MBMED NEWSLETTER

Issue 1 | July 2023

Answering Your Questions

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Answers to MBMed in 2023

How is MBMed doing so far this year?

MBMed Medical Aid Fund is a medical aid scheme established in 1968 and registered under the Medical Schemes Act. Membership of the Scheme is restricted to employees and pensioners of the Mercedes-Benz South Africa Group of Companies.

As of 31 May 2023, the Scheme had **3 847 principal members** and **5 589 dependents (9 436 beneficiaries)**.

3 847
Principal Members

5 589
Dependents (9 436 beneficiaries).

As a small medical aid scheme, MBMed continues offering members competitive benefits at highly competitive contribution rates.

MBMed has excellent financial health, with member reserves at around 66% of annualised income. The statutory solvency reserve ratio is 25%, and MBMed's own risk-based solvency reserve is set at 48%. Member reserves can be leveraged to provide for greater affordability and are a hedge against massive cost claims. Your Board of Trustees are committed to ensuring funding for equitable access to quality health care for all members and their families, and to delivering the best member experience. If this is not what you as a member are getting, we want to hear from you so that we can quickly, efficiently and effectively address your concerns and get better at what we do.

MBMed does, however, face certain risks which are well-understood by the Board. You can be assured that the Board has put the necessary risk mitigation measures in place and regularly monitors these mitigations and levels of risk.

A critical risk to the Scheme is fraud, waste and abuse. For more information on these risks and what we can all do to protect MBMed, please watch this important video online – go to **youtube.com/watch?v=2nM3I64UGZo**

Answers to Ex Gratia Benefits

What are Ex Gratia Benefits?

Members who:

- **have special requests that fall outside the benefits provided in terms of the Rules of the Scheme,**
- **have exceeded their benefits, or**
- **who require assistance as a result of financial hardship, may apply for an ex gratia consideration.**

Consideration for awarding additional benefits on an ex gratia basis is based on medical necessity, assessment of the financial impact on the member and the Scheme, and a review of past Scheme benefit utilisation by the member. All ex gratia decisions are made according to the MBMed Ex Gratia Policy.

Where can I find the MBMed Ex Gratia Policy?

You can access the policy from the MBMed Member Zone at **https://admin.medscheme.co.za/2013/MBMED/**. You will need to register if you have not previously registered. Look under Documents for the Policy. If you need assistance, please call **0860 00 2109** or email **mbmed@medscheme.co.za** or visit a Medscheme walk in centre.

How do I submit an Ex Gratia Application?

Ex gratia application forms are available on the MBMed Medscheme Member Zone or from a Medscheme walk in centre. Once completed, applications with the necessary clinical motivation from your treating doctor/s must be submitted to **mbmedspecialcases@medscheme.co.za,** or handed in at the on-site East London MBMed office.

What Ex Gratia applications are not likely to be considered for approval?

The Board of Trustees of MBMed is accountable for all ex gratia decisions. The Board has mandated the Administrator (under limited, prescribed circumstances) and / or the Ex Gratia Committee to authorise and make final decisions on ex gratia benefit applications.

As a general rule the following will not qualify for an ex gratia award, unless in the sole discretion of the Ex Gratia Committee, good cause exists to approve an ex gratia award:

- Ex gratia requests for additional advanced dentistry benefits, unless these are required because of an underlying medical condition, as confirmed by the Scheme's Clinical Advisor/s;
- Ex gratia requests for additional pharmacy advised therapy benefits;
- Ex gratia requests for expenses above the Scheme Rate;
- Ex gratia requests for claims older than 120 days of treatment date;
- Ex gratia requests for funding of deductibles; and
- Where there is significant risk to the Scheme if the award is granted.

What process should I follow if I am not happy with the outcome of my Ex Gratia Application?

There are two options for members

The first option is the Review Process

If a request for ex gratia benefits is declined, a member may accept the decision or, within a reasonable time, request the Ex Gratia Committee to review the decision. In the event that a review is requested after substantial time has passed, for example more than 21 business days, the Principal Officer will determine if the timeframe is reasonable based on the circumstances and the reasons for the long time period. A review request will only be considered in the event of a substantial change in the circumstances of the member relevant to the ex gratia application and/or any amendments to the Policy relevant to the ex gratia application and/or any additional information becoming available relevant to the ex gratia application, that was not considered by the Committee, and which, in the opinion of the Principal Officer, warrants a review of the original decision by the Committee. The decisions of the Ex Gratia Committee remain discretionary and non-precedent setting.

The second option is the Appeals Process

If a request for ex gratia benefits is declined, a member may accept the decision or, within twenty-one (21)working days, appeal the decision. The appeal request must be submitted to the Principal Officer and must be accompanied by substantive reasons for challenging the correctness of the decision of the Committee. The reasons for the appeal will be restricted to alleged incorrect application or interpretation of the Policy. The appeal request will be considered by the Board of Trustees within seven (7) working days of submission to the Principal Officer by the member. Ex-gratia decisions remain discretionary and non-precedent setting.

Answers to NHI

Why does Government want to introduce a National Health Insurance Scheme?

Before trying to answer this question, it is important to take a step back and look at healthcare in South Africa. Healthcare in South Africa has two distinct divided systems. Approximately 80% of South Africans have no health cover and rely on the public healthcare sector, while about 20% are covered by medical aid schemes and principally use the private healthcare sector.

While there is admittedly significantly higher expenditure and a fair amount of wastage and over-servicing in the private healthcare sector, the quality of services and health outcomes are significantly better than in the public health sector. We all know and accept that this healthcare system is not sustainable in the long run.

South Africans need to work together to develop a healthcare system which is equitable, fair, affordable and meets the needs of all South Africans. This is a constitutional imperative under Section 27 of the Constitution. The current South African government considers National Health Insurance (NHI) as a funding mechanism to ensure equitable access to quality healthcare in line with Section 27 of the Constitution.

In South Africa, NHI is seen as a healthcare financing system that will help the country get to universal healthcare. It would be run sort of like a "super medical aid scheme".

Is the Government planning to nationalise all health care services and employ all the providers (doctors, specialists, etc)?

No. Nationalisation is not planned. Under an NHI scheme, healthcare services will still be privately and publicly owned. Healthcare providers may work for the state, be self-employed or work for privately owned organisations.

Is NHI already law in South Africa?

Not yet. In May 2023, Parliament's Portfolio Committee on Health adopted the NHI bill. In June, Parliament adopted the bill. It has now been sent to the National Council of Provinces for review. It is anticipated that the National Council of Provinces will approve the bill. The National Council of Provinces will convene another round of consultations with interested and affected parties. MBMed is an interested and affected party and will engage the National Council of Provinces through the organised medical aid scheme sector under the Board of Healthcare Funders.

Will private healthcare still be allowed to exist, and what about medical aid schemes?

The NHI bill creates a framework to collect funds, disperse funds and use them to achieve universal health coverage, but the funding mechanism, service delivery model and many other details have not yet been clarified. The role of the private sector still needs to be determined. Equally important, so does the role of medical aid schemes in the future.

The process of bringing NHI into law is expected to take approximately another year. Should developments proceed without any formal legal challenge and the bill is passed into law, it is anticipated that the minimum period to get the Fund established and for the Fund to become a payer of healthcare services is five years.

During this period, the biggest impact on MBMed and other medical aid schemes will be our engagement with the process as it unfolds. As a Board of Healthcare Funders member, MBMed will ensure its members' voices are heard in engagements with Government. It may well be that MBMed decides to join one or other legal challenge to all or parts of the bill as well.

So, what must MBMed members do now?

No action is required at this time. There is no need to panic. It will take some time for NHI to be fully implemented. If it does indeed proceed, the details of NHI implementation still have to be clarified with the existing role players, including MBMed. MBMed has survived many challenges over its more than 50 years. The Board of Trustees, elected by the MBMed membership, remain committed to quality healthcare for its members and all South Africans.

MBMed will be part of the solution to South Africa's tremendous historical challenge healthcare challenges. MBMed and its members have no option but to engage constructively with the NHI as it unfolds.

Answers to Gap Cover

What is Gap Cover?

MBMed often cannot control what specialist healthcare providers charge. In many cases, there is a difference between what a specialist charges and the scheme rates. Gap cover pays for the difference (which is called a 'shortfall'), so members are not out of pocket and don't suffer financially due to unexpected medical expenses.

What is Sanlam Gap Cover for MBMed?

Sanlam Gap Cover for MBMed is explicitly designed for MBMed members. It is also the only gap cover that the Mercedes-Benz South Africa Payroll can use to pay premiums directly. Please note that MBMed is not party to the policy agreement between the member and Sanlam. All queries must be directed to Sanlam, the appointed Administrator, or the appointed Broker at **MBSA@mercermarshbenefits.com.** Please visit the MBMed Member Zone for more information on Sanlam Gap Cover for MBMed. You can access the MBMed Member Zone at **https://admin.medscheme.co.za/2013/MBMED/.** You will need to register if you have not previously registered.

Is there a maximum age limit for the cover, and are there waiting periods on Sanlam Gap Cover?

There is currently no specific age limit for new applications. However, only new employees who join gap cover at their time of employment will be accepted free of underwriting. All existing employees and pensioner members (who did not take up the offer during the previous open window period periods) will be subject to full underwriting and exclusions in line with the policy.

How do I submit Sanlam Gap Cover Claims?

Claims must be submitted using the Claim Forms available from Sanlam, or the appointed Administrator, or the appointed Broker. Claim Forms can also be accessed at the MBMed Member Zone **(https://admin.medscheme.co.za/2013/MBMED/).**

Can I choose another gap cover product, or must I use Sanlam Gap Cover for MBMed?

There is no obligation to purchase Sanlam Gap Cover for MBMed. Participation is entirely voluntary. If you want gap cover and want to shop around for competitive products, you are free to do so. It is always best to consult a registered and accredited personal financial advisor or broker before you take out medical aid scheme gap cover or any other health insurance product.

Answers to Medical Aid and Tax

How do I obtain my tax certificate?

You will receive a copy of your tax certificate via email from **mbmed@medscheme.co.za.** By now, you would probably have received your medical aid tax certificate for the previous financial year. File your certificate safely, as you can use it to reduce the personal income tax you have to pay. This is because the Income Tax Act provides for tax rebates on medical aid scheme fees paid (SARS Medical Scheme Fees Tax Credit).

What is a Medical Scheme Fees Tax Credit?

Medical expense tax credits are used to reduce the tax payable by a household that contributes to a medical scheme. These medical expense tax credits are anticipated to be removed over time to fund the National Health Insurance (NHI).

What tax credits can I expect?

For the 2022/2023 tax year, the medical tax credits are as follows:

- **R347** per month for the main member of the Scheme;
- **R347** per month for the first dependant on the Scheme; and
- **R234** per month for each additional dependant on the Scheme.

You may also be allowed to deduct certain qualifying additional out-of-pocket medical expenses from your taxable income. Read more about these deductions on the official SARS website at **https://www.sars.gov.za/tax-rates/medical-tax-credit-rates/**

Answers to Chronic Medicines

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 for 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 Day-to-Day Benefits and you will probably exhaust this benefit limit quite quickly. On the other hand, by registering on the 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 find out if you have a qualifying chronic condition by contacting the Scheme through any of its communication channels or a walk-in centre.

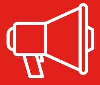
Do I have to use a specific pharmacy for dispensing of my Chronic Medicines?

No, MBMed beneficiaries are free to use any pharmacy for dispensing of their chronic medicines. The rules and managed health care protocols of MBMed are applicable irrespective of which pharmacy you use. Pharmacy Direct is recommended as a pharmacy of choice for employee members who want their medicines delivered to one of the Company Wellness Centres or would like their medicines to be delivered to their home. You find out more about Pharmacy Direct at **www.pharmacydirect.co.za** or by calling **086 002 7800** or by emailing **care@pharmacydirect.co.za.**

Where can I find out more about the Chronic Medicine Benefit?

The best option is to call Medscheme Chronic Medicine Management (CMM) on **0860 002 109** between 08:30 and 16:00 (Mon – Fri) and select the chronic medicine option.

Contact MBMED



Medical Aid Fund made easy!

Visit our website
www.mbmed.medscheme.com

Member Zone
24/7 access to benefits, tax certificates, claims statements and other info about your membership

0860 002 109

Administrator: **Medscheme Holdings (Pty) Ltd** PO Box 1101 Florida Glen 1708
Email: **mbmed@medscheme.co.za**

MBMED Chat
- Chat in real-time with a consultant
- Attach documents
- Receive documents
- View your e-card

HealthCloud
- Look up information on your condition