MBMED

Helping members to make the most of their Scheme benefits

2023

MEMBER GUIDE

1 GET IN TOUCH 3

2 MBMED – THERE FOR YOU 5

3 2023 MEMBER CONTRIBUTIONS 8

4 WHY, WHEN AND HOW TO... 9

A. Register on the web 10

B. Choose and register a Preferred General Practitioner (PGP) 11

C. Get a referral before you see a specialist 12

D. Use ER24's ambulance services 13

E. Pre-authorise hospital admissions and specialised radiology 14

F. Pre-authorise a knee or hip replacement 15

G. Join the chronic medicine management programme 16

H. Join the weight management programme 20

I. Join the smoking cessation programme 21

J. Join the oncology/cancer disease management programme 22

K. Join the HIV management programme 23

L. Claim for medical expenses incurred outside South Africa 24

M. Apply for ex gratia cover 26

N. Benefit from prescribed minimum benefits 28

O. Escalate a query or complaint 29

5 2023 BENEFITS TABLE 30

6 CLAIMING MADE EASY 42

1

GET IN TOUCH

FOR GENERAL QUERIES ABOUT BENEFITS, CLAIMS & MEMBERSHIP

@ mbmed@medscheme.co.za

086 000 2109, Monday to Friday, 8:30 to 16:00

FOR FIRST-TIME CLAIMS SUBMISSIONS

@ claims@medscheme.co.za

FOR MEDICAL EMERGENCIES AND AMBULANCE SERVICES

ER24 – 084 124

FOR HOSPITAL AND SPECIALISED RADIOLOGY AUTHORISATIONS

@ mbmed.authorisations@medscheme.co.za

0860 000 2109

WEBSITE: mbmed.medscheme.com

EMAIL ADDRESSES TO RESOLVE YOUR QUERIES EVEN FASTER

Medscheme has introduced additional email contact addresses with specialised focus, to speed up member query turnaround times. Avoid unnecessary delays by using the email addresses below, depending on your specific query or issue.

General enquiries, including specialist referral management and preferred general practitioners mbmed@medscheme.co.za

Dental and orthodontic quotes mbmeddental@medscheme.co.za

Hospital authorisations mbmed.authorisations@medscheme.co.za

Chronic medicine management mbmedcmm@medscheme.co.za

Queries for out-of-hospital Prescribed Minimum Benefits mbmedapmb@medscheme.co.za

Oncology management cancerinfo@medscheme.co.za

Aid for AIDS afa@afadm.co.za

First-time claims submissions claims@medscheme.co.za

Ex gratia requests mbmedspecialcases@medscheme.co.za

NOTE: This summary is for information purposes only and does not supersede the Rules of the Scheme. In the event of any discrepancy the Rules will prevail. A copy of the Rules can be obtained from Medscheme the Administrator for MBMed.

2

MBMED – THERE FOR YOU!

Many people regard their medical scheme mainly as a way to help cover visits to the doctors, or dentist, or to fund a new pair of spectacles. The monthly contributions then seem disproportionately high, and many medical scheme members (whatever scheme they belong to) complain that they are not getting value for money.

The first thing to understand is that a medical scheme is MAINLY there to help you when things go wrong. It's comparable to your short-term insurance. You may go many years without claiming for anything, but when you're burgled, it's great to be able to claim for everything you've insured.

Likewise, members who are in accidents, develop cancer or need life-saving procedures are usually extremely relieved that they have a medical scheme to fall back on. And because the costs involved in these major medical events are often so high, this is where the benefit amounts are typically the highest, and where MBMed spends most of its money.

During a typical member's lifetime, there will be many occasions where the Scheme's benefits would be extremely valuable. This "journey" shows different life stages, and the type of healthcare challenges a member may face.

THE HEALTHCARE JOURNEY

Joins Scheme

Young and healthy; minimal healthcare needs

Starts relationship; needs medical cover for partner

Road accident or sports injury

GP and Physio visits, Spectacles, etc.

Maternity

Premature birth

Child trauma injury

Chronic disease per year

Tonsil surgery or dental admissions

Dread disease such as cancer

Lifestyle disease such as High Blood Pressure

Healthy lifestyle becomes increasingly important

Specialised treatment for back and neck pain, to avoid surgery

Cardiac conditions or stroke

After retirement; ageing process more pronounced

Hip replacement

Cataract surgery

Medical costs can arise at any stage of your life. The Scheme offers a wide range of benefits to cater for these

YOUR BENEFITS IN A NUTSHELL

Unless otherwise specified, the benefits described in this guide apply to MBMed's benefit year, which runs from 1 January to 31 December. Benefits are not transferable from one benefit year to another.

MBMed offers a wide range of benefits to its members. These can be categorised (and are covered in more detail in chapter 5) as follows:

Preventative benefits, which include health screening tests and vaccines to help you manage your health pro-actively;

Day-to-day benefits, which typically cover expenses such as consultations with GPs and other healthcare professionals, optometry, dentistry, and acute medicine;

Chronic medicine benefits, which help members manage certain chronic conditions in a cost-effective way;

Hospital and major medical benefits, which cover from small in-room procedures to high-cost hospitalisation and treatment for trauma cases, oncology and more; and

Emergency and ambulance benefits, to ensure that you and your beneficiaries can get emergency medical care when you urgently need it.

3

2023 MEMBER CONTRIBUTIONS

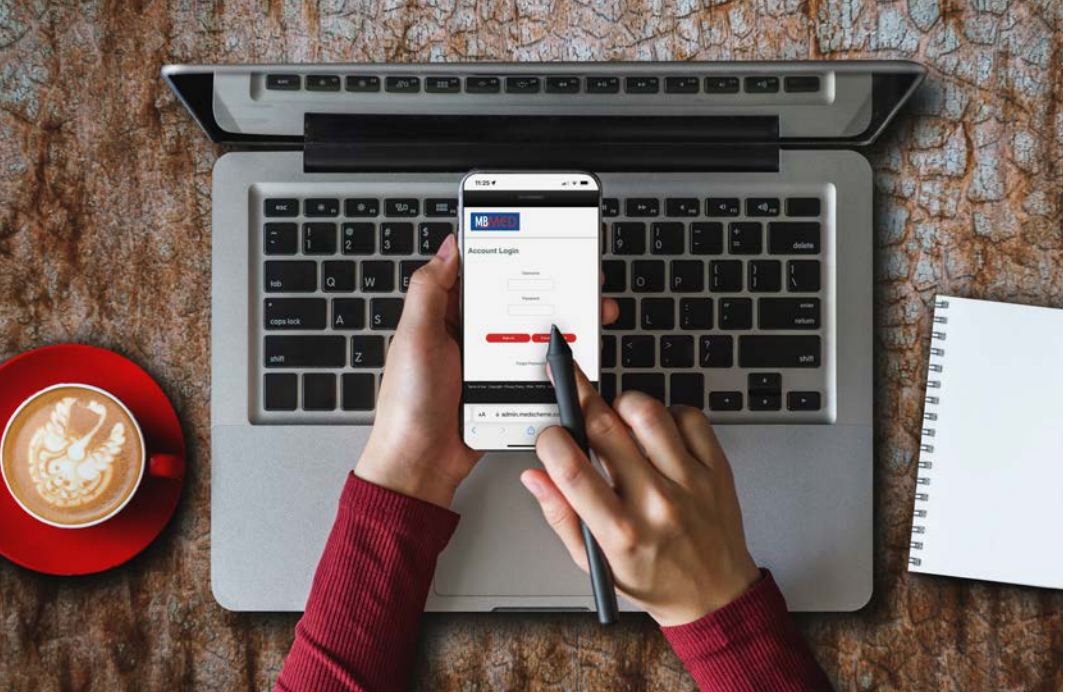
	Income Band	Principal Member	Adult Dependant	Child Dependant
1	R0 – R24 989	R2 404	R1 979	R548
2	R24 990 – R28 059	R2 781	R2 289	R634
3	R28 060 –R37 819	R3 404	R2 834	R812
4	R37 820 – R39 419	R3 424	R2 849	R855
5	R39 420 – R49 799	R3 654	R3 080	R917
6	R49 800 – R62 109	R3 927	R3 393	R977
7	R62 110+	R4 226	R3 702	R1 095

Note: Please contact the HR Division Mercedes-Benz South Africa Group of Companies for details of the Company Medical Scheme Subsidy Policy or contact the Principal Officer for assistance.

4

WHY, WHEN AND HOW TO...

- A REGISTER ON THE WEB
- B CHOOSE AND REGISTER A PREFERRED GENERAL PRACTITIONER (PGP)
- C GET A REFERRAL BEFORE YOU SEE A SPECIALIST
- D USE ER24'S AMBULANCE SERVICES
- E PRE-AUTHORISE HOSPITAL ADMISSIONS AND SPECIALISED RADIOLOGY
- F PRE-AUTHORISE A KNEE OR HIP REPLACEMENT
- G JOIN THE CHRONIC MEDICINE MANAGEMENT PROGRAMME
- H JOIN THE WEIGHT MANAGEMENT PROGRAMME
- I JOIN THE SMOKING CESSATION PROGRAMME
- J JOIN THE ONCOLOGY/CANCER DISEASE MANAGEMENT PROGRAMME
- K JOIN THE HIV MANAGEMENT PROGRAMME
- L CLAIM FOR MEDICAL EXPENSES INCURRED OUTSIDE SOUTH AFRICA
- M APPLY FOR EX GRATIA COVER
- N BENEFIT FROM PRESCRIBED MINIMUM BENEFITS
- O ESCALATE A QUERY OR COMPLAINT



A REGISTER ON THE WEB

By registering on the secure Member Zone, you can check up on claims and various benefits online, instead of having to contact MBMed.

If you have not already registered as a user on the MBMed Member Zone, simply follow the steps below:

1. Visit the MBMed website on mbmed.medscheme.com.
2. Click 'Login', top right.
3. On the next screen, click 'Create Account' and follow the prompts to register. IMPORTANT: Your email address and phone contact details MUST be correct. When choosing and typing in a username and password, remember that the password is case-sensitive.
4. A screen will appear confirming your successful member registration. As part of the registration process, you will be sent an email within 24 hours to confirm your registration on the MBMed Member Zone.
5. You can now log in (see steps 1 and 2 above) using your username and password.

B CHOOSE AND REGISTER A PREFERRED GENERAL PRACTITIONER (PGP)

It is important that one GP is the co-ordinator of your care, so that a record of your medical history can be kept in one place and shared with specialists and other providers when necessary.

Visiting more than one GP on a regular basis holds major disadvantages for members, such as:

- Conflicting diagnoses and treatments;
- Additional costs being incurred where similar diagnostic tests are repeated, or where medicines are duplicated by different GPs.

MBMed has therefore introduced the concept of Preferred General Practitioner (PGP) selection, to encourage you to consistently use a GP of your choice. Each member of the family can have a different PGP.

How do I select a PGP?

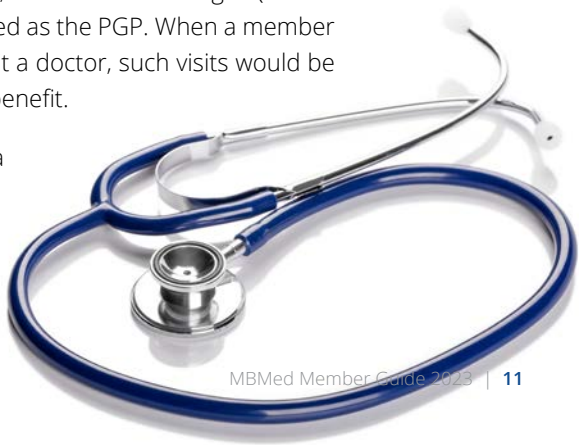
New members should complete a PGP selection on their application form, visit the Site Office, or contact MBMed Customer Services on 0860 00 2109 to load their PGP(s).

What if my specific PGP is not available?

If the PGP is part of a group practice of general practitioners, members may visit any doctor who is part of the group practice, provided the account/claim is submitted under the group practice number.

When the PGP is not available, the doctor standing in (known as the locum) will be considered as the PGP. When a member is on holiday and needs to visit a doctor, such visits would be covered by the "Out of Area" benefit.

Each beneficiary can register a maximum of two PGPs.



C GET A REFERRAL BEFORE YOU SEE A SPECIALIST

To ensure co-ordinated care, and to minimise unnecessary costs, members must be referred to certain specialists by their GP. The GP must contact the Medscheme Call Centre on 086 111 2666 to obtain a specialist referral number for you, before your consultation with the specialist.

If a specialist refers you to another specialist, you must contact your PGP or the Call Centre to update your referral. Without this number the Scheme will not pay for the consultation.

IMPORTANT: It is the member's responsibility to ensure that the GP obtains the specialist referral number. However, a specialist referral number is not a guarantee of payment; claims will be processed from available benefit limits.

D USE ER24'S AMBULANCE SERVICES

You and your registered dependants have access to emergency medical transportation in South Africa 24 hours a day, 7 days per week, **provided that this is authorised by ER24** (MBMed's emergency medical services provider).

In an emergency*, call or get someone to call ER24 on **084 124**.

Tell the ER24 operator that you are a MBMed Medical Scheme member – they will prompt you or the caller to obtain all the information they need to get help to you.

*WHAT IS AN EMERGENCY?

"An emergency medical condition means the sudden and, at the time, unexpected onset of a health condition that requires immediate medical treatment and/or an operation. If the treatment is not available, the emergency could result in weakened bodily functions, serious and lasting damage to organs, limbs or other body parts, or even death."

E PRE-AUTHORISE HOSPITAL ADMISSIONS OR SPECIALISED RADIOLOGY

You need to pre-authorise any admission to hospital unless it is an emergency. The pre-authorisation process ensures added value for you by making sure the planned intervention is medically necessary and appropriate, before the event or admission. This process can be initiated by you, your medical practitioner, or the hospital.

How to pre-authorise

Via the **website** – click on the drop-down arrow in the Login box at the top right-hand corner of the MBMed website and select "member" to log into the secure area. Then click on the pre-authorisation button.

Via **email** – mbmed.authorisations@medscheme.co.za (please ensure that your request is accompanied by all the relevant information to finalise your request).

Via **phone** – Call centre number: 0860 002 109; 08:30 – 16:00, Mon to Fri, excluding public holidays. An automated system is available 24 hours a day, 7 days a week.

Healthcare Professionals can also apply on your behalf by calling 0861 100 220, or logging in to the UMS system on the MBMed website by selecting "Hospital" in the drop-down box and using their UMS login details.

F PRE-AUTHORISE A KNEE OR HIP REPLACEMENT

Use the Scheme's Preferred Provider group for knee and hip replacements to ensure that you do not incur a co-payment for your surgery. These are orthopaedic surgeons that specialise in performing hip and knee replacements according to standardised clinical care pathways. These care pathways have been developed in accordance with evidence-based outcomes to ensure that the quality of the hip and/or knee replacement is of the highest standard, ensuring the best health outcomes. They use a multidisciplinary team dedicated to assist with rapid and successful recovery, keeping the patient as comfortable as possible during the healing period.

How to access an orthopaedic surgeon on the program

Call the MBMed Call Centre on 0860 00 2109 and you will be given the details of an orthopaedic surgeon closest to you or contact your chosen PGP.

Following your consultation with the orthopaedic surgeon and if the decision for surgery is made, an application for an authorisation number will be arranged on your behalf by the admin staff at the practice. This will allow you access to the program and ensure payment in full (subject to your prosthesis benefit) with no co-payments for the procedure. The surgeon will give you a booklet providing you with information on the programme.

The following will be covered as part of your hip or knee replacement:

- All hospital costs
- Surgeons and anaesthetist fees
- Prosthesis (subject to the prosthesis benefit)
- Physiotherapist (pre-, intra-, and post-operative)

G JOIN THE CHRONIC MEDICINE MANAGEMENT PROGRAMME

What is a chronic condition?

A chronic condition is a condition that requires ongoing long-term or continuous medical treatment. However, not all these conditions are necessarily covered by the Scheme's Chronic Medicine Benefits. The Scheme specifies the chronic conditions that qualify for this benefit.

When would it make sense to register on this programme?

If you use medicine for a chronic condition without being registered on the Chronic Medicine Management Programme, it will be covered from your acute medicine benefit limit and you will probably exhaust this benefit limit quite quickly.

On the other hand, by registering on this programme (if you have a qualifying chronic condition as provided for by MBMed), you have access to a far higher benefit limit for your chronic medicine. You can see a list of the qualifying conditions under Documents on the Scheme's website, mbmed.medscheme.com.

Certain terms and conditions apply to the conditions covered, the medicine formularies available for those conditions, and the service provider through which you have to get the medicine [see the section on our Designated Service Provider (DSP) below]. However, for most members the financial benefit of registering for chronic medicine benefits far outweigh the restrictions.

Chronic medicine is indicated for prolonged illnesses that are often life-long. To have access to your chronic medicine benefits, you need to apply and be authorized for a chronic medicine or condition through the Chronic Medicine Management (CMM) Programme, subject to the CMM Clinical Guidelines and Protocols.

How is my medicine approved?

When you apply for chronic medicine, and if you are approved for treatment of your chronic condition, you will have access to a list of pre-approved medicine, referred to as a basket. The quantity of each medicine in the basket is limited to the most commonly prescribed monthly dose.

What if my medicine changes?

If you need to change or add a new medicine for your condition, you can do this quickly and easily at your pharmacy with your new prescription. Not all conditions are managed this way and you will need to contact the Scheme to update medicine telephonically or online if:

- you are joining the chronic program for the first time;
- you are diagnosed with a new additional chronic condition;
- your medicine is not linked to one of your registered baskets; or
- you need a quantity or dosage of a medicine that is more than the quantity listed in the basket.

Pre-approved medicine in the basket may still be subject to the Medicine Price List (MPL) and formulary co-payments. The MPL is a reference pricing system used in conjunction with formularies and preauthorisation, as a health risk management tool.

The reference pricing system does not restrict the choice of medicines – it controls the cost of medication. The system uses a benchmark for generically similar products to limit the amount that will be paid in medicine prices. You are free to use any item which appears on the MPL. However, if the price is more than the reference price, you will be required to pay the difference.

How do I apply?

You, your doctor, or pharmacist can register for, or update, your chronic medicine telephonically or online. Ensure you have a copy of your current prescription with you. There is no need to send it to us, as you will need to give your original prescription to the pharmacy for the dispensing of your chronic medicine.

You will need to have the following information on hand:

- Your membership number
- The date of birth of the person applying
- The ICD10 code of your condition
- Doctor's practice number

To authorise certain medicines, you may also need to supply:

- Medicine details
- The clinical examination data, e.g. weight, height, BP readings, smoking status, allergy information
- Test results, e.g. lipogram results, Hba1c, lung function tests
- Motivation provided by your prescribing doctor

Register telephonically

Call CMM on 0860 002 109 between 08:30 and 16:00, and select the chronic medicine option.

Register online

Visit the MBMed website on mbmed.medscheme.com and click 'Login', top right. Log in with your username and password. (If you are a first-time user you will need to register – see A. REGISTER ON THE WEB earlier in this chapter). Go to "My Authorisations" and click on the "My Chronic Application", click on the dependant code and follow the prompts on the system. Where more clinical information is required, members of the clinical team will review the information supplied and correspond with you and your doctor either telephonically or in writing, on the status of the medicine request. You can follow up on the progress of your application at any time by contacting CMM.

Contact details for Chronic Medicine Management (CMM)

Member Call Centre: 0860 002 109 (08:30 – 16:00, Mon-Fri)

Provider Call Centre: 0861 100 220

Email Address: mbmedcmm@medscheme.co.za

Postal Address: PO Box 38632 Pinelands 7430

Which service provider should I use?

Since 2021 MBMed has contracted with any willing pharmacy to supply members using the Chronic Medicine Benefit with their medicine.

Members who obtain chronic medicines dispensed by a pharmacy not on the MBMed network may have to pay a co-payment on the dispensing fee charged by the pharmacy. Members not accepting the generic equivalent of the prescribed medicine will have to pay a co-payment. (MPL and formulary co-payments will apply whether you use a Network Pharmacy or not.)

Medicine can either be obtained from one of the network pharmacies; or delivered via a direct courier pharmacy to a selected residential or work address.

How do I know if my pharmacy is part of the MBMed Network?

- Speak to your pharmacist.
- Contact the MBMed Call Centre on 0860 002 109.
- Free delivery nationwide: Need to get your chronic or repeat prescription medication but just can't get to the pharmacy? Contact any direct courier pharmacy on the network.

How do I appeal a decision made by CMM?

Your doctor should contact the Chronic Medicine Management Provider Call Centre on 0861 100 220, or submit a clinical motivation to mbmedcmm@medscheme.co.za.

NEW

H JOIN THE WEIGHT MANAGEMENT PROGRAMME

Obesity is a complex disease that is dependent on many factors, including a person's genetics and lifestyle. It is important to implement a longer-term, sustainable plan that will lead to a healthier lifestyle, which is what the Scheme's Weight Management Programme aims to help members do.

HOW CAN YOU ACCESS THE BENEFIT?

If you are interested in this programme and would like to confirm whether you qualify, contact Member Care for more information on:

0860 106 155

@ membercare@medscheme.co.za

JOIN THE SMOKING CESSATION PROGRAMME

Stopping smoking is the single most important decision you can make for your health. The benefits of stopping smoking are almost immediate, but stopping smoking is not easy, as nicotine is highly addictive and smoking is associated with social activities such as drinking or eating and psychological factors such as work pressure, anxiety and body weight concerns.

This benefit covers **R3 310** per beneficiary for services, including medicine. The GoSmokeFree services are provided by trained clinical nurses at Dis-chem, Clicks, Pick & Pay and Independent Pharmacies.

HOW CAN YOU ACCESS THE BENEFIT?

Visit www.gosmokefree.co.za to find out more and to locate your nearest pharmacy.

JOIN THE ONCOLOGY/CANCER DISEASE MANAGEMENT PROGRAMME

To make the most of your oncology benefits, it is important that you are registered on the Oncology Disease Management Programme as soon as possible after the diagnosis of cancer. Your treatment plan must then be forwarded to the clinical team, as all oncology treatment is subject to pre-authorisation and case management. After the treatment plan has been assessed and approved, an authorisation will be sent to your treating doctor.

Who should register on the programme, and how?

Patients who have been diagnosed with cancer and are actively receiving treatment, as well as patients who are in remission.

On diagnosis, your treating doctor should email a copy of your treatment plan to cancerinfo@medscheme.co.za. An oncology case manager will then take the process forward.

For any queries, call 0860 100 572.

What about related treatment?

In addition to obtaining authorisation from the Oncology Disease Management team for oncology treatment, you will need to get pre-authorisation from Hospital Benefit Management for any hospitalisation, specialised radiology (e.g. MRI scans, CT scan angiography) or private nursing/hospice services.

What if my treatment changes?

Please make sure that your doctor advises the Oncology Disease Management team of any change in your treatment, as your authorisation will need to be re-assessed and updated.

K JOIN THE HIV MANAGEMENT PROGRAMME

Aid for AIDS (AfA) is a complete HIV disease management programme that offers both members and beneficiaries:

- Medicine to treat HIV (including drugs to prevent mother-to-child transmission and potential infection) at the most appropriate time;
- Treatment to prevent opportunistic infections (e.g. pneumonia or TB);
- Regular monitoring of disease progression and response to therapy;
- Regular monitoring tests to pick up possible side-effects of treatment;
- Ongoing patient support via a Nurse-line; and
- Help in finding a registered counsellor for emotional support.

If a test shows that you are HIV-positive

Register with AfA as soon as possible to make use of this benefit. Your doctor can also contact AfA on your behalf. After you receive the application form, you and your doctor must complete it and return it to AfA.

Once treatment has been agreed upon, you and your doctor will be sent a detailed treatment plan which explains the approved medicine as well as the regular tests that need to be done to ensure that the drugs are working correctly and safely.

If you have potentially been exposed to infection

If you have possibly been exposed to HIV infection through unprotected sex with a partner living with HIV, sexual assault or needle-stick injury, please ask your doctor to contact AfA to authorise special antiretroviral medicine to help prevent possible HIV infection.

Contact details

0860 100 646 or 083 410 9078 | Mon – Fri | 08:00 – 17:00
SMS (call me): 083 410 9078
0800 600 773
afa@afadm.co.za
www.aidforaids.co.za
+27 21 514 1700 (Cape Town Office) | 0800 227 700 (Doctor & Pharmacist)

L CLAIM FOR MEDICAL EXPENSES INCURRED OUTSIDE SOUTH AFRICA

You will be glad to know that you can claim from the Scheme for medical expenses incurred while travelling outside South Africa whilst on holiday. However, you need to be aware of the following:

- You will be responsible for settling the account upfront. You can then submit the claim to the Scheme when you return.
- If your account is in a foreign language, it must be fully translated into English and detailed before you submit it to the Scheme.

IMPORTANT!

Medical care abroad can be very expensive (depending on the country you will be travelling to) and, given our exchange rate, it would probably not be fully covered, so it may be wise to take out additional medical cover. Your travel agent will be able to assist you with this.

- When you send in foreign claims, please add a cover letter or email explaining the situation. The more detailed your cover letter and claim, the quicker the Scheme can process the claim. You need to clearly indicate the following details:
  - The name of the country in which you were treated
  - Treatment dates
  - Whether there was anaesthesia involved and if so, how long it was for
  - The medicine, materials, treatment, procedures and operations involved. These must all be clearly specified and charged individually.
  - The patient's name
  - The currency in which the claim was paid
- Submit your claim to: foreign.hos@medscheme.co.za
- Your claim will be subject to the Scheme's Rules as if the treatment were rendered in South Africa. In other words, the same exclusions, benefits and limits will apply.
- Your claims will be paid according to the equivalent tariff and will be refunded to you in Rands, at the exchange rate that applied on the treatment date.
- PMB rules are not applicable outside the borders of South Africa.

PLEASE NOTE In the event of the claim being covered under your travel insurance policy, you will not qualify for a refund for the claim from the Scheme. Should you claim from the Scheme and fail to disclose that you have been indemnified by your insurer for this claim, this will be regarded as fraud.

TIP: If you or one of your accompanying dependants use chronic medicine, you must also remember to apply for advance supplies. The completed form, together with a copy of the flight tickets and travel itinerary must reach Chronic Medicine Management at least ten working days before you leave, to ensure that you receive your medication in time.

APPLY FOR *EX GRATIA* COVER

An application for consideration of *ex gratia* benefits is open to all MBMed members and dependants who have exhausted their current benefit limits.

Consideration for awarding of additional benefits on an *ex gratia* basis are based on medical necessity, assessment of financial impact on the member and the Scheme, and a review of past Scheme benefit utilisation by the member.

Ex gratia application forms are available on the MBMed Medscheme Member Zone and the MBSA Intranet. Once completed, applications with the necessary clinical motivation from your treating doctor should be submitted to mbmedspecialcases@medscheme.co.za, or handed in at the on-site East London MBMed office.

These requests are reviewed, where relevant, by the Fund's appointed Clinical Advisor, and then prepared by Medscheme for submission to the *Ex Gratia* Committee, which consists of the MBMed Principal Officer and three member-elected trustees, and convenes fortnightly. Where appropriate, certain *ex gratia* requests are submitted to an appointed medical panel for assessment of the clinical appropriateness of the request, before being submitted to the *Ex Gratia* Committee.

Which *ex gratia* requests are unlikely to be considered?

Ex Gratia requests for advanced dentistry will not be considered for additional benefits, unless it is required following traumatic injury, such as after a motor vehicle accident. *Ex gratia* requests will also not be considered for expenses above the MBMed Scheme Rate. In other words, no *ex gratia* payments will be made for the difference in cost between what a member may be billed by a specialist (so called private rates) and what the Scheme Rules allow (Scheme Rate). Applications for ex gratia benefits must be submitted within 120 days of treatment date.

At the same time...

Above-Scheme-Rate expenses will, however, automatically be covered in the case of Prescribed Minimum Benefits (PMBs - see more about these in the next section). In fact, MBMed will pay at invoice price for PMBs, irrespective of cost.

The role of gap cover to avoid out-of-pocket expenses

Members of MBMed under age 60 can choose the Sanlam gap cover Policy to provide insurance cover for above Scheme Rate expenses.

Members are reminded that Sanlam Gap cover for MBMed has a three-month waiting period and that pre-existing condition exclusions may be applied. More information on Sanlam Gap Cover for MBMed is available on the MBMed website, or from the on-site MBMed office.

Members are also reminded that MBMed is not party to the agreement between the member and Sanlam and all queries must be dealt with by the member directly with Sanlam.

N BENEFIT FROM PRESCRIBED MINIMUM BENEFITS

The regulations published in terms of the Medical Schemes Act No. 131 of 1998 stipulate the scope and level of the minimum benefits to which members of the Scheme are entitled. Prescribed Minimum Benefits (PMBs) are a set of defined benefits that ensure that all medical scheme members have access to certain minimum health services.

These conditions include any life-threatening emergency, 270 defined diagnoses and their associated treatments as well as 27 chronic conditions.

All medical schemes in South Africa must include the Prescribed Minimum Benefits (270 illnesses and 27 chronic conditions) in the benefit options being offered to members. There are, however, certain requirements that a member must meet before they benefit from the Prescribed Minimum Benefits and includes:

- The condition must be part of the list of defined PMB conditions
- The treatment needed must match the treatments in the defined benefits
- Members must use the Scheme's designated healthcare service providers where applicable

When do Prescribed Minimum Benefits not apply?

In some circumstances a member and/or beneficiary may not qualify for PMB cover by their medical scheme. This can happen when a person joins a medical scheme for the first time and has not had medical scheme membership before; or if someone joins a medical scheme more than 90 days after leaving their previous medical scheme.

In both cases, the medical scheme may impose a waiting period during which no PMB benefits would be available, no matter what conditions they might have. Please visit the Council for Medical Scheme's website www.medicalschemes.com or contact the MBMed contact centre for more information.

ESCALATE A QUERY OR COMPLAINT

We understand that members expect reliable and efficient service from the Scheme at all times. To help you resolve medical scheme issues you may have, or have a complaint about service you received, please contact the Call Centre or send an email to mbmed@medscheme.co.za and provide the details of your complaint. The advantage of going through the Call Centre is that calls and emails are recorded and trends can be picked up, allowing the Scheme to identify specific communication needs.

If you are not satisfied with the outcome, you are requested to lodge a complaint in writing to mbmed@medscheme.co.za for the attention of the Principal Officer, detailing the nature of the dispute/complaint. The Principal Officer will try to resolve your query, or alternatively convene a Disputes Committee meeting to adjudicate your complaint and/or dispute. You have the right to be heard at these proceedings if you so wish.

If, after following the procedure detailed above, you are still not satisfied with the outcome of the process, you may contact the Council for Medical Schemes' Complaints Department:

- www.medicalschemes.com
  (follow the "Consumer Assistance – Complaints link")
- information@medicalschemes.com
- 012 431 0500
- 012 431 0608

2023 BENEFITS TABLE

OVERALL ANNUAL LIMIT: UNLIMITED

PREVENTATIVE CARE BENEFITS

SCREENINGS

Cholesterol test (lipogram)	One test per beneficiary per year
Colorectal screening and/or faecal occult blood test	One test per beneficiary per year
HIV screening tests	Two tests per beneficiary per year by a registered nurse at a pharmacy for the following: 1 for pre-testing; and 1 for post-testing.
Infant hearing screening	Unlimited in or out of hospital for all infant beneficiaries up to 8 weeks
Mammogram	One screening per female beneficiary per year
Osteoporosis screening	One screening per beneficiary per year
Pap smear or liquid based cytology	One screening per female beneficiary per year
Prostate specific antigen test (PSA)	One test per male beneficiary per year
Thyroid function screening test (TSH)	One test per infant beneficiary up to the age of 1 month old

VACCINES

Flu	One per beneficiary per year
Pneumonia	One per beneficiary 18 and older, every five years
HPV	As prescribed in terms of Scheme Rules
Pertussis	One vaccine per beneficiary between 7 and 64 years every 10 years
Childhood immunisation Limited to immunisation prescribed by the South African expanded programme of immunisation	Cost or Scheme Rate, whichever is less Pharmacists' administration fee excluded

DAY-TO-DAY BENEFITS

DAY-TO-DAY BENEFIT LIMITS	
Member	R9 770
Member + 1	R15 190
Member + 2	R17 950
Member + 3	R21 450
Member + 4 or more	R24 320

The following services will be covered from the day-to-day benefit limits above:

SERVICE	NOTES
General Practitioner consultations	"Out of Area" visits are to be used when a beneficiary is out of town on business or holiday.
Specialist consultations	Specialist consultations will only be covered by the Scheme if a GP refers the member and a specialist referral number is obtained by the GP's practice.
Acute medication	Acute medicines are routine, day-to-day medicines prescribed by a doctor, including immunisations, and which are not registered under the Chronic Medicine Management Programme. It excludes pharmacy-advised therapy (PAT).
Additional medical services	Additional medical services include alternative health, physical therapy, paramedical, chiropody, chiropractor, dietician, occupational therapy, physiotherapy, speech therapy, etc.
General radiology	General radiology (out of hospital) will only be covered by the Scheme if referred by a GP or specialist.
Pathology	A limit of **R6 370** per family per year applies.

Note: All payments are subject to Scheme tariffs and negotiated rates, unless otherwise specified.

CONSULTATIONS & VISITS	
Out of hospital Subject to day-to-day benefits Out of Area visits: 2 per family	Cost or Scheme Rate, whichever is less
DENTISTRY (BASIC)	
Subject to Medscheme Dental Management	
Treatment by dental practitioner and therapist, including minor oral surgery, oral medical procedures and technical fees Plastic dentures	Cost or Scheme Rate, whichever is less

OPTOMETRY	
Subject to Medscheme Optometry Management	
Benefit	Cost or Scheme Rate, whichever is less. Limited to **R4 460** per beneficiary every 24 months
One eye examination	Included in per beneficiary amount
One set of single, bifocal, or multi-focal lenses	No sub-limit and included in per beneficiary amount
Frames and Lens enhancements	Included in per beneficiary amount and further limited to **R1 700**
Contact Lenses	Included in per beneficiary amount and further limited to **R2 340**
RADIOLOGY	
Out of hospital	Cost or Scheme Rate, whichever is less Subject to day-to-day benefits
MEDICINES and INJECTION MATERIALS	
Contraceptives	100% of single exit price plus the negotiated dispensing fee, to a maximum as dictated by legislation
Pharmacy-advised therapy (medicines prescribed and dispensed by a pharmacist)	100% of single exit price plus the negotiated dispensing fee, to a maximum as dictated by legislation, limited to **R755** per beneficiary per year
APPLIANCES	
Medical and surgical appliances, including hearing aids, wheelchairs	Cost or Scheme Rate, whichever is less, limited to **R27 400** per beneficiary per year
Home oxygen cylinders, concentrators, and ventilator expenses	Cost or Scheme Rate, whichever is less
Foot orthotics	Subject to appliance benefit and further limited to **R3 870** per beneficiary

CHRONIC MEDICINE BENEFITS

100% of single exit price plus the negotiated dispensing fee, to a maximum as dictated by legislation, limited to **R31 900** per beneficiary, and **R54 200** per family per year.	Subject to approval by Medscheme Chronic Medicine Management Programme

HOSPITAL AND MAJOR MEDICAL COSTS

HOSPITALISATION

Private and public hospitals, including step-down rehabilitation centres and Hospice	Cost or Scheme Tariff, whichever is less **AUTHORISATION REQUIRED** from Medscheme Hospital Management
Nursing services: private nursing, nursing agencies	Cost or Scheme Tariff, whichever is less **AUTHORISATION REQUIRED** from Medscheme Hospital Management
Out-patient care and out-patient services, materials, and medicines	Cost or Scheme Tariff, whichever is less
Medicine on discharge from hospital (TTO)	Unlimited if included in hospital account or if obtained from pharmacy on day of discharge

CONSULTATIONS AND VISITS

General practitioners and specialists, in hospital	Cost or Scheme Tariff, whichever is less

NON-SURGICAL PROCEDURES AND TESTS

Procedures performed by general practitioners and medical specialists, in and out of hospital	Cost or Scheme Tariff, whichever is less **AUTHORISATION REQUIRED** from Medscheme Hospital Management

SURGICAL PROCEDURES

Procedures performed by clinical technologists, general practitioners, and medical specialists, excluding services provided, or refractive surgery and organ transplants	Cost or Scheme Rate, whichever is less **AUTHORISATION REQUIRED** from Medscheme Hospital Management

PATHOLOGY AND MEDICAL TECHNOLOGY

In hospital Test performed by general practitioners, medical specialists, medical technologists, and private nurse practitioners	Cost or Scheme Rate, whichever is less

SPECIALISED RADIOLOGY

In and Out of Hospital	Cost or Scheme Rate, whichever is less, limited to **R14 200** per family per year **AUTHORISATION REQUIRED** from Medscheme Hospital Management

PROSTHESES	
External and internal prostheses	Cost or Scheme Rate, whichever is less, limited to **R47 300** per family per year **AUTHORISATION REQUIRED** from Medscheme Hospital Management
ONCOLOGY	
Treatment, medication, materials used in radiotherapy and chemotherapy, including consultations and visits, specialised and biological drugs	Cost or Scheme Rate, whichever is less For oncology specialised drugs a sub-limit of **R300 000** per family per year applies. **AUTHORISATION REQUIRED** from Medscheme Oncology Management
MATERNITY	
Out of hospital Medical services including ante-natal consultations and post-natal services, pregnancy scans and amniocentesis	Cost or Scheme Rate, whichever is less limited to **R13 200** per beneficiary per event
In hospital (public or private hospitals) Accommodation, theatre fees, labour ward fees, dressings, medicines and materials in hospital, normal delivery by a general practitioner, medical specialist or midwife. A letter of motivation is required for a Caesarean section.	Cost or Scheme Rate, whichever is less **AUTHORISATION REQUIRED** from Medscheme Hospital Management

ADVANCED DENTISTRY AND ORAL SURGERY

Subject to Medscheme Dental Management

Inlays, crowns, bridges, mounted study models, metal base dentures, treatment by periodontists and prosthodontists, dental technician fees	Cost or Scheme Rate, whichever is less, limited to **R17 840** per family per year and further limited to **R11 040** per beneficiary.
Osseo-integrated implants and orthognathic surgery (functional corrections of malocclusions)	Cost or Scheme Rate, whichever is less, subject to the Advanced Dentistry Limit
Oral surgery	Cost or Scheme Rate, whichever is less Subject to the relevant managed healthcare programme and to its prior authorisation.
Consultations, visits, removal of teeth, para- orthodontic surgery, procedures and preparation of jaws for prosthesis performed by maxillo-facial specialists	Cost or Scheme Rate, whichever is less Subject to the relevant managed healthcare programme and to its prior authorisation.
Maxillo-facial surgery and orthodontic treatment	Cost or Scheme Rate, whichever is less Subject to the relevant managed healthcare programme and to its prior authorisation.

BLOOD and BLOOD EQUIVALENTS

In and out of hospital

Cost or Scheme Rate, whichever is less

AUTHORISATION REQUIRED from Medscheme Hospital Management

MENTAL HEALTH

Hospitalisation (public or private hospital) Accommodation in a general ward, electro-convulsive treatment (ECT) fees, medicines, materials and hospital equipment	100% of the lower of cost or Scheme **AUTHORISATION REQUIRED** from Medscheme Hospital Management
General practitioner and psychiatrist consultations	In hospital: No limit Cost or Scheme Rate, whichever is less, limited to **R7 010** per beneficiary for out-of-hospital consultations.
Psychologists, psychiatric nurse practitioners and social workers consultations, visits and procedures in and out of hospital	In hospital: Limited to **R16 900** per beneficiary per year for non-Prescribed Minimum Benefits. Out of hospital: Limited to **R7 010** per beneficiary

ALCOHOLISM AND DRUG DEPENDENCY

Cost or Scheme Rate, whichever is less; included in the Mental Health Benefit

AUTHORISATION REQUIRED from Medscheme Hospital Management

IMMUNE DEFICIENCY RELATED TO HIV

Anti-retroviral and related medicines, related treatment including pathology and radiology services	Subject to the relevant managed healthcare programme, and to registration and case management by the programme **AUTHORISATION REQUIRED** from Aid for AIDS

INFERTILITY

Limited to interventions and investigations as prescribed by the Medical Schemes Act. Subject to Medical Advisor approval and the relevant managed healthcare programme.

ORGAN TISSUE TRANSPLANTS

Harvesting of organ or tissue and transplantation thereof, including consultations and visits and the cost of post-operative anti-rejection medicines	Cost or Scheme Rate, whichever is less **AUTHORISATION REQUIRED** from Medscheme Hospital Management

RENAL DIALYSIS (ACUTE and CHRONIC)

All services and materials, including consultations and visits	Cost or Scheme Rate, whichever is less **AUTHORISATION REQUIRED** from Medscheme Hospital Management

AMBULANCE SERVICES

Emergency road and air transport by ER24	Patients only Cost or Scheme Rate, whichever is less **AUTHORISATION REQUIRED** from ER24

6

CLAIMING MADE EASY

Tips on claiming

- Check that prescriptions for medicine show all your details. Also check that the correct quantity of medication dispensed is shown on the claim.
- Dental treatment often requires additional work by a dental technician. He or she bills the dentist, who adds this to your account and attaches a copy of the technician's account. Please submit both accounts and ensure that your name and membership number are reflected on each account.

When to expect payment

Medscheme has a regular payment cycle: three payment runs per month to members and healthcare practitioners. If the month extends to five weeks, four payment runs will take place. All valid claims received by Medscheme will be processed on this basis.

After we receive your claim we will process it and refund either you or pay your healthcare practitioner by direct transfer to a bank account, depending on the payment method that has been chosen and the rate your healthcare practitioner charges.

You will receive an email confirming that we have received your claims and another email once the claim has been processed and is ready for payment in the next payment run. This email will also tell you if you will be refunded or if we will pay the healthcare practitioner. An SMS message indicating the amount that will be credited to your account (if relevant) will be sent to you after the payment run. The Remittance Advice showing these payments will be available on the Medscheme website after the run.

Please ensure that all your personal details including your bank account details are correct for the electronic payment of refunds.

Don't forget to check your statements

The Medical Schemes Act requires that the healthcare providers give full details on all accounts. Please check that your account shows:

- Your name and surname
- Your medical aid number
- The treatment date
- Name of patient (as indicated on the membership card, not a nickname)
- Amount charged
- Rate code where applicable
- ICD10 codes