OLD MUTUAL SUPERFUND RETIREMENT SERIES QUESTIONS & ANSWERS

OLDMUTUAL

CORPORATE

SESSION 3 – MEDICAL AID

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(The answers which are given are general in nature, and therefore do not constitute financial or other professional advice. The answers do not take into account your specific circumstances and should not be acted on without full understanding of your current situation and future goals and objectives by a qualified financial adviser.)

Q. How do you choose a medical aid that changes their services every year? How do you know you will be covered for things now and later too?

Medical aids by law must send you a detailed benefit schedule of exactly what the different benefit options are every year. It is vitally important that you read the material your medical aid provides on what the changes and options for the new year are, and based on that, decide what your needs are and which of the options provided best suit your needs. Remember, it is not the option that is most cost-effective, but the one that offers the best cover for your medical needs.

Q. I just want to know if your retirement was at the age of 63 years and you had to leave at 60 years, what is going to happen about medical aid and retirement money?

I would first ask your Human Resources department about having to leave 3 years before retirement date. As regards your medical aid cover, in most cases the responsibility moves to you as a retired person to select what cover best suits your needs. I would engage a broker to help you make an informed choice.

Q. How is this new government medical aid thing affecting the current medical aid, to which I have paid into all my life and seen no benefit from?

The jury is still out on how the new National Health Insurance (NHI) fund will affect medical schemes, but the best guess at the moment is that a watered-down version of the Prescribed Minimum Benefit (PMB) of medical aids will become the new NHI fund. These benefits will be provided to citizens either through public health or private health facilities. The exact way in which medical aids will operate in conjunction with the NHI is not clear yet.

Q. When on retirement, are you still paying the same amount as now when staying on the same plan?

When you retire the contribution for your plan remains the same as if you were fully employed. Pensioners get no rebate or discount unless they have worked for an employer for a long time and are still on a defined benefit employment condition. However, most employers have convinced all employees to move from a defined benefit to defined contribution structure.

Q. Why do you have co-payment for chronic medication?

There are a number of reasons why you could have a co-payment on your chronic medicines:

- You are not using drugs on your plan's formulary
- You are not using generic and more cost-effective drugs
- Your pharmacy is not on your medical scheme's Designated Service Providers (DSP) network of approved pharmacies.

It is very important to talk to your pharmacist and your medical scheme's chronic department to help you understand why you have to pay a co-payment

Q. I want to visit the same doctor for a certain event and not hop around from one doctor to another for the same illness e.g. cardiologist if they are not on the network later. How can this be overcome?

You could talk to your scheme. However, most would not add a doctor for one member to its network of Designated Service Providers. Most Medical Schemes would prefer your health be managed by a GP on their network who can refer you to a specialist like a cardiologist when required. The cardiologist would then send a detailed report to your family doctor/GP as she/he would be required to coordinate all of your healthcare.

Q. I have been informed that there is in fact a difference between generic and prescribed medicine and I should insist on the prescribed. How much truth is there in this?

Using the generic version of prescription drugs can save you up to 40% on your medical expenses. Generic drugs are in most cases exactly the same as the prescribed drugs.

Q. What happens to my Medical Savings Account (MSA) balance if I exit the medical aid?

There are two things that can happen:

a) If you leave your existing medical aid to join a new one, and both are new generation products, then your Medical Savings Account (MSA) should be transferred legally to the new medical aid.

b) If you select either a hospital plan, traditional plan or network plan in the new medical aid, the MSA balance will be paid to you subject to being taxed.

Q. Shouldn't all illnesses be covered? One does not know what will go wrong with you in the future.

All illness is covered to a point by your medical aid. Not all benefits are paid from the insured benefits and that is where members become confused. The illness is covered but only to the benefit level determined in your plan. If all illness were covered 100%, medical scheme pricing will be much more than at present.

Q. Why do the medical companies not send the care plan automatically, rather than request this each time?

Most medical schemes I have belonged to in my career have sent me my annual benefit plan. Sometimes the details are covered in the annual communication to members. Sadly, most members do not read all the information received from their medical aid.

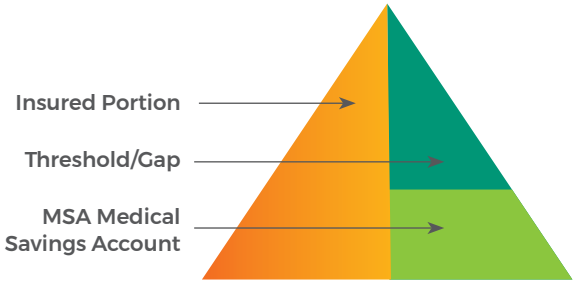
Q. Could you explain the threshold benefits, as this is rather confusing when you have reached your limits and this does not seem to be an automatic claim. In many cases one must request clarification e.g. from savings benefits reach limits etc.

On a new generation product, you have your insured benefits, which include your Prescribed Minimum Benefits (PMB) and then you have a portion that goes into your Medical Savings Account (MSA). You determine how the MSA is used to offset your medical expenses. Medical schemes will allow you to access your full annual MSA value in the first few months of an annual benefit year. Bear in mind that if you should leave your medical scheme before the end of that benefit cycle, the scheme will claw-back any money owing on the advanced benefits (prorated for the months you were a member). Once the MSA is depleted, you then go onto paying for claims yourself on a fixed amount that is pre-determined by your medical scheme which is called the self-funding gap. When this is exhausted, you kick into another benefit structure which is the threshold. Sometimes the threshold can have different sub limits and some benefits have unlimited access.

TRADITIONAL

- Most expensive
- No benefit rollover is the benefits are unused

NEW GENERATION



- Member picks savings which rolls over if unused

Q. What are the pros and cons if I exit a medical aid and re-join at a later date?

From a personal perspective, you will likely save money by joining at a later date. However, when you join again you might have one of the three penalties applied, e.g. for 3 months you will not receive any benefit payments for medical service, some of your existing conditions may be excluded for 12 months and/or you can have up to 75% of a penalty on your contributions. Therefore, it is not advisable to leave and join later as you will be penalised for that.

Q. If medical schemes are so regulated, why are the service providers not? The scale of rates can be astronomical from one provider to another.

If you go back about 20-30 years, the Counsel for Medical Schemes (CMS) did not exist. Instead, the regulatory body then, the Representative Authority of Medical Schemes (RAMS) had a scale of benefits that prohibited providers from charging more than this scale. Since then, the laws have changed, and providers are now allowed to charge in relation to their own professional bodies' tariff schedules. This means there is no limit to what a provider can charge, but there is a limit to what medical schemes will pay. There has been a lot of talk around how to address this, inclusive of a market enquiry, where a suggestion was made that administrative prices be applied for healthcare as it is a social good. Part of the current proposition for the National Health Insurance fund is to set administrative pricing where medical schemes will pay a certain amount and doctors will not be able to charge more than a certain amount. This however, is still in concept phase.

Q. What are expected medical aid/insurance costs in retirement, given that employer contributions no longer exist?

The reality is that you will have to cover 100% of the costs yourself.

Q. Is it of any benefit to remain on your current medical plan?

That depends on what your next year's healthcare needs will be. Use the suggested steps to determine which is the best plan for your future healthcare needs. Remember you can change your plan annually.

Q. When will National Health Insurance (NHI) came into effect and how will that effect medical schemes?

The answer is how long is a piece of string. No one knows the answer at this stage. Most people talk about it being implemented by 2026. Only time will tell. As mentioned in a reply above it is envisaged that NHI will determine a minimum benefit package for all. This could be obtained by either or a combination of public and private sector funders.

Q. How long can you go without medical aid until penalties kick in if you decide to take it out?

The most severe penalty is the late-joiner penalty, and that starts if you join a medical scheme after the age of 35. There is also the 3-month general waiting period and the 12-month condition specific penalty. You can offset your past medical scheme membership years against those when you did not belong to a medical aid, which could reduce the late-joiner penalty, however, you will still be liable for the other two penalties.

Q. Can you recommend affordable medical schemes for pensioners? I am currently with Discovery and will not be able to afford the premiums.

Your medical aid broker is best positioned to advise what will suit your needs.

Q. While the presenter has adequately addressed the options for those wishing to choose a medical aid how does the presentation/information presented relate to choosing a medical aid for retirement as this series is about Retirement Planning?

Choosing a medical plan while actively employed or as a retiree is the same. The principles do not change as detailed in the presentation.

Q. Nedbank scheme now requires all visits to a specialist to be preauthorised and referred from General Practitioner (GP), why is that the case?

If that is indeed so it supports the coordination of care model that has proven over many years to be the most cost effective and efficient way to deliver appropriate healthcare cover.

Q. Threshold limit. Do not stop claiming, otherwise you do not reach your limit and the threshold does not kick in.

This is true if you are on a new generation plan with a threshold. It is also valuable for a retiree as it will help you with tax returns and deductibles.

Q. When will the fees for next year be available?

Most medical schemes publish their new benefit plans in October – November of each year. Members then need to select their plans for the next year which CANNOT be changed during the year. The doctor fees are published by each society at different times. This is not always in the public domain.

Q. In retirement, can you change medical aids if the one you're currently on does not pay for certain events anymore, without being penalised?

You can only switch when there's a change in your employment, e.g. joining a new employer or going on retirement. Switching for any other reason will incur the relevant penalties discussed above and legislated in the Medical Scheme Act.

Q. When can you switch to another medical aid if you retire in December?

If you retire in December, you will have the option of switching plans and you can switch medical schemes to anyone that you choose, bearing in mind that you will need to be able to pay the contributions of the new medical aid. You will not be subject to any late-joiner penalties or any other penalties if you can supply the new medical scheme with copies of your previous membership certificates and you do not already have a late joiner penalty.

Q. I have a concern around the yearly increase in contributions in my retirement. This could result in a change of plan to a lesser plan. Is there a "pensioners" contribution?

When companies moved from Defined Benefit plans to Cost to Company, the risk was transferred to the employee, making them liable for the full contribution after retirement. There are no special rates or discounts for pensioners.

Q. Do retirees get a special premium on the various schemes?

See answer above.

Q. Should hospital plans not cover the same amount and types of benefits at any level at any medical aid?

To do so, they would have to cost the same, and the contributions would be higher.

Q. What advice do you give to someone that is retiring?

Make sure you are selecting a good Medical Scheme that has decent funding, that has been around for a while and that you are sure will be around going forward. Then you need to elect the option in that scheme that best suits your medical needs based on the questions detailed in the presentation. Lastly, make sure that every year you read all the information your medical scheme provides in regards to the changes to and options within the scheme. An additional safety precaution would be to appoint a medical scheme broker to review your selection to ensure what you have selected is solid and addresses your needs, and that you have not missed anything.

Q. Are medical rates significantly different between medical aids?

Always get a quote from a specialist, ask for a discount and check the cost of other services in your hospitalisation.

I strongly support the notion of getting prices and costs before incurring any medical service. 85% of all hospitalisation is planned and not an emergency, so you have time to plan and get costs and know what you can expect. We do that when we purchase other services. If you do this, you can negotiate with your doctor for the best price or alternatives. If you don't apprise yourself on what is going to be done to you and the costs, then nothing can be done about the surprises that may arise.

Q. Can the speaker explain the difference between doctors on the network, with a status of verified, contracted, and not on the network? This seems to have a knock-on effect e.g. the surgeon is not on the network, therefore all the specialists the surgeon deals with when performing the procedure, is likely not on the network, so then claims are only paid at scheme rates (100%).

Yes, this is correct. That is why you must ask for all the pricing and if they are on your schemes network. This additional upfront effort can save you thousands of Rands later.

Q. I have been a member of Nedbank for 21 years, and I'm not sure I can get the FedHealth and Cape Medical from the past before that.

I assume you are talking about a medical certificate of membership. If so, all you have to do is ask and you will be surprised.

If you are talking about becoming a member and if your reason for joining is that you are retiring, then you will be able to join them. However, remember that if you are retiring after having been with Nedbank for 21 years, you could remain on the Nedbank scheme and pay the contributions. Nedbank is a closed scheme and history has shown that closed employer-based schemes are cheaper than open commercial schemes.

Q. When we were much younger, there was no need to keep certificates from medical aids. Those medical aids no longer exist. How would we prove medical aid membership throughout our lives?

Whenever possible, where members leave a medical scheme, they should always request a copy of their membership certificates and retain them for future reference. The alternative is to supply copies of previous claim statements should the new scheme request proof of membership where members do not have their certificates and the scheme no longer exists. The Counsel of Medical Schemes can also provide you with further guidance where required.

Q. Can I make a change to my option during the year?

No, you can only change option/plan once a year, effective 1 January. These medical schemes send members the options for the next year from the end of September of each year. Most have a cut-off date for submitting option/plan change forms in November of each year. Some medical schemes have their annual cycle end from 1 April to 31 March. In that case your new year starts 1 April and you can change your plan during January and February, effective 1 April.

Q. If we travel abroad, is it necessary to inform the medical aid?

Yes, it is necessary. Some medical schemes have international travel cover as an additional benefit if you advise them before you travel. Remember that any claims incurred overseas if claimed when you return to South Africa will be reimbursed at the SA tariff in Rands and be subjected to normal benefit rules.

Q. Medical aid cards usually show the date you became a member.

Yes, that is correct.

Q. Does this presentation include Old Mutual Insure employees that are with the Nedgroup medical aid?

The presentation is a general overview of medical schemes, and not specific to any particular scheme.

Q. I tried using the app to retrieve my statement but no joy. I have input exactly as what it is in my ID.

I would suggest you call your medical schemes client services for assistance.

Q. What about the Platinum plan?

Thank you for the question. Unfortunately, this question is unclear and requires further context, which is why we are unable to provide an immediate response. Please do elaborate by sending an email to **omcorporateevents@oldmutual.com.**

Q. Where does one access reputable, independent medical aid brokers to provide a comparison of schemes and costs at retirement?

I would check with your employer before retirement to see if they have an existing Broker. You could also look on the Council for Medical Schemes (CMS) website https://www.medicalschemes.com CMS lists all accredited brokers. You could Google Health brokers in your area.

Q. I am retiring at the end of April 2021 and have been advised by my employer that we will not be able to stay on their medical aid once retired. I am receiving chronic medication. What are my best options in terms of finding another medical aid?

I would strongly recommend that you engage the services of a broker to assist you. Ask your employer who is their broker.

You may also wish to check your current schemes rules on conditions for continuation membership to make sure you can not remain. Many medical schemes allow employees to remain on the scheme provided they pay the full premiums.

Q. As an Old Mutual staff member, will I have to leave the Old Mutual medical aid on retirement (including early retirement)? If I have the option to stay on it, how will my retirement affect my premium?

You may also wish to check Old Mutual Medical Aid Scheme (MAS) rules on conditions for the continuation membership. Many Medical schemes allow employees to remain on the scheme provided they pay the full premiums

Q. Is the chronic cover provided by the Old Mutual medical aid a predetermined list of conditions?

You will need to get the benefit schedule and the rules of Old Mutual scheme. As a guideline all medical schemes need to provide cover for a list of 26 Conditions which cover the ones defined by Prescribed Medical Benefits (PMBs).

Q. Do most employees who retire from Old Mutual choose to stay on OMSMAF, or do the majority go on to an external medical aid? What's the trend?

Please get in touch with your fund administrator or Principle Officer of the scheme for more information.

Q. I am on the medical savings plan and have a chronic condition. Will the medication costs come from my savings or somewhere else?

If you have registered your chronic condition and have a benefit plan issued that lists your required chronic conditions, then most of the costs will be covered from insured benefits, if you meet the criteria and use the correct network and drug list. However, remember there could be co-payments if you use drugs that aren't on the Formulary list and doctors and pharmacies not on the network. If you meet all the above conditions and have one of the 26 Chronic PMB conditions, the benefits should be paid from your insured benefits and not your savings.

Q. Why is a bi-annual mammogram not common across all major schemes? The Nedgroup scheme does not provide for this.

Each scheme has different protocols and that is allowed. Please check your treatment plan issued each year.

Q. As we get older our health needs change. If you are on a lower level plan when you are younger and then want to move to a more comprehensive plan, will you have to pay penalties?

No, provided you make the move between plans during your scheme's option change window, (which for most schemes is Oct to Nov annually) you will not be penalised. You will however have to pay the higher premium for that plan.

Q. If you are on a lower cost plan and you have a stroke or a heart attack, can you move up to a higher plan after the event? If so, would you be charged a penalty due to your condition?

All plans will cover PMBs which includes heart attacks and some strokes. You can only change plans during the option change window, and you will not be penalised.

Q. Is there a waiting period if one moves from one scheme to another?

Provided, as I mentioned in the presentation, such a move is as a result of a change in employment or retiring and you have had continuous membership to that point without a waiting period, you will not now get a waiting period added.

Q. If the next date for changing plan options doesn't align with my date of retirement, can I still change to a different plan at retirement, or do I have to cancel and join another medical aid?

This depends on the rules of your current medical scheme. Please check the continuation rules for your scheme.

Q. Can dependents be on a different scheme from the main member?

Dependants can't be on a different plan to the main member unless they are on the plan as a main member and pay the main member fee.

Q. Please explain the difference between medical insurance and medical aid.

Medical insurance at the moment is subjected to an exemption which ends 31 March 2022. Medical insurance does not always cover the actual cost of medical services but pays out a Rand amount per event or per day. This amount could be less than the actual costs of the services. Whereas a medical scheme covers the actual cost of services but remember the network and protocols and formularies that apply.

Q. Is the medical certificate applicable to dependants leaving the scheme due to marriage?

Yes, and it is important that Medical certificates for periods of membership as a dependant on your parents' medical scheme are requested and kept.

Q. There has been talk of medical aids dropping late joiner penalties. Is this likely?

No, not likely until replaced by NHI provided by the State.

Q. What is the point of community rating if income is used to discriminate between member eligibility and premiums?

Community rating deals with Age-related charges which are not allowed. Income is allowed to determine contribution levels.

Q. Why can I not choose my benefits from my scheme? At age 57, I do not need maternity cover, but I need more dental and optometrist cover.

That is how benefit plans are determined. You get a range of benefits for a set price. if you could determine what you would like the premiums would be much higher as only you would elect those benefits you would use so there would be no cross subsidy between members.

Maybe you should consider having a medical plan with a savings account for routine care like Dental and Optometrists that will enable you to have choice into how you use your money. if there are funds left over at year end it will be transferred to the next and added to your new annual amount.

Q. Who can one appeal to if your medical aid refuses to pay under PMB?

You can appeal Council for Medical schemes www.medicalschemes.com.

Q. Where can I get Gap cover?

Old Mutual provides a good GAP cover product. You can also do a Google or contact any of the companies I listed in my presentation.

Q. I have a chronic condition and might require a transplant in the future. How can I find out what proportion of the costs of such a procedure my medical aid would cover so that I can factor my portion of the costs into my retirement planning?

Speak to your doctor and if you can get the procedure codes he will use you can send that to your medical scheme and they will let you know how much can be paid. Most transplants, if approved by a Medical scheme, are covered in full again depending on the provider and hospital you use and if they are on your plans network list.

Q. When should I register a condition as "chronic"? And how do I go about doing that?

As soon as your GP diagnoses you as having the condition and requires you to start taking medication or have annual test to measure your progress and level of condition.

Q. The reserve of 25% is great. But some medical aids have reserves of over 45%, which historically is the basis for overcharging for membership. Is this fair?

Many studies have shown that 25% for smaller schemes may not be enough. If your scheme has higher than 25% reserves, it benefits you as investment income is used to keep your annual contributions increases down.

Q. Why are there limits on the amount that can be allocated to a medical savings account?

That is normally based on how much you put into your medical savings account. It is also heavily regulated by Medical Schemes Act and regulations.

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