAPPI Code?

A NAPPI code is the national coding system, used for all pharmaceutical, surgical and healthcare consumable products in South Africa.

NAPPI codes enable the provider to claim for products via a unique, scheme-recognised code and give medical schemes a guideline as to what the acceptable reimbursement rate should be for a specific item.

A medical scheme will only reimburse where a NAPPI code exists.

7. What is Take-home medication?

The medication you get when you leave hospital comes from an in-hospital limit called 'To Take Out' (TTO) or 'To Take Home'

After a hospitalisation event you usually leave the hospital with medication. The cost of this medication is paid partly from a small take home medication benefit which forms part of the hospital benefit; however, the majority of the cost of this medication is paid from the personal medical savings account, or standard 'day to day' medication limit, provided there are funds/limits available. Should these limits and /or savings be exhausted, the cost of the take home medication will be for your own account.

It is recommended that you familiarise yourself with how the take home medication benefit works to avoid any surprises upon being discharged from hospital. If you have a supply of the medication prescribed at home, it may not be necessary to fill the prescription.

8. What is a chronic disease and what is an 'extended chronic disease list'?

A chronic condition describes a medical condition which is persistent and long-lasting. A chronic condition is consistently present and requires managed care. Diabetes, Hypertension or Heart disease is examples of a chronic condition.

Medical schemes must cover at least 27 chronic conditions (including HIV/AIDS), from a list called 'Prescribed Minimum Benefits' (PMB's). This list also includes 271 treatment diagnoses that are associated with these conditions. If you have one of the 27 listed chronic diseases, your medical scheme not only has to cover medication, but also doctors' consultations and tests related to your condition (according to certain stipulated protocols).



- The medical scheme may make use of protocols, formularies (lists of specified medicines) and Designated Service Providers (DSP's) to manage this benefit; each PMB has a list of Minimum treatment standards and protocols.
- Medical scheme formularies are updated on an annual basis and it is important to double check from year to year if the treatment protocols of your medical scheme have remained the same.

PMB Emergencies are defined as, 'sudden unexpected conditions that require immediate medical or surgical treatment, without which a patient faces the loss of life or limb or serious bodily harm'.

In 2010/11, the Council for Medical Scheme's ruled, that medical schemes need to cover PMB conditions and the events leading up to the diagnosis (or Non-Diagnosis) of a particular condition. (Certain rules and conditions may apply). Below is an example of how the PMB's should work:

John goes to the emergency room complaining of chest pains. The doctor examines him and says to John that he suspects that John is having a heart attack. Because a Heart Attack is a PMB, it means that the condition should be paid in full by the medical scheme.

All tests (including blood tests, x-rays, scans) should be paid in full, until the doctor rules that the condition is or isn't a Heart Attack.

If the Doctor rules that it is a Heart Attack, then the members account should be paid in full by the medical scheme, at cost. If the doctor rules that it is not a Heart Attack but Anxiety, then the cost of all the tests leading up to the diagnosis of Anxiety should also be paid by the scheme as it was a suspected PMB at the time of the emergency. Any further treatment for Anxiety in the emergency room will be charged to the member.

PMB's out of hospital

If you are being treated for a PMB condition, which requires on-going medical management (outside of hospital), you will need to visit your doctor or specialist once, or twice a year for him / her to monitor your condition.

In certain cases, one of these visits must be covered by your medical scheme from your chronic benefit. Your medical scheme may only pay this visit at medical scheme rates, and not private rates, and it will only pay for certain procedure codes, not for the whole consultation. To access this benefit, you need to do the following.

1. Contact your medical scheme's chronic department and inform them that you are seeing the doctor or specialist regarding your chronic condition (this is usually allowed once or twice a year).
2. The medical scheme will usually send you a special form to attach to your claim for payment. This is to ensure the claim gets paid by the medical scheme and not by the member.

Additional things to take note of:

- When you are admitted for an emergency condition, or are involved in an accident, you may go to the nearest healthcare facility and be treated, even if it's not your medical scheme's Designated Service Provider. (An emergency can be defined as any life-threatening event, that without treatment, you would not live).
- If you suffer from a chronic condition that is one of the Prescribed Minimum Benefits, your medical scheme may impose certain rules to stipulate what treatment and medicine they will cover. The protocols and formularies that medical schemes use is put in place to reduce and manage the cost to the scheme. This is important when looking at the long-term sustainability of medical schemes.
- Remember if you have a chronic condition and it is a PMB, then in certain cases, for certain conditions you may go at least once a year to the doctor/specialist for a check-up, and it must be paid by the medical scheme, according to the medical scheme's formularies and protocols.



The Prescribed chronic disease list that every medical scheme has to cover is as follows:

1. Addison's disease
2. Asthma
3. Bipolar Mood Disorder
4. Bronchiectasis
5. Cardiac failure
6. Cardiomyopathy
7. Chronic obstructive pulmonary disorder
8. Chronic renal disease
9. Coronary artery disease
10. Crohn's disease
11. Diabetes Insipidus
12. Diabetes mellitus types 1
13. Diabetes mellitus types 2
14. Dysrhythmias
15. Epilepsy
16. Glaucoma
17. Haemophilia
18. Hyperlipidaemia
19. Hypertension
20. Hypothyroidism
21. Multiple sclerosis
22. Parkinson's disease
23. Rheumatoid arthritis
24. Schizophrenia
25. Systemic lupus erythematosus
26. Ulcerative colitis
27. HIV/AIDS

PMB's are covered unlimited, according to your medical schemes protocols and formularies, however, if the medical scheme has an extended chronic disease list, there may be an overall annual limit for these additional conditions that are covered, and each medical scheme will have its own specific list.

Medical scheme formularies are updated on an annual basis and it is important to double check from year to year if the treatment protocols of your medical scheme have remained the same.

9. What is meant by a Managed Care benefit option and Managed Care?

'Managed Healthcare benefit options' are a means of providing primary healthcare services within a defined network of service providers, who then assume the responsibility of managing and providing high quality, cost effective care; whilst ensuring that only appropriate services are delivered'.

Regulation 15H and 15I of the Medical Schemes Act 131 states the following with regards to Managed Care Protocols and Formularies:

'15H. Protocols. – If managed health care entails the use of a protocol –

- Such a protocol must be developed on the basis of evidence-based medicine, taking into account considerations of cost effectiveness and affordability.
- The medical scheme and the managed care organization must provide such protocol to health care providers, beneficiaries and members of the public, upon request; and
- Provision must be made for appropriate exceptions where a protocol has been found to be ineffective, or causes, or would cause harm to a beneficiary, without penalty to that beneficiary.'



151. Formularies. – If managed care entails the use of a formulary or restricted list of drugs-

- Such formulary or restricted list must be developed on the basis of evidence-based medicine, taking into account considerations of cost effectiveness and affordability.
- The medical scheme and the managed health care organization must provide such formulary or restricted list to health care providers, beneficiaries and members of the public, upon request; and
- Provision must be made for appropriate substitution of drugs where a formulary drug has been ineffective or causes or would cause adverse reaction in a beneficiary, without penalty to that beneficiary.'

Managed care plans were introduced to South Africa to help control spiralling medical costs within the South African healthcare industry; these plans were introduced to help both medical schemes, and members, manage their medical costs more effectively. This was to be done without compromising the quality of care.

Managed care benefit options cover most of what you will need, from doctors' visits, to hospitalisation, and you only have to pay one monthly amount. When choosing this option, you will need to choose a doctor or medical practice from the medical scheme's network or providers. This will become your primary doctor or healthcare practice. This doctor or practice will be your 'primary' contact person. Whether you need to go for x-rays or blood tests, or to see a specialist, you will need to go to your doctor or healthcare practice first and they will refer you to these other healthcare providers.

The chosen doctors are paid each month in advance (a negotiated rate) for however many members choose that doctor; they are paid this monthly amount whether you go to the doctor every day or not. This is still subject to the agreed rules and specified providers. The managed care options usually have a very limited set of specialised procedures and 'mostly' have no form of medical savings account.

It is important not to get confused between a 'Managed Care Programme' and a managed care benefit option.

Managed care programs have been introduced to assist medical schemes in managing the costs and quality of care associated with major medical events and illness. Some examples of managed care programs are as follows:

- Oncology programme
- HIV Programme
- Maternity Programme
- Diabetic Programme
- Metabolic Endocrine Programme

If you are unsure or have any question with regards to managed care benefit options you can call the Aon Resolution Centre on 0860 100 404 option 3.

10. Network Hospitals, doctors and other service providers - will they save me money?

Medical schemes may encourage you to utilise specific doctors and specialists who form part of a network, set up by the medical scheme. In these cases the medical scheme has negotiated with the providers on your behalf to ensure that they charge you a predetermined rate that will be paid directly by the medical scheme to the provider, ensuring that you, the member do not experience any co-payments.

These providers are considered to be 'in-network'; this means that the doctors, hospitals or other service providers have agreed to accept a 'negotiated rate' for their services. Many medical schemes have a specialist negotiated rate, called a 'direct paying network', this means that the specialists will charge the rate that it agreed between themselves and the funder, in this case the medical scheme. This does differ between medical schemes so it is important that you speak to your Aon Healthcare Consultant or contact the Resolution Centre to see how this may apply to you.



The provider is obliged by contract to accept that negotiated rate. This Network can also be known as a 'Direct Paying Network' or partnership, where the provider offers a service for a lower amount, in order for the medical scheme to pay the provider directly and quicker, and not refund the member, who in turn must refund the provider.

Out-Of-Network

When a service provider has no contract with any medical scheme, this means that there is no negotiated rate between the service provider and the medical scheme, which means that the service provider can charge whatever amount he/she wishes to charge. It also means that you may be asked to pay the full amount upfront and then claim the amount back from your medical scheme (you will be reimbursed according to your plan's rules and benefit option)

Special attention needs to be paid to the following:

- In-Network Hospital providers operating from a network hospital do not necessarily charge the negotiated or medical scheme or rates; the reason for this is that they only rent rooms in the hospital and can therefore charge whatever they want.
- The Hospital may be an In-Network Hospital, but the Specialist (like an anaesthetist) may be Out-Of-Network, therefore you will have to pay the difference between the In-network rate and the Out-Of-Network Rate (Always ask for a quote first!!!)

11. What is a 'co-payment' and why would I have to pay this?

A 'Co-Payment' is a fixed amount that a medical scheme member is expected to pay out-of-pocket at the time of service (or from their personal medical savings account, providing the member has savings available) at the time of service. This is commonly one of the most difficult concepts for a member to accept, especially since the cost of medical scheme cover is so high; and members feel that they are paying so much already, so why should they have a 'co-payment'?

Medical schemes use 'co-payments' for a number of reasons:

- To control over utilisation of certain procedures: - like MRI/CAT scans; most medical schemes expect a member to pay part of this procedure from their own pocket or from their personal medical savings account.
- To make the benefit option more cost effective for the member - some medical scheme options will have deductibles for a number of procedures; (usually around 10% of the cost of the procedure) (this is also commonly known as the 90/10 plan). This allows the medical scheme to offer a good quality plan at a lower rate, as the member is assuming responsibility for part of the risk.
- When purchasing medication: some medical schemes have started imposing co-payments (levies) on its members for medicine purchases (when buying ethical instead of generic medications).

Because one option is more expensive than the other, this does not necessarily mean there will be no co-payment. On most options, a member will have to pay for something out their own pocket.

Other 'Co-Payments' that a member should be aware of:

- The difference between the amount claimed by a doctor/service provider and the actual amount paid by the medical scheme (the member is responsible for this payment).
- If a hospital admission (or procedure) is not authorised (in time, or post authorised), the member can be charged a Co-Payment of up to 30% or more of the bill.
- Some medical schemes are making members pay a flat fee when they see a GP to help control the amount of times they visit a GP, or a co-payment when visiting a specialist when the member has not been referred by a doctor first.

When purchasing medication: some medical schemes have started imposing co-payments (levies) on its members for medicine purchases (when buying ethical instead of generic medications).



12. What is a new generation benefit option?

New generation benefit options were designed to help keep down the cost of medical schemes and to gain some control over medical inflation. The theory behind a new generation benefit option is to separate major medical expenses (risk) and day-to-day expenses (out of hospital expenses).

The idea of splitting day-to-day and major medical benefits in this way is to make members more responsible for their day-to-day (out of hospital) expenses, through their own personal medical savings account.

This differs greatly to a more traditional option where medical scheme benefits are pooled, and a rand limit is allocated for certain medical expenses on an annual basis.

With a 'new generation' option, your personal medical savings account is yours to manage as you see fit, on medical expenses required for you and your family. Once the funds in the savings account are depleted, all out of hospital expenses are for your account.

Should there be funds remaining at the end of the financial year, these funds will accumulate to your savings for the following year.

Plans that have a safety net/above threshold benefit or extender benefit, will apply annual limits on certain benefits such as optometry, prescribed medication, dentistry, external medical items as well as MRI and CT scans. These restrictions can be scheme specific so it is important that you familiarise yourself with restrictions that may be applicable to your specific option.

Medical Schemes restrict certain benefits within the safety net, above threshold benefit or extender benefit, to assist them in managing the scheme's costs. This is important and it has a direct impact on the premium of the benefit option. The higher the cover of a particular benefit option, the higher the premium will be. It is important to note that set benefits apply in your medical savings account and safety Net/above threshold benefit.

Risk Benefits:

Risk benefits, hospitalisation, and other major medical expenses are 'insured' benefits and are covered within the limits set by the medical scheme. Hospitalisation may be unlimited or have an annual limit, but there is no carryover of benefits from the risk portion on a year to year basis. Before you join a medical-scheme option with a personal medical savings account, you need to understand that while traditional options offer you insured medical benefits, a savings account option only offers some insured benefit and the rest you self-fund with the money in your medical savings account. This empowers you as a member in the choices you make in deciding how to spend your money on medical expenses.

Remember that the money in a new generation plan's savings account belongs to the members' and not the medical scheme. Because of this the member needs to negotiate with their healthcare providers, to ensure that they charge medical scheme rates only (or as close to them as possible). The less money in your savings account used per visit, the longer the personal savings account will last.

Funds that are left in your personal medical savings account at the end the year will be carried over to the following benefit year.

13. What is a Personal Medical Savings Account and how does it work?

A personal medical savings account option offers SELF-FUNDED BENEFITS by placing money into a personal medical savings account for out of hospital expenses. This gives you the freedom to decide which medical expenses to use your money for, but at the same time this arrangement carries some risk.

If the money in your personal medical savings account is not enough to cover your expenses, you have to pay for the difference yourself (from your own pocket).



Medical schemes have set certain out of hospital annual limits on the plans that have a 'defined above threshold'. This is to prevent abuse on certain high claiming items such as spectacles, medication and dentistry. Without these limits in place, abuse could take place, and ultimately cause higher medical inflation year on year.

Personal medical savings account limits are set annually at a maximum of 25% of your risk contribution. The percentage amount of your savings can be varied accordingly to the medical scheme rules and could be at a predetermined rate which is lower than the 25%, but it cannot exceed the 25% in terms of legislative requirements.

Due to the fact that funds in a personal medical savings account belong to you the member, it is important that you manage these funds appropriately.

Whatever money is left in a member's personal medical savings account at the end of each year gets carried over to the following year.

Should you terminate your medical scheme membership or move to an alternative medical scheme the funds from your personal medical savings account will be transferred across to your new medical scheme after a four-month period. (This is only the case if you are moving to a medical scheme that also has a personal medical savings account component). If you are moving to a medical scheme that does not have a personal medical savings account component to it, then the funds will be paid out to you. It remains your responsibility to declare the savings received on your annual tax return.

Before personal medical savings accounts were introduced, plans were 'Traditional Plans'. Traditional plans offered you insured medical benefits; this meant that you paid one amount over to a medical scheme and then the medical scheme would allocate annual rand amounts, or numeric limits for 'day to day' (out of hospital) benefits.

If you didn't use these benefits, you would lose them, and nothing would be carried over from one year to the next. These traditionally structured benefits are still available with certain medical schemes.

14. What is a self-payment gap (SPG)?

A self-payment gap can cause confusion and frustration with a medical scheme. Particularly, when the member has run out of savings, and is not yet in their above threshold/extender benefit (the insured benefit); and they need to pay for doctors accounts, medication, spectacles, etc. (day to day benefits), out of their own pocket. (This is known as the self-payment gap).

Members of a medical scheme that have a threshold and a self-payment gap, usually resent paying so much money towards a medical scheme (because it's usually the more expensive plans that have a threshold and thus a self-payment gap), when they still have to pay for some day to day benefits out of their own pockets.

Simply put, a self-payment gap is the difference between what you have in your medical savings account and the threshold level that the medical scheme sets as their limit, which you have to reach in accumulated claims, before you start utilising this risk benefit. (i.e. the medical schemes' money, which means the medical scheme, will begin to reimburse you for your day to day claims).

You as a member may be allocated R5000 in your annual Personal Medical Savings Account to spend for day to day benefits; however, the Medical Scheme has set an annual threshold at R7000. This means that the member will have a R2000 self-payment gap. (R7 000 – R5 000 = R2 000.)

Example:

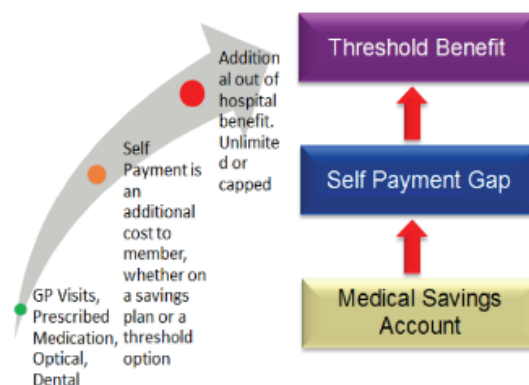
- John has R5000 for the year as savings and he has an unlimited above threshold benefit. He has the R5000 to spend in his Personal Medical Savings Account (PMSA) but his threshold is set at R7, 000.

- John knows that no matter what happens he will have to pay at least R2000 (at medical scheme rates) out of his own pocket (if he uses all his savings) before he gets into the insured benefits. The self-payment gap is variable and will grow according to how the member has claims reimbursed (at cost or at medical scheme rates), and/ or if the member buys over the counter medications. So, the initial R2000 self-payment GAP is a minimum self-payment gap that may apply. It is advisable that John sets money aside to fund this potential self-payment gap, in the event of him reaching this SPG.

How it works:

John goes to the doctor and it costs R500 for the consultation. The medical scheme rate is R350. John chose to have his bills are paid at cost from his medical savings account, therefore the following will happen:

- Initial savings was R5000, but after the Doctor was paid R500 the available amount reduced to R4500.
- The initial self-payment gap was R2000 only. The R350 medical scheme rate accumulates towards the above threshold, therefore the R150 difference (R500 – R350) is added to the self-payment gap and increases the self-payment gap to R2150.
- R350 accumulates towards the threshold, therefore John needs to spend another R6650 (R7000 – R350 = R 6650) before he reaches his threshold, and can access benefits from his ATB.



The following will increase your self-payment gap:

- Buying over the counter medication This will be paid for from John's medical savings account. But will not accumulate to the threshold, which means the savings will be diminished from John's Savings account BUT NO MONEY will accumulate to the threshold, thus increasing the self-payment gap.
- Paying Day-to-Day claims from savings at Cost When a Doctor or Service Provider is paid at cost from John's medical savings account, this means that whatever the doctor or service provider charges, is what the medical scheme will pay (if John has enough money in his medical savings account). By doing this the savings account will decrease by the amount that is charged, BUT, only the medical scheme rate will accumulate towards the threshold; which means that the difference between the medical scheme rate and the cost charged will be what the self-payment gap will increase by.
- Always check what limits are imposed on external medical items and spectacles. If you have funds in your personal medical savings account you can fund these items, however if the cost of the item/s exceed/s the limit imposed by the medical scheme this will contribute towards increasing your self-payment gap, as the medical scheme will only accumulate the medical scheme rate towards the annual threshold limit. In order to reduce your potential self-payment gap, it is advisable that you elect to have all claims reimbursed at medical scheme rates; opt for generic medication wherever possible and avoid claiming for over the counter medication from your personal medical savings account. If you are unsure regarding your self-payment gap, you can contact your Aon Healthcare Consultant, or the Aon Resolution Centre for further assistance.



15. What are over the counter medications?

'Over the counter' medications are medications for which you do not need a prescription; they are any drug or medication you can buy from a quick shop, supermarket or off the shelf at your pharmacy.

Cough medicines, Panado, Aspirin, Disprins, Rennie's, as well as some paediatric antibiotics are some examples of over the counter medication. If you purchase these through your medical scheme, you will grow your self-payment gap and decrease your savings.

NOTES:

- Certain medical schemes will pay for schedule 0, 1 or 2 medications in the following manner: If you get a script from your doctor and he has recommended a schedule 0, 1 or 2 drug, then the medical scheme will pay for it, from your personal medical savings account, but it will not accumulate to the threshold, even though it's on a prescription from the doctor. This will in turn increase your self-payment gap.
- Examples of a schedule 3 – 7 drugs are any antibiotic, for which you will need a script and which cannot be bought over the counter. It is, however, important to note that certain children's antibiotics are classified in the 0 to 2 schedule category and, therefore, do not accumulate towards your above threshold benefit.

16. What are waiting periods and how are they applied?

The Medical Scheme's Act, 1998, makes provision for medical schemes to impose certain waiting periods on new members joining a medical scheme for the first time; re-joining a medical scheme after a period of absence, or when members elect to voluntarily change medical schemes.

The Medical Schemes Act allows for waiting periods to be imposed in the following instances:

- John joins a medical scheme; he has never been on a medical scheme before and has a pre-existing condition, or chronic condition (e.g. asthma, diabetes, or hypertension etc.). The medical scheme may impose the following waiting periods in respect of his membership:
 - a. A 3-month general waiting period and,
 - b. A 12-month condition specific waiting period (for each specific pre-existing condition/chronic condition),
 - c. No access to Prescribed Minimum Benefits.
- John joins a medical scheme; he has been on a medical scheme for a period between more than 3 months, but 1 day less than 24 months, (without a break in cover) and he has a pre-existing condition or a chronic condition (viz. asthma, diabetes, or hypertension etc.). The medical scheme may impose the following waiting periods in respect of his membership.
- A 12-month condition specific waiting period only,
 - a. John will have access to Prescribed Minimum Benefits during this 12-month condition specific waiting period.
 - b. John joins a medical scheme; he has been on a medical scheme for longer than 24 months (with no break in membership), he has a pre-existing condition or a chronic condition (e.g. asthma, diabetes, or hypertension etc.). The following waiting periods may be imposed:
- A 3-month General waiting period only,
 - a. John will have access to Prescribed Minimum Benefits during this 3-month general waiting period.



Let's look at the following scenario to facilitate an understanding of how underwriting may be applied:

John may apply to get his monthly chronic medication paid by the medical scheme; even though he has a 3-month general waiting period, (as long as his condition complies with the list of prescribed minimum benefit conditions). This will usually be covered by the medical scheme, provided John obtains his medication from the medical scheme's designated service provider/s (DSP. This rule only applies if a member applies to join an alternative medical scheme, with a minimum of 24 months previous membership, and has no break in cover. This rule also applies should John need to be hospitalised for any of the 271 predefined PMB conditions, and in the event of an emergency, as stated in the Medical Schemes Act.

- John joins a medical scheme; he has, OR has not been on a medical scheme before, but has no pre-existing conditions, and has not had a hospital event in the past year. In this instance the medical scheme may waive any waiting period in respect of his membership application.
- Waiting periods are medical scheme specific; some medical schemes impose no waiting periods or Late Joiner Penalties on their entry level plans. Imposition of waiting periods is at the discretion of the medical scheme, and they can exercise this discretion when deciding whether to impose waiting periods or not.
- Medical schemes may impose a 3 month general waiting period on new members regardless of their health (risk profile), if they have not had continuous medical scheme cover in South Africa for a period of 24 consecutive months prior to application, and they have had a break in cover exceeding 90 days.
- If you are on a medical scheme and have had a twelve month condition specific waiting period imposed on you, and after 10 months you elect to change to an alternative scheme; the new medical scheme cannot impose another 12 month waiting period, but may impose the remaining 2 months of your 12 month waiting period. (12 months – 10 months already served = 2 remaining months.)
- If you move from Medical Scheme A (which is a closed medical scheme/restricted medical scheme, i.e. it is only available to employees of that employer,) to medical scheme B (an open medical scheme), due to a change in employment; you will not be entitled to remain on Medical Scheme A, due to its' closed nature. Medical scheme B is not entitled to impose any waiting periods on your application for membership, as this is deemed an involuntary change, i.e. you had no choice in moving to another medical scheme. Membership cover in foreign countries does not count as part of credible coverage.

If you are retiring from a company that has a 'closed / restricted medical scheme', find out from the company if you can remain on the restricted medical scheme after retirement. If this is permissible, then it would be in your own interests to remain on the restricted medical scheme, because if you choose to move to a different medical scheme, then the new medical scheme may impose waiting periods and late joiner penalties on you. The reason being you are moving out of choice on a voluntary basis, and not because you are forced to because your eligibility of the restricted scheme has fallen away.

Declare everything to the medical scheme, don't hide something to avoid a waiting period, the medical scheme is likely to become aware of any non-disclosure and may revoke your membership of the medical scheme.

If you are unsure of any underwriting that has been applied, or if you have any questions, you can contact the Aon Resolution Centre on 0860 100 404 option 3.



17. What is a Late Joiner Penalty (LJP)?

A Late Joiner Penalty is a financial penalty that Medical Schemes can impose on potential medical scheme members who have not enjoyed uninterrupted Medical Scheme cover within the borders of South Africa. This penalty can only be imposed on members joining a medical scheme after the age of 35.

If an LJP is added to your contribution, it will be for the rest of your life (as long as you are a member of the medical scheme). The LJP is only applicable to members over the age of 35 and is not applicable on the whole family (unlike a 3-month general waiting period).

Late Joiner Penalties are imposed according to a formula in the following manner:

Number of Years an applicant Was not a member of a medical scheme	Maximum penalty
1 – 4 years over 35	= 5% LJP added to contribution
5 – 14 years over 35	= 25% LJP added to contribution
15 – 24 years over 35	= 50% LJP added to contribution
25 + years over 35	= 75% LJP added to contribution

The formula is applied in the following manner:

$$A = B - (35+c)$$

A = Penalty Band

B = Age of applicant

C = Credible coverage: i.e. proof of previous medical scheme membership, either as a member or as a dependant of a medical scheme.

If a member has been on a medical scheme before age 35, either as a principal member or as a dependant, then these years count towards reducing the LJP. The only variation to this is in the event of a member or a dependant of the Permanent Force Continuation Fund, wherein any period of cover before the age of 21 years is not included in the above calculation.

Calculation of Late Joiner Penalties

Example 1:

Jane joins a medical scheme; she is 55 years old and has never been on a medical scheme before; she could have the following LJP:

- $55 - 35 = 20$ years not on medical scheme = 50% LJP for 20 years over age 35

Example 2:

Jane joins a medical scheme, she is 55 years old and has not been on a medical scheme from age 40 but can show she was on a medical scheme from age 35 for 5 years. She could have the following LJP:

- $55 \text{ years} - 40 \text{ years} (35 \text{ years} + 5 \text{ years of creditable coverage}) = 15 \text{ years}$
- 15 years not on medical aid = 50% LJP
- If 10 years of credible coverage, then the LJP would be based on 10 years and the penalty 25%



If you are unsure of any late joiner penalties applied or if you have any questions on the LJP's please call the Aon Resolution Centre on 0860 100 404 option 3.

18. When can I upgrade or Downgrade my plan?

Upgrade:

Members are entitled to upgrade their plan option at the end of the year for effect the 1st of January the following year.

Most medical schemes do not usually allow you to upgrade during the year, to discourage 'anti-selective' behaviour. Members usually try to upgrade when they run out of benefits, or if they need to upgrade their benefits due to the onset of an illness. This is classified as anti-selective behaviour. Medical schemes calculate premiums based on the calculated risk a particular benefit option will be exposed to. If members were allowed to upgrade when they run out of benefits or fall ill, it would adversely affect the risk pool of that benefit option, thus jeopardising the long-term financial stability of the medical scheme.

Certain medical schemes do allow upgrades during the year, subject to certain qualifying criteria being met. Typically, these upgrades would be allowed if a life changing event had occurred and you could support this with documentation from your medical practitioner. The upgrade would be affected, backdated to the beginning of the calendar year, and the premium adjusted accordingly. These additional premiums would have to be paid in by the member.

Downgrade:

Downgrading is easier than upgrading, some medical schemes allow you to down grade (or buy down) at any time and some don't. Always ask your intermediary if this is allowed on the medical scheme you are choosing.

Always seek advice from your accredited intermediary before upgrading or downgrading as your intermediary is best positioned to assist you in making the right choice that is appropriate for you and your family.

If you have any further questions regarding upgrading or downgrading, you can contact the Aon Resolution Centre on 0860 100 404 option 3.

Always check with your medical scheme as to what rules are applicable to upgrades and downgrades. Most medical schemes do not allow upgrades to be done during the year, because it is deemed anti-selective.

19. What is a solvency ratio of a medical scheme?

The Medical Scheme's Act 131 of 1998 stipulates that a medical scheme needs to have 25% of the medical scheme's gross annual contributions in reserve, in case there is a 'disaster', like a cholera outbreak and the medical scheme has to pay abnormally high extra claims; or claims of an increased frequency.

It is important to consider a medical scheme's solvency levels when choosing a medical scheme. A medical scheme that has less than the required 25% reserve will have to formulate ways in which to reach the stipulated reserve level. This could result in premium increases and benefit reductions on the part of the medical scheme.

Solvency, however, is not the only indicator to consider when choosing a medical scheme, and sometimes the reserve ratio can be very deceiving, as in some instances a medical scheme may have a very high solvency ratio that can be linked to the movement of members from the medical scheme. If a member leaves a medical scheme, they do not transfer their reserves with them. This can result in a medical scheme increasing their solvency ratio, resulting in this ratio being higher than the stipulated 25%, but the number of members on the medical scheme is diminishing. Likewise, a medical scheme that is growing fast will struggle to maintain the required 25% solvency levels due to the fact that new members joining the medical scheme are not transferring across with their accumulated reserves, which remain with their previous medical scheme.



The new medical scheme, therefore, must start accumulating reserves for these new members from scratch.

As mentioned above, solvency is not the only factor to consider, it is best to discuss appropriate options with your Aon Healthcare Consultant who will be able to give you the most appropriate advice.

20. How do I submit a claim?

Submitting a claim can be done in a several ways:

- E-mailing the claim to the medical scheme.
- Faxing the claim to the medical scheme.
- Putting it in the designated claims box.
- Let the Doctor submit it directly on your behalf.
- Posting the claim to the medical scheme.

Always make a copy of the claim if you are posting the claim, the original must be submitted to the medical scheme.

Always ensure that all claims are submitted within 4 months of date of service to ensure payment.

When submitting a claim to your medical scheme always ensure that the claim contains the following information to facilitate easy processing:

- Your full name and membership number.
- The name and practice number of the service provider.
- Date of service.
- Full amount charged by the service provider.
- Codes relating to the claim (Nappi codes or ICD 10 codes whichever are applicable).

Regulation 6 of the Medical Schemes Act 131 states:

6. Manner of payment of benefits:

1. A medical scheme cannot withhold any benefit or payment to a registered member of the medical scheme, any benefit or payment that the member is entitled to, provided the member has submitted his claim before the end of the fourth month -
 - a. From the last date of the service rendered as stated on the account, statement, or claim; or
 - b. During which such account, statement or claim was returned for correction.
1. If a medical scheme is of the opinion that an account or statement is unacceptable for payment, it must inform the member and the health provider within 30 days of receipt of the account, and full reasons as to why it is unacceptable. (3) After the member and the relevant health care provider have been informed as referred to in Question 2 above, the member and /or health provider have 60 days in which to resubmit the corrected account.
2. If the medical scheme does not advise the member or health provider that an account or statement is incorrect, it will remain the responsibility of the medical scheme to prove that that the account was incorrect, if the matter is raised in a dispute.
3. The medical scheme must provide its members with statements of accounts including the following:
 - a. The name and the membership number of the member,
 - b. The name of the supplier of service,
 - c. The final date of service rendered by the supplier of service on the account or statement which is covered by the payment,
 - d. the total amount charged for the service concerned and
 - e. the amount of the benefit awarded for such service.



21. What are my rights as a medical scheme member?

The Medical Schemes Act 1998, makes certain provision for the protection of medical scheme members, some of the rights of medical scheme members include, but are not limited to the following:

- The principal of open enrolment, this means that any member, no matter how old, ill or frail cannot be refused cover by a medical scheme.
- The principal of community rating - medical schemes have to charge all members of a benefit option the same premium. Contributions may not be differentiated on age, or health status.
- Medical schemes, administrators and managed care organizations are required to treat members' information in a confidential manner.
- Medical schemes may not subject applicants to medical investigations for treatment received for medical conditions at least 12 months prior to the date of application for membership.
- All medical schemes, and benefit options within those medical schemes must provide members with full cover for the prescribed minimum benefits, medical schemes do, however, have the right to restrict treatment to certain protocols and formularies. If, however, the treatment or medication is ineffective, or harmful to the member, the medical scheme must then substitute the treatment with an effective alternative.
- Only a small number of members are required to call an annual general meeting of the medical scheme.
- Claims submitted must be paid within a specified period, if a medical scheme wishes to reject a claim it needs to do so within 30 days of receipt of the claim.
- If members are not satisfied with the decision of a medical scheme, they can exercise the following rights:
 - a. Lodge a dispute with their medical scheme,
 - b. Lodge a complaint with the Council for Medical Schemes,
 - c. Take any legal action they wish.

What process do I follow when lodging a dispute or complaint with my medical scheme or the Council for Medical Schemes?

Disputes with Medical Schemes

Any member of a medical scheme may lodge a dispute with his or her medical scheme by means of an alternate dispute resolution process. This process is free of charge to members. Members can choose to prosecute their case themselves, or use the services of their broker or intermediary, or any other person. If the member chooses to be represented by a professional, e.g. an attorney, the costs must be borne by the member.

The Medical Schemes Act clearly states that the rules of a medical scheme must include guidelines on how complaints or disputes must be settled; these guidelines are usually found in rule 28 of the medical scheme rules.

- Complaints to the medical scheme must be submitted in writing,
- Complaints submitted to the medical scheme must be responded to within 30 days of being submitted to the medical scheme.
-

The disputes committee consists of independent representatives who are not trustees, employees or officers of the medical scheme. The dispute committee usually consists of three people, one of which will have some form of legal expertise.

The principal officer of the medical scheme is compelled to convene a dispute hearing, in which the person that lodged the complaint has the right to be heard; call witnesses and cross examine witnesses.

If the complainant is not satisfied with the ruling of the disputes committee, they have the right to appeal this decision to the Registrar of the Council for Medical Schemes.



Complaints to the Registrar of the Council for Medical Schemes

Any member of a medical scheme has the right in terms of Question 47 of the Medical Schemes Act to lodge a complaint with the Registrar of the CMS (Council for Medical Schemes).

Complaints to the Registrar must be in writing. The Registrar will then give the party against whom the complaint has been lodged 30 days to respond in writing, after which the Registrar will either resolve the complaint, or refer the matter to the Council for Medical Schemes to resolve.

Any member who is aggrieved by a decision of either a Dispute committee or the Registrar has the right to lodge an appeal to the Council for Medical Schemes. The appeal must be in the form of an affidavit and must be lodged within 3 months of the decision by either the Registrar or the disputes committee.

Any person, who is aggrieved by a decision made by the Council for Medical Schemes, can in terms of the Medical Schemes Act appeal to the Appeal Board. This appeal should be in the form of an affidavit and should be lodged within 60 days of the decision by the Council for Medical Schemes.

The Appeal Board has the same powers as the High Court, to summon witnesses, to cause an oath or affirmation to be administered, to examine witnesses, and to call to produce documentation.

The Appeal Board conducts its hearing in public, and parties to the appeal are entitled to be represented by a legal practitioner.

22. 20 Tips to Remember

The money in a medical savings account belongs to the member, it is held in trust, and cannot, therefore, be seized by creditors, even if the member is declared insolvent. Your personal medical savings account has the same status as the money invested in a pension fund, it remains inviolable, as the property of the member.

1. Do not use your medical savings account to purchase 'over the counter' medication (schedule 0, 1 or 2 drugs). This will cause the savings to decrease but will also increase the self-payment gap, if applicable.
2. Try and obtain generic medication instead of ethical medication, as it's cheaper and the medical scheme will usually pay for generic medication in full (subject to available savings). If you really need ethical medication, you will have to pay a co-payment (levy) of the difference between the price of the 'ethical' medication, and that of the generic.
3. If you are retiring, find out from the company you are employed with, if you can remain on their 'closed / restricted medical scheme' post retirement. AFROX is an example of this. They have their own in-house medical scheme and when you retire you have the option of continuing the medical scheme. If you chose to move to an open medical scheme, then you may have LJP's and waiting periods imposed.
4. Declare everything about your health status to the medical scheme, at the point of application; don't hide anything, to avoid a waiting period.
5. Always have a hospital stay authorized, if it is not authorized you could be liable for anything from a percentage of the account, to paying the entire account. In an emergency you have 48 hours to post authorize your hospital admission. (The hospital's admissions department usually does this, but as a member you have a responsibility to ensure that it has been done.)
6. If you are in hospital for a procedure and it becomes necessary to perform an additional procedure, the second procedure must also be authorized separately, or the medical scheme will not pay for it. Alternatively ensure the first authorization is amended to include the additional treatment.
7. Cost is not an indicator of a doctor's competence. If a doctor is charging more than other doctors, this does not necessarily mean he is a better doctor. So, shop around and remember - it's your money, so be wise and negotiate.
8. Make sure you are on the correct medical scheme option by requesting a one on one consultation with your accredited Aon Healthcare Consultant.



9. Make sure you understand the rate of reimbursement applicable to your chosen option.
10. Investigate Gap Cover and Top-Up Cover options, to ensure higher in hospital cover and reduce out of pocket co-payments.
11. If you are diagnosed with a chronic condition, double check your benefits on your chosen option to ensure that your particular condition is covered by the medical scheme, and what restrictions may apply in terms of formularies, or designated service providers.
12. If your medical scheme makes use of medication formularies and defined medication lists, double check that your medication is part of that list to ensure better cover.
13. Familiarize yourself with what are PMB procedures to ensure that you do not incorrectly incur out of pocket expenses.
14. Familiarize yourself with any co-payments that may exist on your current option to avoid any surprise out of pocket expenses.
15. Do you understand the concept of a new generation option? If not, make sure you contact your accredited Aon Healthcare Consultant to arrange a one on one session to explain this concept to you.
16. Make sure you understand what a self-payment gap is, and how it is created. This will assist you in avoiding unnecessary out of pocket expenses.
17. Familiarize yourself with the medical scheme underwriting that may be applicable. This can affect your decisions with regards to changing medical schemes.
18. If you have had a LJP applied, double check whether you have proof of previous medical scheme cover that could be submitted to reduce this additional cost.
19. If you have a mid-year life changing health event and need to upgrade your option, check with your Aon Healthcare Consultant and your medical scheme to see whether an upgrade will be allowed.
20. Should your chronic medication on a formulary change, it is always advisable to discuss this with your doctor.

If, and when your medical scheme changes the formulary list of any one of your chronic medications, it is advisable to discuss if the new medication/s is/are appropriate for you, and whether you should change.

Medical Scheme word usage & Definitions to Assist You

PMB Prescribed Minimum Benefits

These are the minimum benefits which must by law be provided by a medical scheme to its members; there are 27 different chronic diseases that are PMB's and 271 treatment diagnosis, plus emergency treatment.

DSP

Designated service providers – This is a list of healthcare providers that have been selected to provide its members diagnosis, treatment and care in respect of one or more of the PMB conditions; it's also a list of service providers that have a direct paying arrangement with the different medical schemes.

NHRPL

National Health Reference Price List – This is made up of the old SAMA and BHF rates that used to determine the 'Medical Aid Rate' The NHRPL rate is essentially a guideline that utilizes benchmark values and standardised assumptions. Its aim is to create differentiation of benefit pricing levels based on medical scheme specific considerations.

MSR

Medical Scheme Rate – This is the amount that medical schemes will pay as their negotiated 'Medical Scheme Rates'. This means that there is no standard 'Medical Scheme Rate', each medical scheme sets their own rates.

CIB

Chronic Illness Benefit – Covers the diagnosis, medical management and medication, to the extent that it is provided for in terms of the prescribed 27 PMB conditions (including HIV/AIDS).



SPG

Self-Payment Gap – This is the amount a member will have to pay once they have depleted their savings account and before they reach the accumulated limit of the above threshold benefits. It is important to understand that claims accumulate only at the medical scheme rate, and the self-payment gap is only closed when the accumulated amount as per the medical schemes tariffs is finally reached.

CDL

Chronic Disease List – This is the list of 27 different chronic conditions that by law, medical schemes have to cover, in full, for the diagnosis, treatment and medical management of the diseases listed

ICD 10

International Classification of Disease Code – Every medical condition and diagnosis has a specific ICD 10 Code. These codes are used primarily for medical schemes to accurately identify the conditions for which healthcare services were sought.

LJP

An applicant or dependant of an applicant who, on the date of the application, is 35 years or older. (Additional conditions other than age are contained in regulation 11 relating to the qualifying criteria for late joiners). Medical Schemes are entitled to charge higher premiums to such prospective members, subject to certain conditions and maximum penalties.

TTO

To Take Out /Take home medication – This is the medication that a member will get from the hospital pharmacy when they are discharged from hospital. (Remember that this is paid for from the member's medical savings account, or medicine benefit, or if neither are applicable - from the member's own pocket.)

MSA

Medical Savings Account – a member contributes a fixed monthly amount towards day to day expenses; this money is paid into the personal savings account monthly, but the money is usually credited upfront by the medical schemes, and the full annual amount will be available to the member as at the first day of the financial year's benefits., The maximum amount that can be paid into a medical savings account is 25% of the member's total monthly contribution. Percentages in terms of the savings amount to be credited to the personal savings account may vary according to the option chosen by the member, but the maximum amount allowed in terms of legislation is 25% of the total monthly contribution.

Cover

This refers to the amount that the medical scheme will pay for treatment or care. Remember not all healthcare services are covered in full.

Co-Payment

The difference or short fall that very often has to be paid out of the member's own pocket to a healthcare provider for services received. This happens when the service provider/s charge more than the medical scheme is willing to reimburse.

Day to Day Limit

A member and their dependants can spend a specific amount of money each year for out of hospital expenses. Day to day benefits are usually limited with either a financial or quantitative ceiling and tend to be frequent in nature and occur out of hospital. – E.g. a visit to a GP.



Dependant

This is an emotive point, because when medical schemes first started you could enrol adult family members who were 'financially' dependent on the principal member, onto the medical scheme membership. These dependants included parents, grandchildren, or even a sibling. Today the person has to be an immediate family member, i.e. spouse or legitimate children, whether by co-sanguinity, adoption, or legally fostered. Students and any disabled child of adult age, who is financially dependent on the main member, may remain on cover as adult dependants. (It is important to note that if you adopt a child, or become the legal guardian of a child, the child will only be admitted to your membership as a beneficiary, as and when their status is confirmed legally.)

Emergency

A medical emergency is an injury or illness that poses an immediate threat to a person's life or long-term health, which would require immediate medical treatment.

Generic Medication

Generic medication is medicine that contains the same active ingredients as their ethical equivalents and is essentially similar to the branded equivalent. This happens when the patent for the branded product expires. As a result, these medicines are usually cheaper, and are increasingly prescribed by doctors as effective alternatives to higher-priced original or ethical pharmaceutical products.

Open Medical Scheme

This is any registered medical scheme that is open for any member of the public to join.

Closed/Restricted Medical Scheme

A restricted medical scheme is closed to the public and usually open only to a certain type of demographic profile. For example, only Accountants can join CAMAF, a scheme which restricts its membership to the accounting fraternity only, another example is Bankmed, which restricts its membership to bank employees only.

Waiting periods

Depending on your previous medical scheme membership history, and your current health status including whether you have a chronic or ongoing health condition, a medical scheme may impose waiting periods on you. Waiting periods enable the medical scheme to build up reserves and protect the medical scheme from 'unknown' bad risk exposure. The medical scheme may impose a 3-month general waiting period and/or a 12 month condition specific waiting period.

Pre-Authorization

This is the process of getting pre-approval for planned hospital admissions and for certain procedures before you undergo treatment

Capitation

This is a payment model whereby a fixed amount of money is paid by a managed care organization to a network of healthcare providers. It is a pre-determined amount per covered person. In return for the capitation payment, the provider assumes responsibility for the provision of health services for that person for the agreed time period. The opposite of a capitation model is a fee-for-service model. A Fee-for-service model is where the providers receive payment on a per service basis.

Claims paying ability

The claims paying ability of medical schemes can be measured in the months of cover in cash. This is the number of monthly claims that the scheme can cover with its existing cash and cash equivalents.



Community rating

The process of developing contribution rates based on the overall community or members' claims experience on an option, rather than on group-specific claims data.

Claims experience

The experience the medical option or group has for total health related claims for a specific period.

Continuation membership

Principal members of medical schemes are entitled to remain members of the medical scheme after retirement, even if the employer no longer subsidises the members' contributions. In the event of the death of the principal member, the dependants will still be covered by the medical scheme.

Contracted Out

If a doctor is contracted out (of medical scheme rates) it means that he/ she charges fees that are higher than the rate at which the medical schemes reimburse claims.

Deductible

An amount of a hospital or medical bill which must be paid by the member, in terms of the rules of the option the member has chosen. This may apply to both in and out of hospital expenses. A deductible is similar to an insurance 'excess'.

Diagnosis and Treatment Pairs (DTPs)

The list of 271 Prescribed Minimum Benefits in the Medical Schemes Act is grouped into different categories referred to in the Medical Schemes Act as Diagnosis and Treatment Pairs.

Dread Disease

Major medical conditions such as cancer and heart attacks are grouped together under some insurance policies as 'dread disease cover'. Definitions of cover range between different insurance policies.

Exclusions

Some medical conditions and procedures may be excluded from medical schemes as part of the design of the medical scheme. Traditionally these would have included cosmetic surgery and self-inflicted injuries.

First rand cover

When your medical claims are paid from the very first rand you spend.

Formulary

A defined list of a medical scheme's approved medicines used in the treatment of various diseases.

Health Maintenance Organizations (HMO's)

These are organized healthcare systems that are accountable for both the financing and the delivery of a broad range of extensive health services to an enrolled membership base.

Hospital plans

These can be options sold within medical schemes or as insurance-based products. They cover you for major events or pay out certain amounts of money for defined health events, which normally entail hospitalisation.



Managed Care

A process of clinical and financial risk assessment which monitors how you, your medical scheme and healthcare providers utilise health services, within the constraints of protocols which are designed to facilitate appropriate and cost-effective services.

Managed-care organisations

An organisation that has been accredited through the Council of Medical schemes and is doing the business of managed care. These organisations must contract with a medical scheme and thereby act between the service providers and the members of a medical scheme thereby rationalising the costs of care.

Medical insurance products

Products offered by a short-term or a long-term insurance (profit-making) company. These products – mostly called top-up cover – are governed by the Long-term Insurance Act and the Short-Term Insurance Act and not by the Medical Schemes Act. Whereas traditional-type medical scheme products cover you for all the medical expenses you incur, insurance-based medical products cover you for a list of medical conditions and will pay out a stipulated sum of money according to the benefits assured, if you are affected by one of these health conditions or events.

Medical scheme

A legal entity created for the purpose of providing access to health care services for its members. This entity is an independent not-for-profit organisation, which acts as a third-party payment mechanism for its members, paying claims incurred by them, to service providers, through a medical scheme administrator.

Medical Schemes Council

Appointed by the Minister of Health, this council can have up to 15 members. The function of the Council is to protect the interest of medical scheme members; to control and co-ordinate the functioning of medical schemes in line with national health policy; make recommendations to the Minister for Health, measuring the quality and outcome of health services; and investigate complaints.

Medical service providers

These range from doctors to hospitals, pharmacies, and specialists etc, i.e. all providers who offer members of the public healthcare services.

Member

The person who signs the contract or application form for admission to a medical scheme, thereby becoming liable for paying premiums to the medical scheme in return for the benefits offered by the medical scheme. A member (also known as the principal member) is the primary person registered with a medical scheme.

New generation medical scheme

A medical scheme offering you cover which is split between your day-to-day claims, like GP visits, and your major medical incidents, like hospitalization. Further, in terms of your day to day benefits, after your personal medical savings account has been exhausted, you will be required to fund the claims yourself until a specific level or threshold is reached. Thereafter the medical scheme will fund your day to day claims again.

Non-declaration

Non declaration occurs when a member does not disclose all relevant facts of their health status on application for membership of a medical scheme. The Medical Schemes Act does not prohibit non-declaration but does prohibit material non-declaration.



Open enrolment

This is a legal requirement imposed on medical schemes, which refers to the fact that no medical scheme may exclude, or underwrite, anyone on application to become a member of the medical scheme.

Per Diem contracts

Per Diem contracts are an option of reimbursement by a medical scheme to a hospital. Reimbursement of a hospital is based on a set rate per day rather than on itemized charges and is differentiated by the diagnosis related group. Per Diem reimbursement can be varied by service (e.g. Medical/mental health, ICU, etc) or be uniform regardless of intensity of services.

Pre-authorisation

A mechanism used in managed healthcare, which refers to a process whereby before you are admitted to hospital you have to contact your managed care organization /medical scheme to inform them of your pending admission. Pre-authorisation is used to channel patients to the most appropriate and cost-effective facility. Medical schemes can deny benefits if hospital, or other procedures, as stipulated in their rules, were not pre-authorised. Pre-authorisation only confirms that the member is a registered member and does not guarantee full payment.

Reinsurance

This is a form of risk management and refers to an insurance contract taken out by a medical scheme to cover it for claims over a certain amount. In this way the scheme knows that one or two very large claims will not spell financial disaster for the scheme. Or the contract may say that if the scheme's claims experience goes higher than 120 percent of the contributions, then the reinsurance company must pay for those claims in excess of the 120%.

23. What is Gap Cover?

Most people today are puzzled by their medical scheme shortfalls. Even the term 'Comprehensive' when used to describe a medical scheme plan today is not by definition Comprehensive.

This is because there has been a widening gap over the years between what a medical scheme reimburses members and what doctors and specialists charge patients. Often medical schemes refer to 100% cover, this means 100% of the medical scheme rate and not necessarily what the doctor will charge.

It is also important to note that Gap cover and Top up policies are designed to cover the shortfalls that members experience while in hospital and do not relate to day to day expenses. Quite often patients have a nasty shock when leaving the hospital as it becomes apparent that the medical scheme is not going to meet all the expenses incurred, and members are faced with 'out of pocket' expenses which they have to fund themselves.

The gap is the difference between the fee charged, by the hospital or the amount the doctor charges for services in hospital and the amount covered by the medical scheme

or

Gap covers pay you the difference between what doctor's charge in hospital and what the medical scheme actually pays

or

A benefit which is limited to 5 times the medical scheme tariff, for treatment or services rendered by providers whilst you are in-hospital.



Ask your consultant about additional products available under your Gap cover policy that can cater for:

1. Tariff Shortfall - difference between a provider's fee for in-hospital treatment and your medical scheme benefit.
2. Co-payments or Deductibles – these can range from around R1, 000 up to as much as R11 000 and more depending on your medical scheme plan and in-hospital procedure.
3. Annual Sub-Limits - limitations imposed on certain in-hospital items, e.g. prosthesis used for joint replacements.
4. Oncology Co-payments – 20% of Oncology treatment above a certain threshold.
5. Medical Scheme Contribution Waiver – which continues to pay your medical scheme contributions for the dependants after the death of the principal member, up to a period of 6 months.
6. Daily cash benefit for prolonged in hospital care, normally pays after your third day in hospital. However, this does not pay retrospective to day 1.

Some examples of the gaps in cover are listed below:

Procedure	Service Provider Charge	Tariff	Gap Payment	%
APPENDICECTOMY	R 3,595.23	R 1,198.41	R 2,396.82	300%
OVARIAN CYST	R 6,947.32	R 3,081.82	R 3,865.50	225%
CHILDBIRTH	R 8,300.00	R 2,367.40	R 5,932.60	351%
WISDOM TEETH EXTRACTION	R 8,239.75	R 2,042.30	R 6,197.45	403%
DENTAL PROCEDURES	R 8,884.70	R 2,561.90	R 6,322.80	347%
ARTHROSCOPY	R 8,875.57	R 2,533.23	R 6,342.34	350%
CAESAREAN SECTION	R 8,689.70	R 2,201.54	R 6,488.16	395%
FRACTURE	R 15,257.58	R 5,477.57	R 9,780.01	279%
LAPAROSCOPY	R 16,323.38	R 5,908.20	R 10,415.18	276%
KNEE REPLACEMENT	R 43,698.80	R 14,628.80	R 29,070.00	298%
BRAIN SURGERY	R 158,858.00	R 48,926.00	R 109,932.00	325%

In addition to the above in hospital gap payments, there are more and more co-payments being applied to procedures including scopes, MRI or CT scans, and dentistry and hospital admissions.

Fortunately, there are insurance products called Gap Products which have been developed specifically to assist members in overcoming some of these alarming shortfalls with their medical scheme coverage.

These products will pay-out shortfalls experienced by members using providers who do charge more than the medical schemes rates. Add on benefits will also allow members to 'insure' any co-payments for which they can claim against the insurance company and be reimbursed for these out of pocket expenses. Sub-limits for certain categories of in hospital treatment can be extended, and there are even specific gap products to assist members diagnosed with cancer, which today is no longer an unlimited benefit..



The costs of these Gap products are inexpensive, and they can only be sold to members of a medical scheme as they are not designed to substitute a medical scheme. They are exactly what they profess to be – Gap Insurance, designed to cover gaps in cover on your medical scheme.

How to access further information:

For additional information on the above products and benefits available please contact the Aon Resolution Centre on 0860 100 404 option 3.

24. What is Gap Cover not?

Medical scheme Gap Cover is not a Medical scheme or an alternative to a Medical Scheme. It is an insurance policy designed to complement your Medical scheme.

Gap Cover is not a product designed to cover the Self Payment gap which can occur when one has exhausted your Personal Medical Savings Account but not yet reached the stipulated Threshold, when the medical scheme will continue to pay your claims. Gap Cover does not pay any costs incurred by a patient, which is a stipulated exclusion in terms of the Medical Scheme rules. Gap Cover is not an additional cover to a member's personal medical savings account. In other words, if member's savings has run out, Gap Cover does not pay any day to day claims as an alternative benefit to the Personal Medical Savings account.

25. Serious Illness Protection Plan

Most of us have a fear of being struck down with a serious illness which will impact on our abilities to support our families.

This fear is unfortunately becoming a growing reality in our stress filled society, where more and more people are subjected to the scourges of stress and succumb to diseases which are far too common today. Cancer, heart disease, stroke, paraplegia is some of the diseases which can overtake a seemingly healthy individual at short notice and change one's life forever.

We are seldom prepared for the emotional trauma related to these events, but it is possible to be prepared financially for such events through insurance, and a Serious Illness Protection Plan is such a policy.

These policies will pay out a fixed benefit up to a maximum financial amount on the diagnosis of a specified disease. It is normally only applicable to adults and will exclude children in the family, and for the pay-out to be affected you need to survive the original diagnosis by of a period of 30 days. Thereafter a lump sum benefit will be paid out.

This money can be used to offset medical bills which may have not been met by the medical scheme; it can also be used for a holiday to facilitate the convalescence of the patient. It is a windfall which can be used at the discretion of the policy holder for whatever they choose.

The costs of this type of cover are very inexpensive when compared to other types of insurance and is a small investment for financial peace of mind.

26. What is National Health Insurance?

Government announced their intention to change the healthcare system and to implement a National Health Insurance (NHI) System. In this Question we will not go into the detail of what a NHI system is or what other models are available in other parts of the world. We will at this stage just keep it very simple.

In South Africa we have two types of systems, namely medical schemes and then also a public health system. Commonly we read that the private sector is expensive but provides quality care and that the public system is free but that the care in the public hospitals is dismally poor. Both these statements can be attacked from an accuracy point, but such an attack will not serve any positive purpose.



The intention of the health reforms is to ensure that all citizens of South Africa have access to quality care. The intention is for government to provide more healthcare services to more people, expand the types of healthcare services, and to reduce the amount of out of pocket expenditure. To achieve this objective, it is easier said than done, and will require lots of debate, allocation of resources, and proper research.

The public sector is often referred to as being so bad that one does not want to land up in a public hospital. This fear that we have is legitimate, and as a result we purchase medical scheme benefits out of fear.

The private providers also charge what the market can bear and as a result we find private healthcare to be very expensive. For the people older than 40 years old you will remember that when you grew up you all made use of public hospitals. They were good and we had none of our current fears.

So, picture a situation where the public hospitals once again return to a position where they can provide a real alternative to the public system. We will then look at the two systems and decide which one provides the best value for money, and purchase healthcare benefits based on value and not on fear anymore. This is a good position to strive towards.

We should thus remain optimistic as a real alternative is proposed. Before that happens, however, a lot of work needs to be done to fix all the ills of the private and the public sector. It stands to reason, therefore, that it is responsible to retain medical scheme cover until such stage that a real alternative is available.

COVID-19 Vaccination FAQ's

1. What is South Africa's vaccination strategy?

The South African government has procured sufficient vaccines for the national vaccination program. This program aims to vaccinate between 250 000 - 300 000 people per day at the peak of the program, after commencing the next phase of the rollout which began in May 2021.

The program completion is targeted for February 2022. Vaccines will be administered in phases according to a national prioritisation framework, to ensure that those most vulnerable and at risk in the South African population are vaccinated first:

- Phase 1 - healthcare workers
- Phase 2 The current phase of the national COVID-19 vaccination programme is open to people over the age of 60 years and healthcare workers. Everyone who falls within this category is being scheduled for their vaccination and being allocated to vaccination sites by the national Electronic Vaccination Data System (EVDS). Site allocation is largely dependent on a person's proximity to open vaccination sites and demand for vaccination in that area.
- Phase 3 (currently underway) - remaining population


2. Why do I have to register on the EVD system?

By registering on EVDS you will automatically be allocated a place in the virtual queue for your vaccination. The queue is based mainly on age, where the elderly is scheduled first. The queue is not determined on a first-come / first-served basis, but on the national prioritisation framework. You must, register on the EVDS system to secure your place in the queue and to receive your unique vaccination code that you will be required to present on the day of your scheduled vaccination.

3. What are the steps to my vaccination?

- You first need to verify the phase that vaccination roll out is in and if you qualify for this phase.
- Register on the Vaccination Data System (EVDS)- <http://vaccine.enroll.health.gov.za/> Those unable to self-register can visit walk-in centres and vaccination sites.
- You will receive a SMS as confirmation of registration and reference number.
- When it is your time to go for the vaccination you will receive an SMS detailing the date, time and venue.

South African COVID-19 Vaccination Programme Registration

 **health**
Department:
Health
REPUBLIC OF SOUTH AFRICA

This is the official South African COVID-19 Vaccination Programme registration portal.

- Vaccination is voluntary.
- Everyone who registers will be offered vaccination. We will start with people 60 years and older and move down the age groups as quickly as we can.
- When it is your turn, you will receive an SMS with the date, time and place for your vaccination.

Are you a Health Care Worker?

Next

Example of the SMS you will receive from the EVDS system

Hi Gillian
Randall. You
have been
scheduled for
vaccination
on 21 May
between
10 AM and
12 PM at 1
Discovery
Place. Please
bring your
vaccine code

4. If my medical scheme offers a vaccination portal - do I have to register on both or only the medical scheme?

You are required to first register on the government EVDS portal, if you do not register you will not be eligible for the vaccine. It is voluntary to register on your medical scheme portal should your medical scheme offer a portal. However, we would strongly advise that you register on the medical scheme portal as well as this will keep you well informed.

5. Are the vaccination sites specific to my medical scheme?

These sites are not exclusive to medical scheme clients; all vaccination sites are open to every person in South Africa who has registered and obtained a valid vaccination code from the government's Electronic Vaccination Data System (EVDS).



6. Can I select where I want to be vaccinated?

Currently during Phase 2 of the national vaccine rollout process, the EVDS system will automatically assign a vaccination site based on proximity to your home address that you entered as part of your EVDS registration. You will receive an SMS from EVDS notifying you of your allocation. This is where you would need to go for your vaccination.

7. Can you choose which vaccine you would prefer?

There aren't mechanisms in place nationally or worldwide for people to pre-select their vaccine of choice. Given the limited supply of and demand for vaccines globally, it is advisable that people get vaccinated with the vaccine that is made available at the time. All approved vaccines have met the required clinical efficacy standards.

8. Who will administer my vaccine?

Current regulation only allows for medical practitioners whose current scope of practice includes administering injections, to administer the COVID-19 vaccine. For example, dentists, paramedics, registered nurses, enrolled nurses and doctors. All vaccinators will be fully trained and accredited healthcare professionals and will have completed all required vaccinator training. There will also be dedicated medical support onsite should you require any additional assistance. The vaccinators have undergone extensive training on the prescribed clinical guidelines required to be adhered to for safe administration of the COVID-19 vaccine. These include those of the National Department of Health, and the Centre for Disease Control ("CDC") international guidelines.

9. How many vaccines will I need?

This depends on the type of vaccine administered as your first dose. Some vaccinations, like Pfizer BioNTech, need two shots to provide a stronger immune response. Others, like Johnson & Johnson, currently only need one dose for a similar effect. Our team on site will tell you which vaccine you are getting and whether you need to come back for your second dose.

10. If I require a second dose, what process do I follow to get the second dose?

You need to ensure that you get your second dose as soon as possible after at least 21 days. You should not wait more than 42 days to get your second dose, otherwise you may be reducing your vaccine's efficacy. You will be logged on the system as receiving the first of a two-dose vaccine if applicable. When you leave the vaccination site, you will be reminded when you need to have your second dose by, via a reminder card which you will be given at the site.

11. What is the process after having my vaccination?

If you require a second vaccine dose, you will receive a SMS reminder for your second vaccination appointment. You will also receive confirmation of your vaccine including a link to a post vaccination questionnaire to capture your vaccination outcomes. Any clients who report adverse reactions are referred to a healthcare professional. You will also be notified once your digital vaccine card is ready.

12. When should I not be vaccinated?

Please delay your vaccination if:

- You do not feel well or have a temperature above 37.5°C
- You do currently have COVID-19
- You are in the 10-day COVID-19 recovery period.
- You have been in hospital with COVID-19 in the last 28 days.
- You have received any other vaccination in the last 14 days.



Follow the medical advice you have been given if:

- You have been advised by a medical doctor not to get vaccinated
- You had a severe or immediate allergic reaction (within four hours) to your first dose of COVID19 vaccine

13. Will I get a bad reaction?

After you have had your vaccination, common effects that show the vaccine is working include mild pain and swelling at the injection site and occasionally, fever, headache, chills, tiredness, headaches, muscle pain and nausea. Very rare side effects include anaphylaxis and blood clots. Any side effects experienced; one should consult with your general practitioner.

14. When am I fully vaccinated?

It takes time for your body to build protection after the vaccine. People are considered fully vaccinated two weeks after their last shot of the COVID-19 vaccine. COVID-19 vaccines are highly effective; but none provide 100% protection. This means a very small number of people might become infected after being fully vaccinated, but these infections are rare and typically mild or symptom-free.

Even after you've been fully vaccinated against COVID-19, you should keep taking precautions in public places like wearing a mask, staying 2 meters apart from others, avoiding crowds and poorly ventilated spaces, and washing your hands often.



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