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South Africa

Medical aid, PMBs & gap cover guide

6 chapters · every source listed

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Medical aid, PMBs & gap cover guide 2026

For members of a medical scheme in South Africa, or people choosing one: prescribed minimum benefits, hospital plans, gap cover, the tax credit and where the NHI stands.

This guide puts together 6 pages of Tulinde South Africa (tulinde.co.za), word for word. Each chapter states the date it was last reviewed; the 16 sources are listed at the end. Compiled on 28 October 2026. Laws, prices and rules change: check the online version of each chapter (its address is under its title) before you rely on it.

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Chapter 1

Medical aid in South Africa: the 16 open schemes, what it costs and how to compare

Reviewed 28 October 2026 · online: https://tulinde.co.za/health-insurance/

Short answer Checked 28 October 2026

Medical aid in South Africa means membership of a **medical scheme registered under the Medical Schemes Act 131 of 1998** and supervised by the **Council for Medical Schemes (CMS)**. By the end of March 2026 there were **70 registered schemes (16 open, 54 restricted)** covering about **9.17 million beneficiaries**. Schemes may not price you on your health or age: contributions depend only on **income and number of dependants**, but a scheme can impose waiting periods of up to **3 months (general) and 12 months (condition-specific)** and a **late-joiner penalty** if you join at 35 or older.

Medical aid is a medical scheme, not an insurance policy

In South Africa the word "medical aid" refers to a **medical scheme** registered under the Medical Schemes Act 131 of 1998. Schemes are regulated by the **Council for Medical Schemes (CMS)**, set up by section 3 of the Act. Products sold by insurers — gap cover, hospital cash plans, travel medical cover — are a different thing, regulated by the insurance laws (see gap cover and hospital plans).

Three rules of the Act protect you whatever scheme you choose:

- **Community rating** — section 29(1)(n): contributions may be set only on the basis of **income, the number of dependants, or both**. Not on age, sex, past or present state of health, or how often you see a doctor.
- **No exclusion of applicants** — section 29(3)(a): a scheme's rules may not exclude an applicant or dependant, except where a restricted scheme limits who is eligible.
- **Prescribed Minimum Benefits** — Regulation 8: every benefit option must pay a defined list of conditions in full (see prescribed minimum benefits).

Open schemes and restricted schemes

	Open scheme	Restricted scheme
Who can join	Anyone who applies	Only people linked to an employer, industry, profession or other group named in the Act's definition of a "restricted membership scheme" (section 1)
Can refuse you?	No — section 29(3)(a)	Only if you are not eligible under its rules — section 29(3)(b)
Number (end of March 2026)	16	54

The figures come from the CMS Annual Report 2025/26, which counts **70 registered schemes**, **36 administrators**, **42 managed care organisations**, **2,182 broker organisations and 7,793 individual brokers**. The number of schemes has fallen from **144 in 2000**. Beneficiaries rose from about **9.13 million in 2023 to 9.17 million in 2024**.

If your employer has a restricted scheme, ask HR for its rules and benefit options before looking at open schemes: a scheme can only be compared with another once you know you are allowed to join it.

The 16 open medical schemes (CMS list, 31 March 2026)

Anyone can join these schemes. The list is the Council for Medical Schemes' register of schemes "registered in terms of the Medical Schemes Act (131 of 1998), as at 31 March 2026", printed in its Annual Report 2025/26. Alphabetical order, as on the register — Tulinde does not rank schemes.

Open medical scheme
Bestmed Medical Scheme
Bonitas Medical Fund
Cape Medical Plan
Compcare Medical Scheme
Discovery Health Medical Scheme
Fedhealth Medical Scheme
Genesis Medical Scheme
KeyHealth Medical Scheme
Makoti Medical Scheme
Medihelp Medical Scheme
Medimed Medical Scheme
Medshield Medical Scheme
Momentum Medical Scheme
Sizwe Hosmed Medical Fund
Suremed Health
Thebemed Medical Scheme

The other **54** registered schemes are **restricted** — for the employees of a company, an industry or a profession (for example GEMS for government employees, POLMED for the police, Bankmed or Profmed). Ask your employer's HR first: if you are eligible for a restricted scheme, it belongs in your comparison.

Check the scheme's financial health too. The CMS reported that **Sizwe Hosmed Medical Fund** was placed under **curatorship on 4 September 2025**, and that, on unaudited figures at 31 December 2025, Sizwe Hosmed (14.07%), Compcare (21.59%) and the restricted scheme GEMS (24.70%) were below the **25% minimum solvency** of Regulation 29, each with a business plan or curatorship in place (CMS Annual Report 2025/26). Check the latest CMS report before you join or switch.

What medical aid costs in 2026: the official averages

Each scheme sets its own contribution table per option, so there is no single price. The CMS publishes the **average** monthly contribution across all options (Tables 60 and 61, CMS Annual Report 2025/26). "Gross" includes the medical savings account; "risk" is the pooled part only.

Average monthly contribution, 2026	Open schemes (gross)	Restricted schemes (gross)	All schemes (gross)	All schemes (risk)
Main member	R3,969	R3,407	R3,759	R3,394
Adult dependant	R3,493	R2,798	R3,208	R2,894
Child dependant	R1,407	R1,310	R1,356	R1,237
Weighted average per beneficiary	R3,146	R2,434	R2,839	R2,567

For an **average family** (1 member, 0.45 adult dependant and 0.74 child dependant), the CMS puts the gross contribution at **R6,204.78 a month in 2026**, up **6.7%** from R5,817.16 in 2025; the risk contribution rose 7.0% to R5,610.30. Gross contributions rose **6.8%** on average for 2026, against projected CPI of 3.4%.

These are averages over every option, from hospital plans to comprehensive cover: your quote can be well above or below them.

Cheapest medical aid: the options the law allows

There is no official "cheapest medical aid" and Tulinde does not rank schemes. What the law does say is which kinds of cover cost less — and what each gives up:

Lower-cost route	What you keep	What you give up
Hospital plan option of a registered scheme	Hospital cover per the rules, **all PMBs in full** (Regulation 8), community rating	Most day-to-day benefits — see hospital plans
Network or DSP option	The same PMB protection, at the scheme's designated hospitals and doctors	A co-payment if you voluntarily use a provider outside the network (Regulation 8(2))
Income-banded option	Contributions set by income band — the Act allows pricing by income and dependants only (s 29(1)(n))	Read the option's benefits, limits and networks in its rules before you choose a band
Primary health care insurance (not a medical scheme)	Primary health care cover sold by insurers under a CMS exemption, extended to **31 March 2027** (CMS Circular 9 of 2025)	It is insurance, not medical aid: Regulation 8 binds medical scheme options only, so no PMB guarantee

Sources: the Medical Schemes Act and Regulations and the CMS Annual Report 2025/26, which also notes that the Low-Cost Benefit Option framework for schemes was still under review in 2026. The cheapest contribution is not always the cheapest year: add the co-payments and the out-of-pocket costs below. Each scheme's lowest and highest published 2026 contribution, side by side: compare medical aid schemes.

Waiting periods: what a scheme may and may not impose

Section 29A of the Act is the only source of waiting periods a scheme can apply. What you face depends on your cover in the last 90 days:

Your situation when you apply	General waiting period	Condition-specific waiting period
No medical scheme cover in the 90 days before applying — s.29A(1)	Up to 3 months	Up to 12 months
Covered for up to 24 months, ended less than 90 days ago — s.29A(2)	Only the unexpired part of a previous waiting period	Up to 12 months, but not for PMBs
Covered for more than 24 months, ended less than 90 days ago — s.29A(3)	Up to 3 months, but not for PMBs	None
Moving because you changed jobs or your employer changed scheme — s.29A(6)	None (except the unexpired part of an old one, s.29A(8))	None
Changing option within the same scheme — s.29A(4)	None (except the unexpired part of an old one)	None
Child born while you are a member — s.29A(5)	None	None

A condition-specific waiting period applies to conditions for which you received or were recommended advice, diagnosis, care or treatment in the **12 months** before applying — the scheme may only ask for a medical report about that period (s.29A(7)), and it must pay for any tests it requires (Regulation 12).

> Keep proof of every period of cover (membership certificates). A break of **90 days or more** puts you back in the strictest category of section 29A.

Late-joiner penalties: the exact bands

Regulation 13 allows a scheme to add a **late-joiner penalty** to the contribution of a member or adult dependant who is **35 or older** when applying (Regulation 11). People who were continuously covered since before 1 April 2001 without a break of more than three months are not late joiners. The penalty applies only to that person's share of the contribution, and it may follow you if you move scheme (Regulation 13(5)).

The band is found with the formula **A = B − (35 + C)**: B is your age when you apply, C is your years of "creditable coverage" (earlier scheme membership, excluding years as a dependant under 21).

A (years)	Maximum penalty
1 – 4	0.05 × contribution (5%)
5 – 14	0.25 × contribution (25%)
15 – 24	0.5 × contribution (50%)
25 or more	0.75 × contribution (75%)

Example: you apply at **45** with **2 years** of earlier cover. A = 45 − (35 + 2) = 8, so the band is 5–14 and the scheme may load your contribution by up to **25%**. If you later prove more creditable coverage, the scheme must recalculate the penalty from that date (Regulation 13(4)); a sworn affidavit is accepted when documents cannot be found (Regulation 13(6)). These are maximums: the scheme's rules say what it actually applies.

How to compare medical aid cost honestly

There is no official "cheapest medical aid": each scheme publishes its own contribution table every year, and the right price depends on your income band, your dependants and the benefits you will actually use. Tulinde does not rank schemes. Compare like this:

1. **Check the scheme is registered** on the CMS list of regulated entities — and that the broker who advises you is accredited.
2. **Ask for the rules and the benefit schedule of each option**, not a brochure. The rules are what the scheme must pay (section 29).
3. **Work out a full year**: monthly contribution × 12, plus the co-payments and day-to-day limits for what your family used last year. A low contribution with a small savings account can cost more over a year.
4. **Check the designated service providers (DSPs)** for hospital and chronic medicine: using another provider can mean a co-payment (Regulation 8(2)).
5. **Ask in writing** which waiting periods and late-joiner penalty they will apply to you, with the section 29A paragraph and Regulation 13 band.
6. **Check what you would still pay yourself**: the CMS reports that out-of-pocket payments by scheme members reached **R46.3 billion in 2024**, led by medicines (35.09%) and specialists (28.47%) (CMS Annual Report 2025/26). Shortfalls on specialist bills are what gap cover is sold for.

7. **Count the tax credit**: SARS deducts a fixed monthly credit per member and dependant from your income tax, whatever the option — see medical aid tax credit.

If your scheme refuses to pay

First use the scheme's own dispute process. If it fails, complain to the CMS by e-mail to complaints@medicalschemes.co.za with the complaint form, proof that you escalated to the scheme, and your accounts (CMS). The CMS asks for complaints preferably within **3 years**. Under section 47 the Registrar sends your complaint to the scheme, which has **30 days** to reply; a decision can be appealed to the Council within **3 months** (section 48). In 2025/26 the CMS registered **2,455 formal complaints**. The CMS, its complaint form and contacts: Council for Medical Schemes. More on complaints and policyholder rights.

Frequently asked questions

What is the Council for Medical Schemes?

The statutory regulator of medical schemes, established by section 3 of the Medical Schemes Act 131 of 1998. It registers schemes, accredits administrators, managed care organisations and brokers, and handles complaints against them.

How many medical aid schemes are there in South Africa?

70 registered schemes at the end of March 2026 — 16 open and 54 restricted — according to the CMS Annual Report 2025/26.

Can a medical aid refuse me because I am sick?

An open scheme may not exclude you (section 29(3)(a)) and may not set your contribution by your health (section 29(1)(n)). It may impose waiting periods within the limits of section 29A.

What is the late-joiner penalty?

A loading of up to 5%, 25%, 50% or 75% of the contribution, under Regulation 13, for people who join at 35 or older without enough years of earlier cover. The band is A = age − (35 + years of creditable coverage).

Is medical aid tax deductible in South Africa?

Not as a deduction, but as a tax credit: for the 2027 tax year, R376 a month for the main member, R752 with one dependant and R254 for each extra dependant (SARS), plus an additional credit for out-of-pocket costs. See medical aid tax credit.

Which is the cheapest medical aid?

No official ranking exists and Tulinde does not rank schemes. The lower-cost routes the law allows are a scheme's hospital plan, network or income-banded options — all still pay PMBs in full — or a primary health care insurance product, which is not medical aid. Compare the full-year cost of each

option — contributions plus co-payments and limits — from the scheme's own rules and benefit schedule.

Which medical aids are open schemes in South Africa?

16 at 31 March 2026 (CMS): Bestmed, Bonitas, Cape Medical Plan, Compcare, Discovery Health Medical Scheme, Fedhealth, Genesis, KeyHealth, Makoti, Medihelp, Medimed, Medshield, Momentum Medical Scheme, Sizwe Hosmed, Suremed Health and Thebemed.

How much is medical aid per month in 2026?

It depends on the scheme, option, income band and dependants. The CMS average for 2026 is R3,759 a month for a main member (R3,969 in open schemes), R3,208 for an adult dependant and R1,356 for a child, gross of savings; an average family pays R6,204.78 a month.

Chapter 2

Prescribed Minimum Benefits (PMBs): what every medical aid must pay

Reviewed 28 October 2026 · online: https://tulinde.co.za/prescribed-minimum-benefits/

Short answer Checked 28 October 2026

Prescribed Minimum Benefits (PMBs) are the conditions that **every medical scheme benefit option must pay in full, without co-payment or deductible** (Regulation 8 of the Medical Schemes Act regulations). They cover **any emergency medical condition**, about **271 conditions listed as Diagnosis and Treatment Pairs** and **26 chronic conditions** on the Chronic Disease List, according to the Council for Medical Schemes. Your scheme may require you to use its **designated service provider (DSP)**, and can charge a co-payment if you choose another provider voluntarily.

What the law says

Regulation 8(1) of the regulations under the Medical Schemes Act: "any benefit option that is offered by a medical scheme must pay in full, without co-payment or the use of deductibles, the diagnosis, treatment and care costs of the prescribed minimum benefit conditions."

Regulation 7 defines a PMB condition as a condition in the **Diagnosis and Treatment Pairs (DTPs) of Annexure A** or **any emergency medical condition**. Annexure A also contains the **Chronic Disease List (CDL)**.

PMBs matter in money terms: the CMS reports that schemes spent **R135.66 billion on PMBs in 2024**, **52.31% of all benefits paid** (CMS Annual Report 2025/26).

The three parts of the PMB package

Part	What it covers	Source
Emergencies	The sudden, unexpected onset of a condition needing immediate treatment, where no treatment would seriously impair bodily functions or organs, or put life in serious jeopardy	Regulation 7
Diagnosis and Treatment Pairs	About 271 conditions, each paired with a treatment (for example a condition and the operation or medical management it needs)	Annexure A; CMS count
Chronic Disease List	26 chronic conditions: diagnosis, medical management and medicine, as set by treatment algorithms published in the Gazette	Annexure A; CMS count

The CMS PMB page lists the CDL conditions: Addison's disease, asthma, bipolar mood disorder, bronchiectasis, cardiac failure, cardiomyopathy, chronic obstructive pulmonary disorder, chronic renal disease, coronary artery disease, Crohn's disease, diabetes insipidus, diabetes mellitus types 1 and 2, dysrhythmias, epilepsy, glaucoma, haemophilia, hyperlipidaemia, hypertension, hypothyroidism, multiple sclerosis, Parkinson's disease, rheumatoid arthritis, schizophrenia, systemic lupus erythematosus and ulcerative colitis (diabetes types 1 and 2 count as two, which gives 26).

> **Exclusions do not apply to PMBs.** The CMS example: cosmetic surgery stays excluded, but if you develop septicaemia after it, the septicaemia is a PMB and must be covered. PMBs are diagnosis-based — how you got the condition does not matter.

Some HIV care and menopausal management are part of the DTPs; for these, the CMS says public-sector treatment protocols apply.

Designated service providers and co-payments

Regulation 8(2) lets a scheme's rules say that a PMB is paid in full only if you use its **designated service provider (DSP)** — a hospital group, pharmacy network or doctors chosen by the scheme — and that a **co-payment** set in the rules applies if you go elsewhere.

But **no co-payment is allowed when you used another provider involuntarily**. Regulation 8(3) says this is the case when:

- the service was not available from the DSP, or not without unreasonable delay;
- you needed immediate treatment in circumstances or a place that reasonably prevented you from reaching the DSP (an emergency or accident); or
- there was no DSP within reasonable distance of your home or workplace.

A scheme may also use **pre-authorisation, treatment protocols and formularies** (Regulation 8(4)). If you knowingly refuse a formulary medicine that is appropriate and choose another, a co-payment may apply (Regulation 8(5)). In an emergency, a scheme may not stop a provider from treating you before authorisation is given (Regulation 8(6)).

How to get a PMB claim paid

1. **Make sure the diagnosis is coded correctly.** The CMS explains that PMBs are identified by ICD-10 codes on the account and prescription; a wrong code can send the claim to your savings account or leave it unpaid once limits are used.
2. **Ask your doctor to say it is a PMB condition** and, for planned treatment, get pre-authorisation from the scheme.
3. **Register chronic conditions** on the scheme's chronic medicine programme so medicine, consultations and tests for a CDL condition are paid as PMBs.
4. **Use the DSP and formulary** if your option has them, unless one of the Regulation 8(3) situations applies — then write down why.
5. **If a claim is paid from savings or short-paid, dispute it in writing** with the scheme, quoting Regulation 8(1) and the ICD-10 code.
6. **Then complain to the CMS** (complaints@medicalschemes.co.za) with the complaint form, proof that you escalated to the scheme, clinical reports and the account statements (CMS complaints procedure).

In 2025/26 the CMS registered **2,455 formal complaints**, issued **602 clinical opinions** and resolved **1,879 complaints** (CMS Annual Report 2025/26). A decision on a complaint can be appealed to the Council within **3 months** (section 48 of the Act). See also complaints.

What PMBs do not do

- They do not cover every illness — only the conditions in Annexure A and emergencies. Treatment beyond what the DTP or CDL algorithm describes is paid by your option's normal benefits, if at all.
- They do not oblige the scheme to pay any provider's full fee when you voluntarily ignore the DSP: a co-payment set in the rules may apply.
- New members without recent cover can still face a waiting period: section 29A(1) does not exempt PMBs, while sections 29A(2) and (3) do for people who had cover until less than 90 days

before joining (see medical aid).

Frequently asked questions

What are prescribed minimum benefits?

A minimum set of conditions — emergencies, about 271 diagnosis-treatment pairs and 26 chronic conditions — that every medical scheme option must pay in full under Regulation 8 of the Medical Schemes Act regulations.

How many chronic conditions are PMBs?

26 on the Chronic Disease List, according to the Council for Medical Schemes (diabetes mellitus types 1 and 2 are counted separately).

Can my medical aid charge a co-payment on a PMB?

Only if its rules name a designated service provider and you chose another provider voluntarily, or knowingly refused a suitable formulary medicine. No co-payment applies when you used another provider involuntarily (Regulation 8(3)).

Does a hospital plan cover PMBs?

Yes. Regulation 8 applies to every benefit option a scheme offers, including hospital plan options. See hospital plans.

Are there 26 or 27 chronic conditions on the PMB list?

The Council for Medical Schemes counts 26 Chronic Disease List conditions, with diabetes mellitus types 1 and 2 counted separately. If a document shows another number, compare it condition by condition with the CMS list and Annexure A of the Regulations.

Is pregnancy a prescribed minimum benefit?

Yes, for hospital care: Annexure A lists the pair "pregnancy — antenatal and obstetric care necessitating hospitalisation, including delivery", alongside conditions such as ectopic pregnancy. Antenatal visits out of hospital depend on your option's rules.

Is an emergency always a PMB?

Yes. Regulation 7 makes any emergency medical condition a PMB condition, and Regulation 8(6) says a scheme may not stop a provider from treating you in an emergency before authorisation is given.

Where do I complain if my PMB claim is rejected?

First to your scheme, then to the Council for Medical Schemes at complaints@medicalschemes.co.za, with proof of the escalation and your accounts. See Council for Medical Schemes.

Chapter 3

Hospital plan vs comprehensive medical aid vs hospital cash plan

Reviewed 28 October 2026 · online: https://tulinde.co.za/hospital-plan/

Short answer Checked 28 October 2026

In South Africa a **hospital plan** is a **benefit option of a registered medical scheme** that mainly covers hospital admissions; like every option it must pay the **Prescribed Minimum Benefits** in full. A **comprehensive option** of the same scheme adds day-to-day cover. A **hospital cash plan** is different: it is an **insurance policy** that pays a fixed amount per day in hospital — limited in 2026 to about **R4,537 per day** — for non-medical costs, and cannot replace medical aid.

The three products side by side

	Hospital plan option	Comprehensive option	Hospital cash plan
What it is	A benefit option of a medical scheme	A benefit option of a medical scheme	Insurance: "non-medical expense cover as a result of hospitalisation"
Supervised by	Council for Medical Schemes	Council for Medical Schemes	Insurance regulator (Demarcation Regulations, category 2)
Law behind the product	Medical Schemes Act	Medical Schemes Act	Long-term or Short-term Insurance Act regulations
Prescribed Minimum Benefits	Yes, in full (Regulation 8)	Yes, in full (Regulation 8)	No
Day-to-day doctor visits, medicine	Limited or none, per the option's rules	Yes, within the option's limits	No
Price based on	Income and dependants only (s.29(1)(n))	Income and dependants only (s.29(1)(n))	Group rating; higher premium allowed by entry age
What it pays	Hospital accounts, per the option's rules	Hospital and day-to-day accounts	A fixed sum per day or a lump sum, not linked to the bill

Sources: the Medical Schemes Act and Regulations and the Demarcation Regulations.

A hospital plan is still medical aid

Because a hospital plan is a scheme option, you get every protection of the Medical Schemes Act: no refusal by an open scheme (s.29(3)(a)), contributions set only by income and dependants (s.29(1)(n)), and the waiting-period limits of s.29A (see medical aid).

Regulation 8(1) obliges **any benefit option** to pay the PMBs in full — so a hospital plan must also pay for the **26 chronic conditions** on the Chronic Disease List and the PMB conditions treated out

of hospital, through its designated service providers (see PMBs).

What a hospital plan usually leaves to you: GP visits, acute medicine, dentistry and optometry that are not PMBs. The CMS reports that hospital services were **35.95% of all benefits paid** by schemes in 2024 (CMS Annual Report 2025/26) — hospital cover is the biggest risk a scheme carries for you.

Hospital cash plans: the limits for 2026

Category 2 of the Demarcation Regulations allows insurers to pay **a fixed sum per insured person per day** in hospital, or a **maximum lump sum per year** whatever the number of days. The benefit must start no later than after **3 days** in hospital, then counts from day 1, and **may not be paid to the hospital or doctor**. It may not indemnify you for medical expenses (Regulation 7.3(1)).

Limit (from 1 April 2026)	Long-term Insurance Act table	Short-term Insurance Act table
Per insured person per day	R4,537.18	R4,537.61
Maximum lump sum per year	R30,250.74	R30,312.74

Sources: Treasury's 2026 escalation tables for the Long-term and Short-term Insurance Acts, published with the 1 September 2026 media statement (CPI 3.2%). The two annexures print slightly different amounts; the original 2017 limits were R3,000 per day or R20,000 per year.

> By law, a hospital cash plan may not be marketed with the word "hospital" or "medical" on its own: it must be called **non-medical expense cover as a result of hospitalisation**, and its marketing must say it is **not a medical scheme** (Regulation 7.5). A product sold as a "hospital plan" by an insurer rather than a registered scheme deserves a question.

Which one fits you?

- **You want protection against a big hospital bill at the lowest contribution**: compare hospital plan options of registered schemes. Check the hospital network (DSP) and co-payments for specific procedures in the rules.
- **Your family sees a doctor often or takes regular non-chronic medicine**: price a comprehensive or savings option over a full year, not just the monthly contribution.

- **You already have medical aid and worry about specialist shortfalls**: that is the job of gap cover, not a hospital cash plan.
- **You want cash for transport, childcare or lost income while in hospital**: a hospital cash plan can help, within the 2026 daily limit — but it does not pay medical bills.

Frequently asked questions

What does a hospital plan cover in South Africa?

Hospital admissions according to the option's rules, plus all Prescribed Minimum Benefits in full, including the 26 chronic conditions — because a hospital plan is a medical scheme benefit option.

Is a hospital cash plan the same as a hospital plan?

No. A hospital cash plan is an insurance policy that pays a fixed amount per day in hospital (about R4,537 per day from 1 April 2026) for non-medical costs. It is not medical aid and does not pay PMBs.

Can I have a hospital plan and gap cover together?

Yes. Gap cover pays part of the difference between a provider's bill and what your scheme paid, within R226,881.03 per insured person per year from 1 April 2026.

Is a hospital plan cheaper than medical aid?

A hospital plan is a medical aid option, so compare it inside each scheme's own contribution table: it leaves out most day-to-day benefits, which is what you trade for the lower contribution. The CMS 2026 averages across all options are R3,759 a month for a main member and R6,204.78 for an average family (gross) — see medical aid.

Does a hospital plan cover emergencies?

Yes. Any emergency medical condition is a Prescribed Minimum Benefit (Regulation 7), and every benefit option, including a hospital plan, must pay PMBs in full (Regulation 8); in an emergency the scheme may not stop treatment before authorisation (Regulation 8(6)).

Can a hospital plan refuse me because of my health?

An open scheme may not refuse you (section 29(3)(a)) or price you on your health (section 29(1)(n)), but it can apply waiting periods under section 29A and a late-joiner penalty if you are 35 or older.

Chapter 4

Gap cover in South Africa: what it pays, its 2026 limit and when it is worth it

Reviewed 28 October 2026 · online: https://tulinde.co.za/gap-cover/

Short answer Checked 28 October 2026

Gap cover is a short-term insurance policy — called **"medical expense shortfall"** cover in the law — that pays **the difference between what a health service costs and what your medical scheme paid**. Under the Demarcation Regulations its benefits may not exceed, in aggregate, **R226,881.03 per insured person per year from 1 April 2026** (National Treasury, 1 September 2026). It **does not replace medical aid**: it only pays on top of a scheme's payment.

What gap cover is in law

Insurers may sell some health products without being a medical scheme only if they fit the **Demarcation Regulations** — Part 7 of the regulations under the Short-term Insurance Act (and the matching part under the Long-term Insurance Act). Category 1 of the table in Regulation 7.2(1) is the **medical expense shortfall** contract: its purpose is "to cover the difference or a part of the difference between the total costs or expenses of a relevant health service and the amount a person's medical scheme paid towards such costs".

This is the product sold as gap cover. What a given policy pays (a multiple of the scheme rate, co-payments, cancer shortfalls…) is set in its own terms — read the policy schedule.

The annual limit for 2026

The original limit was **R150,000 per insured person per year** from 1 April 2017. Regulation 7.2(2) escalates it every year by CPI. On **1 September 2026** National Treasury published the 2026 amounts: the escalation uses the **2025 CPI of 3.2%** (media statement).

Effective date	Maximum gap cover benefits per insured person per year (in aggregate)
1 April 2017	R150,000.00
1 April 2024	R210,580.06
1 April 2025	R219,845.96
1 April 2026	**R226,881.03**

Source: Treasury annexure for the Short-term Insurance Act. The limit is **per insured person**, not per policy, and applies from **1 April 2026** until the next escalation date (1 April 2027).

Rules that protect you

Regulation 7.3 of the Demarcation Regulations applies to gap cover:

- **Group underwriting, no discrimination**: no pricing or refusal on race, age, gender, state of health or similar grounds — but a higher premium may apply to everyone who joins a product line after a given age.
- **The insurer may not refuse you** unless you previously committed insurance fraud.
- **Waiting periods**: up to **3 months general** and up to **12 months** for a condition you were treated for in the 12 months before joining. No new condition-specific waiting period if you had a similar policy for at least 90 days and had already served it.
- **Premium increases** may follow the claims of the whole product line, not your own claims.
- **Cancellation by the insurer** only for non-payment, fraud, or closure of the product line with **90 days' notice**.
- **Commission caps**: from 5% (premium above R1,200 a month) to 20% (below R300) — Regulation 5.3.

Is gap cover worth it? What the official figures show

Gap cover exists because schemes pay specialists and hospitals at their own rate, and the bill can be higher. The CMS measures what members pay themselves: **out-of-pocket payments reached R46.3 billion in 2024**; medicines were the largest part (**35.09%**) and payments to **specialists rose from 27.59% to 28.47%** of the total (CMS Annual Report 2025/26).

- **More useful** if your option pays specialists at 100% of the scheme rate, you expect a planned operation, a birth or cancer treatment, or your family's specialists charge above the scheme rate.

- **Less useful** if your scheme option already pays a higher multiple of its rate, or you use network specialists who agree to charge the scheme rate.
- **Check the overlap**: medicines were the largest out-of-pocket item in the CMS figures, so read the policy schedule to see whether out-of-hospital costs are covered at all.

Gap cover premiums are set per product line, and a higher premium may apply to everyone who joins after a set age (Regulation 7.3 of the Demarcation Regulations). Ask for the premium in writing and compare it with the shortfalls on your last year's accounts.

What gap cover cannot do

- **It cannot replace a medical scheme.** It pays only the gap after your scheme has paid, so without medical aid there is nothing to top up. Its marketing must carry the statement: "This is not a medical scheme and the cover is not the same as that of a medical scheme. This policy is not a substitute for medical scheme membership." (Regulation 7.5).
- **It cannot pay more than the annual limit** — R226,881.03 per insured person for the year from 1 April 2026.
- **It does not change your scheme's obligations**: Prescribed Minimum Benefits must still be paid in full by the scheme when you use its designated provider (see PMBs).

> Before buying, ask the insurer: what is paid as a multiple of the scheme rate, which waiting periods apply to you, and whether out-of-hospital procedures are covered. Compare with what your medical aid option already pays.

Complaints about a gap cover claim

Gap cover is insurance, not a medical scheme. A rejected gap cover claim goes first to the insurer, then to the ombud: for complaints against short- and long-term insurers the CMS points to nfosa.co.za (CMS). See complaints.

Frequently asked questions

What is the gap cover limit for 2026?
R226,881.03 per insured person per year, in aggregate, from 1 April 2026 — the CPI-escalated amount published by National Treasury on 1 September 2026.

Can I buy gap cover without medical aid?
Gap cover pays the difference between the cost of a health service and what your medical scheme paid, so it only works on top of medical scheme membership.

Is there a waiting period on gap cover?

Insurers may apply up to 3 months general waiting period and up to 12 months for conditions treated in the 12 months before joining (Regulation 7.3(5)).

Can a gap cover insurer refuse me?

Only if you previously committed a fraudulent act related to insurance (Regulation 7.3(3)).

Is gap cover worth it in South Africa?

It depends on how your scheme option pays specialists. The CMS reports R46.3 billion of out-of-pocket payments by scheme members in 2024, with specialists at 28.47% of that total — the shortfall gap cover is designed to pay, within R226,881.03 per insured person per year from 1 April 2026.

Is gap cover the same as medical aid?

No. Gap cover is short-term insurance under the Demarcation Regulations; by law its marketing must state that it is not a medical scheme and not a substitute for medical scheme membership (Regulation 7.5).

Chapter 5

Medical aid tax credit 2026/27: the amounts, who gets them and the additional credit

Reviewed 28 October 2026 · online: https://tulinde.co.za/medical-aid-tax-credit/

Short answer Checked 28 October 2026

For the **2027 tax year (1 March 2026 to 28 February 2027)**, the **medical scheme fees tax credit** is **R376 a month** for the taxpayer, **R752** for the taxpayer and one dependant, and **R254** for each additional dependant (SARS). It is deducted from the income tax you owe, whatever your age. On top of it, the **additional medical expenses tax credit** gives back **33.3%** of qualifying out-of-pocket costs (and of fees above three times the credit) if you are 65 or older or a person with a disability is in the family, and **25%** of costs above **7.5% of taxable income** for everyone else.

The monthly amounts

From SARS's medical tax credit rates, updated on 25 February 2026 with the Budget:

Who the fees cover	2027 tax year (Mar 2026 – Feb 2027)	2026 tax year	2025 tax year
The taxpayer (or one dependant, if the taxpayer is not a member)	R376	R364	R364
The taxpayer and one dependant (or two dependants)	R752	R728	R728
Each additional dependant	R254	R246	R246

Worked out from these SARS amounts, a family of a main member, a spouse and two children on medical aid for the whole 2027 tax year gets **R752 + 2 × R254 = R1,260 a month**, or **R15,120 for the year**, off its income tax. The credit is applied month by month for each month the fees were paid.

> The credit is deducted from the normal tax you owe. It applies only to fees paid to a medical scheme registered under the Medical Schemes Act (or a similar fund registered abroad) (SARS, Taxation in South Africa 2026, §2.17). Gap cover and hospital cash plans are insurance policies, not medical schemes.

Who gets the credit

- **Every age.** Since the switch from deductions to credits, the credit applies "irrespective of their age and whether or not they or their dependant(s) are persons with a disability" (SARS, §2.17).
- **Paying for a parent.** If you are not on medical aid yourself but pay the fees of a dependant who is — a parent, for example — you get the first-person credit (SARS, §2.17).
- **Employer-paid fees.** Contributions your employer pays for you are a taxable fringe benefit, but they are **deemed paid by you** for the credit (SARS, §2.17). Your payroll usually applies the credit through PAYE.

The additional medical expenses tax credit (section 6B)

Out-of-pocket medical costs that your scheme did not pay — co-payments, costs above the scheme rate, medicines, and so on — can earn a second credit. How much depends on your category (SARS, Taxation in South Africa 2026, §2.18):

Category	Additional credit
Aged 65 or older	33.3% of the medical aid fees above **3 ×** your monthly credits, plus 33.3% of qualifying out-of-pocket expenses
You, your spouse or your child has a disability (as defined in s 6B(1))	Same as above: 33.3% of fees above 3 × the credits, plus 33.3% of qualifying expenses
Everyone else	25% of the amount by which [fees above **4 ×** the credits + qualifying expenses] exceeds **7.5% of taxable income**

SARS's own example, from Taxation in South Africa 2026 (2026 tax year, under 65): fees of R22,800, minus 4 × R4,368 of credits = R5,328; plus R30,000 of qualifying expenses = R35,328; minus 7.5% of a taxable income of R410,000 (R30,750) = **R4,578**; 25% of that = an additional credit of **R1,144.50**.

A second SARS example (same guide, 2026 tax year): a taxpayer aged **66** who is **not on medical aid** and paid **R13,800** of qualifying medical expenses gets an additional credit of **33.3% × R13,800 = R4,595.40**, with no income threshold — because the 7.5% rule applies only to the "any other case" category.

The detailed rules — what counts as a qualifying expense and how a disability is confirmed — are in SARS's Guide on the Determination of Medical Tax Credits (IT07).

How to claim it

1. **Employees**: give your employer your medical aid details and the number of dependants; the monthly credit is then applied in your PAYE.
2. **At filing season**: your scheme sends a **tax certificate** for the tax year. Check the months, the dependants and the fees on it against your return.
3. **Out-of-pocket costs**: keep invoices and proof of payment for every expense the scheme did not pay; they support the additional credit on assessment.

How medical aid works, waiting periods and late-joiner penalties: medical aid in South Africa. What your scheme must pay in full: prescribed minimum benefits. Covering the gap between the scheme rate and the specialist's fee: gap cover.

> Premiums for policies that cover loss of income through illness, injury, disability, unemployment or death are **not** deductible: section 23(r) of the Income Tax Act prohibits it (SARS, Taxation in South Africa 2026).

Frequently asked questions

What is the medical aid tax credit for 2026/27?

For the 2027 tax year (1 March 2026 to 28 February 2027): R376 a month for the taxpayer, R752 for the taxpayer and one dependant, and R254 for each additional dependant (SARS, rates updated 25 February 2026).

What was the medical tax credit in 2026?

For the 2026 tax year (1 March 2025 to 28 February 2026) it was R364 for the taxpayer, R728 with one dependant and R246 for each additional dependant — unchanged from the 2025 tax year.

Do pensioners get a bigger medical tax credit?

The monthly credit is the same at every age. Taxpayers aged 65 or older get a larger additional credit: 33.3% of fees above three times their credits plus 33.3% of qualifying out-of-pocket expenses, with no 7.5%-of-income threshold.

Can I claim the tax credit for my parents' medical aid?

Yes, if your parent is your dependant and you pay the fees. If you are not a member yourself, you get the first-person amount (R376 a month in the 2027 tax year).

Is the medical tax credit a deduction?

No. Since 1 March 2012 (1 March 2014 for taxpayers aged 65 or older) it is a credit deducted from the tax you owe, not from your income (SARS medical tax credit rates page).

Does gap cover qualify for the medical tax credit?

No. The credit applies to fees paid to a medical scheme registered under the Medical Schemes Act. Gap cover is an insurance policy.

Chapter 6

NHI in South Africa: where the National Health Insurance Act stands in October 2026

Reviewed 28 October 2026 · online: https://tulinde.co.za/national-health-insurance/

Short answer Checked 28 October 2026

The **National Health Insurance Act 20 of 2023** was signed by the President on **15 May 2024** and published in the Government Gazette on **16 May 2024**, but it **only takes effect on dates the President proclaims**. On **24 February 2026** the Presidency announced that **no section will be proclaimed** until the Constitutional Court rules on challenges to Parliament's public participation, heard on **5–7 May 2026**. As at 29 October 2026 we found no judgment in those cases on the Court's website, so **nothing changes yet for medical aid members**.

The Act

The National Health Insurance Act, 2023 is **Act No. 20 of 2023** — it is often called the "2024 Act" because it was assented to on **15 May 2024** and published in **Government Gazette No. 50664 of 16 May 2024**. It creates a **National Health Insurance Fund** that would buy health services for users from public and private providers.

Section 59: the Act "takes effect on a date fixed by the President by proclamation in the Government Gazette", and different dates may be fixed for different provisions.

Commencement status in October 2026

Date	What happened	Source
15 May 2024	President assents to the NHI Act	Gazette 50664
16 May 2024	Act published in the Government Gazette	Gazette 50664
24 February 2026	The President, after consulting the Minister of Health, agrees to delay the proclamation of any section until the Constitutional Court rules; the undertaking was expected to be made an order of court that day	Presidency, SAnews
5–7 May 2026	Constitutional Court hearing of the challenges on public participation in the passing of the NHI Bill	Presidency
29 October 2026	No NHI judgment appears among the Court's recent judgments	Constitutional Court

Press reports name the applicants in the public participation cases as the **Board of Healthcare Funders** and the **Western Cape provincial government**, and report that judgment was reserved after the May hearing (press, not a primary source).

> Section 57 of the Act describes Phase 1 (2023–2026) and Phase 2 (2026–2028). These are the Act's planned phases; they do not apply until the relevant provisions are proclaimed.

What changes for medical aid members — and what does not yet

Today: nothing. Without a proclamation, the Medical Schemes Act applies in full: your scheme must keep paying the Prescribed Minimum Benefits, contributions stay based on income and dependants, and you can still join, change or leave a scheme under the usual rules (see medical aid).

Later, if the Act is brought into force as written: section 33 says that "once National Health Insurance has been fully implemented as determined by the Minister through regulations in the Gazette, medical schemes may only offer **complementary cover** to services not reimbursable by

the Fund." The Act defines complementary cover as third-party payment for services not reimbursed by the Fund, "including any top up cover offered by medical schemes".

In other words, the restriction on medical schemes depends on three later steps: proclamation of the provisions, regulations by the Minister declaring full implementation, and the Fund actually reimbursing the services.

The CMS notes in its Annual Report 2025/26 that it has built the NHI provisions into its strategic planning and is preparing schemes for the change, including the rule that schemes may not cover services reimbursed by NHI once implemented.

What to do now

- **Do not cancel medical aid because of NHI.** No part of the Act is in force, and leaving a scheme can expose you to waiting periods and a late-joiner penalty if you rejoin at 35 or older.
- **Keep proof of your cover history** — it reduces any late-joiner penalty (Regulation 13).
- **Treat sales pitches about NHI with care**: any product presented as "NHI-ready" or as a replacement for medical aid should be checked against the law. Gap cover and hospital cash plans must state that they are not a medical scheme (gap cover).
- **Watch for a Constitutional Court judgment and any proclamation in the Government Gazette** — those are the two events that would change the position.

Frequently asked questions

Is NHI in force in South Africa?

No. The NHI Act 20 of 2023 was signed on 15 May 2024 but takes effect only on dates proclaimed by the President, and on 24 February 2026 the Presidency said no section would be proclaimed until the Constitutional Court rules.

When was the NHI Act signed?

On 15 May 2024. It was published in Government Gazette No. 50664 on 16 May 2024.

Will NHI end medical aid?

Not now. Section 33 says that once NHI is fully implemented, as determined by the Minister in regulations, medical schemes may only offer complementary cover for services the Fund does not reimburse.

Should I cancel my medical aid because of NHI?

No part of the Act is in force, and rejoining a scheme later can mean waiting periods and a late-joiner penalty from age 35.

What is the Constitutional Court NHI case about?

Challenges to the public participation process followed by Parliament before it passed the NHI Bill, heard on 5–7 May 2026. As at 29 October 2026 we found no judgment on the Court's recent judgments page.

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