ENGEN | Medical Benefit Fund

Administered by Discovery Health

MEMBER GUIDE 2019

This Member Guide is intended to summarise the Rules of Engen Medical Benefit Fund applicable to the principal member and his or her dependants registered with the Fund. A copy of the full set of Rules can be obtained from the Fund's website at www.engenmed.co.za.

If a discrepancy arises between this Member Guide and the Rules of the Fund, the Rules of the Fund will take precedence.

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INTRODUCTION

We trust that you will find the information in this Membership Guide informative and helpful.

Please take time to familiarise yourself with the contents of the Member Guide and the summary of your benefits so that you are fully informed about your membership and the benefits available to you. Should you have any enquiries regarding your membership and/or benefits, please contact the Client Service Department on 0800 001 615.

Overview

Engen Medical Benefit Fund was established in 1997 to provide funding for healthcare to Engen employees and their families.

The Engen Medical Benefit Fund is managed by a Board of 10 Trustees. Five of the Trustees are nominated by the Employer and the other five are elected by the members of the Fund.

The Board of Trustees is responsible to ensure compliance with all relevant legislation, setting of the Rules that govern the Fund, determining the benefits available to members and the contributions charged, whilst ensuring the financial stability of the Fund and equitable access to benefits for all members.

Golden Rules

- Familiarise yourself with the Rules of the Fund.
- Understand your rights and responsibilities as a member.
- Obtain pre-authorisation where necessary.
- Remember authorisation does not guarantee full settlement of a claim.
- Always make use of the Designated Service Providers (DSP) available to you.
- If possible, negotiate rates with service providers to mitigate or reduce payments due by yourself.
- Make sure to access the wellness benefits offered by the Fund.
- If you have any chronic conditions, enquire about the Fund's specific baskets of care and management programmes.
- Check your claims notification or member statement and review the claim details and available benefit limits. You can also review claims information and benefits on the Fund's website www.engenmed. co.za.

MEMBERSHIP

Who is eligible for membership on the Engen Medical Benefit Fund?

- The Engen Medical Benefit Fund is a closed medical Fund and membership is restricted to permanent employees, pensioners and disability claimants of Engen Limited.
- At the time of their application, or at any time thereafter, employees who join the Fund may apply to have children and/or adults added to their membership as dependants. Dependants have to qualify for Fund membership.

Who is not eligible for membership on the Engen Medical Benefit Fund?

- Members of the Fund who resign from the employment of Engen Limited, together with their dependants, lose their membership to the Fund.
- Employees who were not members of the Fund before retirement, or the termination of their services on account of ill-health or other disability, are not eligible to become members of the Fund.
- The dependants of a deceased member who initially retain membership after the death of the main member, but who later resign from the Fund for any reason whatsoever, are not allowed to re-join as members once they have resigned.
- Those dependants of deceased members, or members who are retirees or who suffer from ill-health and disability, lose their membership to the Fund if the Fund terminates their membership as a result of non-payment of contributions.

Retention of membership in the event of retirement, ill-health or death

- Members may retain their membership of the Fund when they retire or when their employment is terminated by Engen Limited on account of ill-health or other disability.
- Registered dependants may continue membership in the unfortunate event of the death of the main member as long as they continue to pay all contributions that become due.

How to apply for membership

Obtain

An application form can be obtained from:

1. Your HR Department; or
2. The Fund's website **www.engenmed.co.za**
3. You may also apply by using the online application process. Your payroll person will guide you.

Complete

Complete your application in hard copy or online and attach the required supporting documentation.

Submit

Submit the completed application and supporting documentation to your HR Department.

If you are applying online and you have attached all the necessary documents, you don't have to submit a hard copy of the application form. You'll just click 'submit' and we'll process the application.

Incomplete and outstanding supporting documentation

Please note that incomplete applications and/or those submitted without the supporting documentation, as requested when you apply, will not be processed. If you are applying online, you will not be able to continue to submit your application until all the requirements are met. That means you must be ready with electronic copies of all IDs and all other relevant documents which you may need to attach to that online application, before you start the process.

When you complete a hard copy application form

Application forms must be stamped and submitted via your Human Resources (HR) Department. No direct submissions to the Fund can be accepted.

When you complete your application for membership online

Where applicable, please have electronic copies of the following documents ready to insert where the application tool asks you for it:

- Copy of ID(s)
- Copy of Birth Certificate(s)
- Copy of marriage certificate/affidavit
- Proof of student registration
- Proof of disability.

No underwriting and waiting periods apply to employees and their dependants who join the Fund within the first thirty (30) days of employment or after having served the previous scheme's notice period.

If you have not received your Welcome Pack and membership card within 21 days of submitting your application, please call our Client Service Department on 0800 001 615 to enquire about the status of your application.

If underwriting would have applied at joining, the Fund could retrospectively impose underwriting if the member does not disclose any and all relevant medical information when applying for membership.

All new applicants, who are joining after the date of employment or not immediately after having served the previous scheme's 30 day notice period, are required to complete the medical questionnaire. Applicants must disclose to the Fund information regarding any medical condition for which medical advice, diagnosis, care or treatment was recommended or received over the twelve (12) months prior to their date of application. This requirement applies to the applicant and his/her dependants and includes, but is not limited to, medical conditions and/or diseases that:

- A member or dependant suffers from as at the date of application;
- A member or dependant was diagnosed with sometime over the past 12 months before the application date, including conditions that were diagnosed but managed with lifestyle changes, e.g.high cholesterol;
- A member or dependant was treated for over the previous 12 months before the application date including treatment received and treatment that was recommended, but not necessarily taken;
- A member or dependant obtained medical advice about, not from a doctor but from another healthcare professional such as a pharmacist;
- The member or dependant had any symptoms for which no illness was specifically diagnosed by a doctor, or for which no specific treatment was provided.

Waiting periods

Where an employee joins the Fund after commencing employment or after having served a previous medical scheme's 30 day notice period, the Fund may impose the following waiting periods as provided for in terms of the Medical Schemes Act (No. 131 of 1998):

Category	Three (3) month general waiting period	12 month condition-specific waiting period	Access to Prescribed Minimum Benefits (PMBs) during Waiting Period
New applicants, or persons who have not been a member of a medical scheme for the preceding 90 days.	Yes	Yes	No
Applicants who were members of another medical scheme for less than 2 years.	No	Yes	Yes
Applicants who were members of another medical scheme for more than 2 years and who did not join within 30 days of employment or date of leaving their previous medical scheme.	Yes	No	Yes
Child-dependants born during a period of membership and registered within 30 days of birth/ adoption.	No	No	Yes
Addition of a spouse/life-partner within 30 days of marriage/proof of common household.	No	No	Yes

Membership cards

The Fund provides members with a Welcome Pack, which includes a membership card for the main member and all of the adult dependants on his/her membership.

Membership cards may only be used by the registered member and registered dependants. It is fraudulent to permit someone else to use your Fund card and benefits.

Welcome Packs and membership card(s) are sent directly to members at the postal address registered on the administrator's system. It is very important that contact details, including addresses are correct. Please advise the administrator immediately when your details change.

Change of personal details

For the Fund to communicate effectively with you, it is important for you to notify us immediately if any of your contact details change.

HR departments do not inform the Fund of any changes made to personal details. Therefore any changes to personal details should be separately directed to the Fund.

Update your information – it's as easy as 1… 2… 3…

Step 1

To update your personal information, log on to the Fund's website www.engenmed.co.za and go to the 'YOUR DETAILS' section. You can also obtain the ***Change of personal details*** application form from the Fund's website under the tab 'Find a document', or phone our Client Service Department at 0800 001 615 for assistance.

Step 2

Complete the form, ensure it is signed and that a copy of your Identity Document (ID) is attached.

Step 3

Your completed form may be returned to the Fund in one of the following ways:

- Email: membership@engenmed.co.za
- Fax: 011 539 2766
- Registered post:
  Engen Medical Benefit Fund Membership Department
  PO Box 652509
  Benmore 2010

The Fund shall not be liable if a member's rights are prejudiced or forfeited as a result of neglect to comply with these requirements.

Monthly contributions

Membership contributions are deducted by the employer from the employee's monthly remuneration. This is paid to the Fund every month in arrears on behalf of the member.

The employer subsidy is determined by Engen Limited.

Late contribution payments can result in suspended benefits, or cancellation of membership.

The Fund calculates your contribution using the Contribution Table (applicable to the particular year) based on:

- The income (rate-of-pay/ROP) of the principal member.
- The number of adult dependants defined as spouses, life-partners and any immediate family for whom the principal member is liable, including children from the age of 21 years. Additional adult dependants must be financially dependent on the member and evidence to this effect is required for acceptance on to the Fund; Spouses, life-partners and any immediate family for whom the principal member is financially responsible, may apply to become a dependant, including children who are older than 21 years.
- The number of child dependants: all child dependants younger than twenty-21 years are considered to be child dependants. Children from the age of 21 years, registered as bona fide students at an educational institution up to the age 25 years, subject to providing proof of current registration at a tertiary institution to the Fund annually, are also considered to be child dependants.

Late joiner penalties

If a special dependant (for instance the member's mother or father) who is older than 35, joins the membership, late joiner contribution penalties may be imposed as per the Medical Schemes Act and the membership rules noted in this guide.

Termination of membership

You may terminate the membership of any of your dependants by notifying your Human Resources (HR) Department, giving 1 calendar month's written notice to the Fund.

Principal members may only terminate membership when they resign from employment with Engen Limited, or when they provide proof of alternative medical scheme cover (as a dependant on their spouse's medical scheme). A calendar month's notice is required using the necessary Fund documentation.

STRUCTURE OF BENEFITS

The benefit structure of the Engen Medical Benefit Fund includes a 10% Medical Savings Account (MSA) component for primary care (day-to-day) expenses. Once the MSA has been exhausted, the Primary Care Benefits are paid by the Fund from the insured portion of the benefits, subject to the applicable limits indicated in the Benefit Schedule.

Expenses payable from the Fund's insured or risk portion

The Fund will cover expenses such as those noted below from the insured or risk portion of benefits. Note that payment may be subject to:

- Pre-authorisation
- Managed Care Protocols and Clinical Guidelines generally accepted in the industry as best practice principles
- Co-payments
- Sub-limits

The following are covered from the insured or risk portion of your benefits:

- Hospitalisation (including ward fees, theatre fees, ward medicine and treatment, surgery and anaesthesia etc.). Post operative rehabilitation benefits provided for a period of 6 weeks, subject to approval.
- A 7 day supply of medication on discharge from hospital (To-take-out/'TTO')
- General Practitioners, specialist and technician consultations and treatment while in hospital
- Physiotherapy and occupational therapy while in hospital
- Organ transplants including donor costs, surgery and immuno-suppressant drugs
- Chemotherapy, radiation and dialysis treatment
- Injuries sustained in motor vehicle accidents, subject to an undertaking in favour of the Fund
- Routine diagnostic endoscopic procedures (performed in a doctor's rooms) or endoscopic procedures as part of an authorised hospitalisation
- Outpatient or emergency department visits with a final diagnosis of a PMB, or Priority Emergency, or leading to an immediate admission
- Specialist consultations out-of-hospital (full cover for Designated Service Provider (DSP) specialists)
- Pathology
- Prescribed Minimum Benefits in- and out-of-hospital (full cover when the services of DSP providers are used)
- In-hospital dentistry – theatre and Anaesthetist accounts for children under the age of 8 years
- Specialised radiology such as CT, PET and MRI scans and radio-isotope studies, subject to authorisation and applicable limits
- Basic radiology
- Maternity benefits (including home delivery), subject to registration on the Maternity Care Programme
- PMB Chronic Disease List chronic medication, subject to registration on the Chronic Illness Benefit
- Prostheses (some limits may apply)
- Hearing aids (including repairs), subject to sub-limits. Benefits for a second hearing aid subject to clinical criteria and authorisation
- Appliances i.e. nebulisers, glucometers and blood pressure monitors, subject to applicable limit
- Ambulance and emergency services through ER24
- Home-nursing, step-down facilities and hospice services as an alternative to hospitalisation, subject to approval and applicable limit
- HIV management
- Infertility interventions and investigations in line with PMBs
- Conservative and specialised dentistry including orthodontics, subject to applicable limits
- Maxillo-facial and oral surgery.

Expenses payable from your Medical Savings Account (MSA) and Primary Care Benefits

In any financial year, Primary Care (day-to-day) Benefits are first covered from your MSA until your funds are used up. In any financial year, once the MSA limit has been reached, the following services are paid for from the Insured Risk Benefits, subject to the limits indicated in the Benefit Schedule:

- General Practitioner, medical specialist and registered private nurse practitioner consultations and non-surgical procedures out-of-hospital
- Auxilliary services:
  - Acupuncture
  - Chiropractic treatment
  - Dietetics
  - Non-surgical prostheses
  - Audiology and speech therapy
  - Occupational therapy
  - Private nursing and registered private nurse practitioners
  - Podiatry/chiropody
- Eye tests
- Prescribed acute medication
- Homeopathy and Naturopathy consultations and medication
- Physiotherapy and bio-kinetics out-of-hospital
- Psychology and social services

The following services will simultaneously fund from MSA and your Insured Risk Benefits:

- Basic Dentistry
- Spectacles and/or contact lenses

The following services will fund from MSA only:

- Self-medication or medication obtained over-the counter
- Screening and Preventative Benefits

Important things you should know before using your benefits

Designated Service Providers (DSP)

The Fund has Designated Service Provider's (DSPs) in place. You should make sure that you use these appointed DSPs to minimise any co-payments for services obtained in- or out-of-hospital, and/or to prevent claims from being rejected.

Visit the Fund's website at **www.engenmed.co.za** and log on to the MaPS tool to find a DSP provider or Preferred Provider near you.

Fund appointed DSPs

- For Ambulance services:
  - ER24.
- The Premier A or Premier B Specialist Network
- The Discovery Health GP Network.

Note: Exceptions are only allowed in an emergency as defined in the Medical Schemes Act, No. 131 of 1998.

These are specific providers of healthcare services, for example hospitals, GPs and specialists, who have agreed to provide services according to certain agreed rules. The Fund pays these providers directly.

When you use the service of a DSP, all claims including Prescribed Minimum Benefits, are paid in full. This means you will not have to make any out-of-pocket payments.

If you do not use the services of the DSP

For PMB claims to be funded in full you must use a DSP for certain services, as indicated in this booklet and your Benefit Schedule. If these providers are not used, the Fund may pay claims up to the agreed rate only or apply co-payments.

You will not have to make any co-payments if you have involuntarily obtained a service (had no other choice) from a provider other than a DSP, and it is an emergency, for example hospital admissions the service was not available from the DSP or would not have been provided without unreasonable delay as there was no DSP within a reasonable distance from your place of business or residence.

The Fund's DSPs for the diagnosis, treatment and ongoing care costs (which may include medicine) for Prescribed Minimum Benefit (PMB) conditions are:

- Certain DSP Premier Rate Specialists and General Practitioners (GPs), who have agreed to deliver services in accordance with their Direct Payment Arrangement (DPA) with the Fund
- Contracted hospitals for all in-hospital treatment and care
- National Renal Care (NRC) for care of patients requiring renal care, including dialysis
- SANCA, RAMOT and Nishtara Lodge for all PMB benefits related to drug and alcohol detoxification and rehabilitation.
- Other service providers, as selected by the Fund from time to time.

It is likely that the Fund will contract with and appoint more DSPs, particularly provider networks, in its ongoing efforts to control and reduce costs for members.

Pre-authorisation is required to access the following benefits

- Hospital admissions/home nursing/step down/sub-acute/ rehabilitation and hospice, and all services in lieu of hospitalisation
- Some radiology scans: IVP tomography, contrast studies, bone densitometry, MRI, PET and CT scans
- All internal appliances and prostheses
- Benefit confirmation is required for Orthodontic treatment
- All chronic medication
- Certain Outpatient procedures

Obtain pre-authorisation at least 48 hours prior to a planned hospital event and within 48 hours after an emergency.

Some benefits have limits

Out-of-hospital pathology, including consumables and materials	Refer to the Benefit Schedule for the limit amount per beneficiary
Psychiatric hospitalisation	21 days per beneficiary
Alcohol and drug rehabilitation in hospital	21 days per beneficiary
External and Internal prostheses Hearing aids and hearing aid repairs Other appliances	Refer to the Benefit Schedule for the applicable limit amounts per beneficiary or family
*Dentistry (overall limit applicable to basic and specialised, in- and out-of-hospital) *Includes orthodontic (braces) treatment	Refer to the Benefit Schedule for the limit amount per family
Basic Radiology (black and white X-rays and ultrasonography)	

Maternity limits (subject to registration on the Maternity Programme)

Ultrasound scans	2 ultrasound scans per pregnancy. 3D or 4D scans are paid at the cost of 2D scans only
Antenatal classes	Refer to the Benefit Schedule for the limit amount per pregnancy

BENEFITS

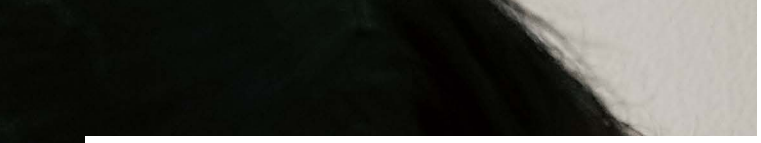
The Benefit Schedule shows the expenses that are covered by the Fund and limits, co-payments, authorisation requirements and DSP arrangements that may apply.

Hospital admission and treatment whilst in hospital

The details of the authorisation, including possible exclusions, will be emailed to you (if details are available), your treating healthcare professional and the hospital.

Make sure to clarify any uncertainty you may have with your treating practitioner or the Fund prior to your admission as some procedures, items and medication may not be covered or you may have to pay some of the costs. Should the treating practitioner disregard the terms and conditions of the authorisation, you will remain responsible for the costs incurred.

- Where possible, make use of specialists and other medical service providers on the Fund's Designated Service Provider (DSP) or Preferred Provider lists to optimise benefits and minimise co-payments for treatment while in hospital. Please visit the Fund's website at www.engenmed.co.za for a list of DSPs of the Fund.
- Funding of accommodation in a private ward is subject to a motivation from the attending practitioner and authorisation.
- A co-payment applies in the case of elective investigative endoscopies, if these procedures are performed in hospital (Colonoscopy, Sigmoidoscopy, Proctoscopy, Gastroscopy, Cystoscopy, Arthroscopy, Laparoscopy and Hysteroscopy).



Authorisation – is a clinical confirmation, not a guarantee of payment

Pre-authorisation is provided based on a clinical decision and enables the Fund to ensure the treatment provided to you is clinically appropriate and cost-effective. It should be noted that pre-authorisation is not a guarantee of payment.

Failing to obtain an authorisation may, in terms of the Rules of the Fund, lead to claims not being paid, or substantial co-payments, even if the medical condition is a PMB.

Specialised dentistry

- Specialised dentistry is limited based on the size of your family. If the treatment is performed in theatre with pre-authorisation, the complete treatment event, including all related accounts (e.g. dentist, surgeon), are paid from this limit with the exception of theatre and anaesthetist accounts which will be paid from the unlimited hospital benefit.
- When a maxillo-facial surgeon performs a standard dental procedure in theatre, the event is still payable from your annual family specialised dentistry limit. Only when a maxillo-facial surgeon performs surgery pertaining to the jaw and face that is specialised and pre-authorised, will services be paid from the unlimited risk portion of the Fund's benefits.

The payment of unauthorised services

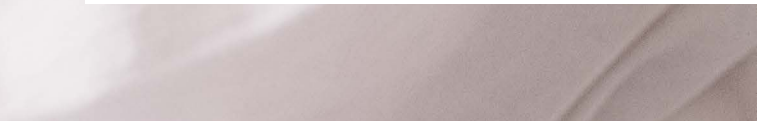
If you fail to obtain authorisation as required in terms of the Rules of the Fund, the Fund may:

- Pay for the service from your available MSA for non-PMB diagnoses, or reject the account if you do not have medical savings available; or
- Apply a penalty equal to the difference between 100% of the Fund rate and the cost charged by the service provider for PMB diagnoses.

Cover for chronic conditions

- The Fund covers approved chronic medicine for the 26 Prescribed Minimum Benefit (PMB) Chronic Disease List (CDL) conditions.
- We will pay your approved PMB chronic medicine in full up to the Fund rate if it is on the Fund's medicine list (formulary).
- If your approved chronic medicine is not on the medicine list, we will pay your chronic medicine up to the Maximum Medical Aid Price (MMAP).
- Out-of-pocket expenses can be avoided by using alternative products that are less expensive. Discuss your options with your treating provider or pharmacist.
- The Fund also provides chronic illness benefits for non-PMB conditions for which the member must use medicine on a continuous basis for more than 3 months. This benefit is limited, as indicated in the Benefit Schedule.
- You must apply for cover by completing a Chronic Illness Benefit application form with your doctor and submitting it for review. For a condition to be covered form the Chronic Illness Benefit, there are certain benefit entry criteria that needs to be met.
- If your Chronic Disease List (CDL) condition is approved by the Chronic Illness Benefit, the Chronic Illness Benefit will cover certain procedures, tests and consultations for the diagnosis and ongoing management of the condition in line with Prescribed Minimum Benefits.
- If you suffer from a related condition, you must make use of the services of a Premier Plus GP , who can register you on one of the following disease management programmes:
  - the Diabetes Management Programme
  - the Cardio-Vascular Management Programme
  - the Mental Health Programme.

The Fund pays for specific additional benefit baskets of care once you are registered on the Programme.



The Fund covers the following Prescribed Minimum Benefits Chronic Disease List conditions:
Addison's Disease
Asthma
Bipolar mood disorder
Bronchiectasis
Cardiac Failure
Cardiomyopathy
Chronic renal failure
COPD and emphysema
Coronary artery disease
Chron's Disease
Diabetes insipidus
Diabetes mellitus type 1
Diabetes mellitus type 2
Dysrhythmia (arrhythmia)
Epilepsy
Glaucoma
Haemophilia
Hyperlipidaemia
Hypertension
Hypothyroidism
Multiple sclerosis
Parkinson's disease
Rheumatoid arthritis
Schizophrenia
Systemic lupus erythematosis
Ulcerative colitis

How to avoid out-of- pocket expenses

- **Confirm** that we have your latest email and cellphone details as authorisation confirmation will be sent to you on the contact details that we have on system in the event of a hospital admission.
- **Read the authorisation letter/SMS** and make sure you understand the terms and conditions i.e. Fund exclusions and limits associated with the procedure. If you have any questions, or are not sure about anything, please speak to your treating healthcare professional and/or one of our Case Managers before you are admitted to hospital.
- **You may go** to any hospital as long as your procedure is authorised.
- Make **use of a Designated Service Provider** (a contracted doctor/specialist) as the Fund has negotiated fees with them and they are not allowed to charge more than has been agreed with them by the Fund. If they do charge more than the agreed upon rate, please notify us without delay so that we can assist you in resolving the matter. If you do not use the services of these DSPs, and your doctor or specialist charges more than the agreed rate, you will have to pay the difference.
- Very few anaesthetists charge at the Fund rate. It is therefore a good idea to ask your doctor/surgeon which anaesthetist he/she makes use of and **negotiate** fees with them upfront.

Preventative healthcare

Preventative care is an important part of maintaining good health and we encourage our members to make use of this special benefit. Refer to the Benefit Schedule for more detail.

Cover for the following:

Flu immunisations from your MSA*

- Flu vaccination – 1 per beneficiary per year.

Baby and child immunisations

- Standard immunisations for children up to the age of 12 years in accordance with the Department of Health protocols
- MMR vaccine for measles, mumps, and rubella (also called German measles).

Health risk assessments covered from your MSA

- Blood glucose test
- Total serum cholesterol test
- Blood pressure test
- Faecal occult blood test
- Human papilloma virus (HPV) screening.

Scans covered from your MSA*

- Cervical cytology
- Mammography.

For the expecting mother

- Antenatal classes (in and out of hospital) limited as indicated in the Benefit Schedule
- 2 ultrasound scans per pregnancy. The Fund only pays for 2D scans

* 1 per beneficiary per year at 100% of the Fund rate.

For a smoker

A smoking cessation benefit, paid from the Medical Savings Account is available. The benefit is limited to R730 per beneficiary per month.

The medical savings paid, will be reimbursed if, after the treatment, the nicotine test result is negative.

BENEFIT SCHEDULE

In-hospital cover

A list of the designated service providers (DSPs) is available at www.engenmed.co.za or by calling the Client Service Department on 0800 001 615

Service	Benefit	Limits (Subject to managed care rules and protocols)	Authorisation Requirements	Designated Service Provider (DSP)
Admission to hospital – Failure to make use of a DSP or failure to pre-authorise any hospital admission will result in a R1 000 co-payment				
Hospital stay in a general, labour or high care ward or intensive care unit, theatre, including costs of dressing materials consumed and equipment used while in hospital	100% of Fund rate	Unlimited cover	Yes, at least 48 hours prior to admission or within 24 hours of an emergency admission	–
Psychiatric hospitalisation	100% of Fund rate	21 days per beneficiary per year or 15 outpatient psychotherapy sessions, subject to Prescribed Minimum Benefits		–
Day clinic or day theatre admission	100% Fund rate	Unlimited cover		–
Treatment whilst in hospital				
Consultations, surgical procedures, physiotherapy, ward and theatre medication and blood transfusions	100% of the DSP or Fund rate	Unlimited cover	Forms part of the related hospitalisation	Subject to Specialist/GP DSP
Anaesthetics administered in theatre	100% of Fund rate	Unlimited cover		
Pathology	100% of Fund rate	Unlimited cover		
Endoscopic investigations	100% of Fund rate	Unlimited cover	Yes, at least 48 hours prior to procedure. A co-payment of R1 200 applies for each elective scope. This does not apply to PMB treatment	
To Take Out (TTO) drugs	100% of Fund rate	7 day supply No levy applicable	Forms part of the related hospitalisation	–
Organ transplants (organ and patient preparation, harvesting and transportation and immunosuppressant medication)	100% of Fund rate	R430 000 per family per year, subject to Prescribed Minimum Benefits	Yes, at least 48 hours prior to admission or within 24 hours of an emergency admission	–
Renal dialysis, including procedure, treatment and associated medication and drugs	100% of Fund rate	Unlimited cover	Yes	–
Mental health or drug and alcohol rehabilitation	100% of Fund rate	Limited to 21 days in-hospital treatment; and 15 out-of-hospital consultations per beneficiary per year, subject to Prescribed Minimum Benefits	Yes, at least 48 hours prior to admission or first out-of-hospital consultation	–
Internal prostheses	100% of Fund rate Multiple external and internal prostheses are subject to a joint overall limit of R86 000 per beneficiary per year and to the sub-limits as indicated	The following limits apply per prostheses type per procedure per year: **Hip replacements** Bilateral hip: R70 000 Total hip: R40 000 Partial hip R22 250 Revision hip R76 000	Yes. as part of the related hospitalisation	–

Service	Benefit	Limits (Subject to managed care rules and protocols)	Authorisation Requirements	Designated Service Provider (DSP)
		Knee replacements Without patella R 44 500 With patella R 50 000 Bilateral knee R 89 000 Revision knee R 77 000 **Shoulder replacements** Total shoulder R 53 000 Bilateral shoulder R 67 000 **Spinal fusion** Level 1 (without cage) R 24 000 Level 1 (with cage) R 46 000 Level 2 (without cage) R 32 000 Level 2 (with cage) R 51 000 Level 2 (with 2 cages) R 75 000 **Artificial Limbs** Below the knee R 23 000 Above the knee R 38 500 **Artificial eyes** R 23 000 **Finger joint prostheses** R 5 700 **Pacemakers** With leads R 48 000 Biventricular R 79 000 **Intra-cardiac devices** R265 000 **Cardiac valves** (each) R 36 500 **Aortic aneurism repair grafts** R152 500 **Cardiac Stents** (maximum 3 per year) per stent With delivery system R 26 000 Drug-eluting R 32 500		
Dentistry: maxillo-facial surgery	100% of Fund rate	Unlimited	Yes, at least 48 hours prior to admission or within 24 hours of an emergency admission	–

Service	Benefit	Limits (Subject to managed care rules and protocols)	Authorisation Requirements	Designated Service Provider (DSP)
Admission to hospital				
Voluntary admission: Hospital stay and all related services including consultations, surgical procedures, treatment, medication, physiotherapy, anaesthetics, etc.	100% of Fund rate	Unlimited cover	Yes, at least 48 hours prior to admission or within 24 hours of an emergency admission	–
#Emergency/involuntary non-DSP admission: qualifies for the same benefits as for a DSP hospital admission	100% of Fund rate	Unlimited cover	Yes, at least 48 hours prior to admission or within 24 hours of an emergency admission	–
#emergency as defined in The Medical Schemes Act, No. 131 of 1998				
Motor vehicle accidents and third party claims				
Payment is subject to an undertaking and completion of an accident injury form and report by the member	100% of Fund rate	Unlimited cover	Yes, at least 48 hours prior to admission or within 24 hours of an emergency admission	–
Post-operative therapy and rehabilitation				
Post-operative therapy and rehabilitation	100% of Fund rate 100% of cost	Post–operative physiotherapy, occupational and speech therapy, limited to a six-week period for the same condition for which the patient was hospitalised Surgical appliances	Yes, before treatment commences	–
Out-of-hospital cover				
Chronic medication				
PMB CDL Chronic medication benefit is applicable to members and/or dependants registered on the Chronic Illness Benefit	100% of Fund rate	Unlimited cover (subject to MMAP, chronic medicine list and PMBs)	Yes, once diagnosed	–
Non-PMB Chronic medication	100% of Fund rate	Includes cover for approved medication and injections where ongoing treatment is required in excess of three months. Limited to R13 250 for a single member and R26 000 per family per year	Yes, once diagnosed	At a pharmacy
Specialised medication benefit	100% of Fund rate	Limited to R152 500 per family per year	Benefits for a defined list of specialised medication, authorised based on clinical motivation by the treating healthcare professional	If a co-payment is applied by the pharmacy, the member will be personally liable to pay the amount directly to the pharmacy
Outpatient procedures and emergency visits				
Outpatient or casualty procedure that results from a procedure previously requiring hospital admission (within 48 hours post-event)	100% of Fund rate	Unlimited cover	Yes, at least 48 hours prior to procedure or within 24 hours of an emergency admission	At DSP
Outpatient or casualty consultations, procedures, medication and treatment defined as an #emergency	100% of Fund rate	Unlimited cover	None	At DSP
Specialist and GP consultations and treatment out-of-hospital				
Consultations, material and visits (including outpatient visits)	100% of DSP or Fund rate from MSA, once MSA is depleted, up to the Primary Care (day-to-day limit)	M R2 700 M + 1 R4 450 M + 2 R5 200 M + 3 R5 700 M + 4 R6 600	Paid in full at DSP for PMB or non-PMB services. If services of non-DSP providers are used, paid up to 100% of the Fund rate only	DSP: Discovery GP Network Premier A or Premier B Specialist Networks
Procedures performed in doctors' rooms (Specialists and GPs)	100% of Fund rate	Unlimited		–

Service	Benefit	Limits (Subject to managed care rules and protocols)	Authorisation Requirements	Designated Service Provider (DSP)
Oncology				
Any oncology treatment including chemotherapy, medicines and materials used, radiation in- and out-of-hospital and PET scans	100% of Fund rate	A threshold of R210 000 applies per beneficiary per year, subject to Prescribed Minimum Benefit. Once the threshold is reached, non-PMB claims are paid at 80% of the Fund rate	Yes, registration on oncology programme required and submission of a treatment plan	–
Stoma and oxygen products	100% of Fund rate	Subject to joint limit of R25 500 per family per year for Stoma therapy and Oxygen devices		–
Radiology and pathology				
Radiology and Pathology: including all radiology and pathology, X-rays Includes endoscopic investigations performed in doctor's rooms	100% of Fund rate	Unlimited cover	Yes, forms part of a related hospitalisation Endoscopic investigations preformed in doctor's rooms do not require authorisation	Preferred Provider use recommended to avoid co-payments i.e. Ampath, Lancet and Pathcare
Specialised radiology				
MRI and CT scans	100% of Fund rate	Limited to 2 scans per beneficiary per year in- and out-of-hospital, subject to Prescribed Minimum Benefits	Yes, at least 48 hours prior to procedure.	–
Any other specialised radiology	100% of Fund rate	Unlimited cover	None	–
Clinical and medical technologists				
Clinical and medical technologists: includes services rendered, materials and apparatus supplied	100% of Fund rate	Unlimited cover	No pre-authorisation required	–
Maternity benefit				
Hospital and home confinements; water births and post-natal care by a midwife	100% of Fund rate	Unlimited cover	Yes, registration on the Maternity Benefit	–
Antenatal ultrasound scans	100% of Fund rate	2 ultrasounds per pregnancy. We pay 3D scans at 2D rates only		–
Antenatal classes (in and out of hospital)	R950 per pregnancy		Post-natal care by a midwife subject to motivation by healthcare provider	–
Chronic appliances				
Oxygen therapy, including appliances inclusive of oxygen products, cylinders and ventilation expenses	100% of Fund rate	Subject to joint limit of R25 500 per family per year for Oxygen appliances and Stoma Therapy	Yes, subject to management and prior approval by the Fund	Subject to DSP
Medical and surgical appliances – excludes benefits for internal medical appliances and prostheses listed above, but includes conditions not covered under the post-operative / rehabilitation benefit				
Medical and surgical appliances, including Wheelchairs and Hearing Aids. (Includes the net cost after discount for the supply and fitment of hearing aids and hearing aid repairs)	100% of Fund rate	Limited to R25 500 per family per year	No pre-authorisation required	–
Second hearing aid	100% of Fund rate	Limited to R12 500 per family per year	Clinical motivation and authorisation is required. Strict criteria applies	–

Service	Benefit	Limits (Subject to managed care rules and protocols)	Authorisation Requirements	Designated Service Provider (DSP)
Immunisations				
Baby and child immunisations (up to 12 years)	100% of Fund rate from MSA. Once MSA is depleted, up to the Primary Care (day-to-day) limit	M R 2 700 M + 1 R 4 450 M + 2 R 5 200 M + 3 R 5 700 M + 4 R 6 600	None	–
Dentistry				
Specialised dentistry (periodontics, bridgework, crowns, dentures and dental implants)	100% Fund rate from Insured Benefits	M R 8 500 M + 1 R11 750 M + 2 R14 750 M + 3 R17 250 M + 4 R19 000	None (unless in-hospital treatment is required)	–
Orthodontics	100% of Fund rate	Subject to the Special Dentistry limit	Benefit confirmation is required	
In-hospital dentistry and maxillo-facial surgery: refer to in-hospital cover above				
Appliances				
Medical and surgical appliances, including wheelchairs and first hearing aid. Costs for the supply and fitment of hearing aids and hearing aid repairs Second hearing aid (issued in the same year for any one in the family)	100% of cost	R25 500 per family per year R12 500 per family per year	Yes, subject to clinical criteria, motivation and approval	Excludes prostheses listed under the Internal prostheses benefit
Ambulance services				
Air and road emergency services for emergency medical transport or inter-hospital transfers	100% of Fund rate at DSP	Unlimited if ER24 is used	Yes, subject to authorisation Any unauthorised use of ambulance services will be limited to the Fund rate, negotiated with the DSP and be subject to Prescribed Minimum Benefits	Through DSP ER24
A 40% co-payment will apply for voluntary, non-emergency use of any other service provider.				
Blood transfusions				
Blood transfusions	100% of Fund rate	Unlimited cover, subject to Prescribed Minimum Benefits	No pre-authorisation required	–

Service	Benefit	Limits (Subject to managed care rules and protocols)	Authorisation Requirements	Designated Service Provider (DSP)
Home nursing, step-down, recuperation and rehabilitation facilities				
Home nursing, step down, sub-acute (physical) rehabilitation facilities. Subject to Managed Care Rules and Protocols	100% of Fund rate	Unlimited	Yes, subject to authorisation. Services must follow pre-authorised hospitalisation	–
Private nursing and registered private nurse practitioners, including frail/hospice care				
Private nursing and registered private nurse practitioners, including frail/hospice care	100% of Fund rate from MSA. Once MSA is depleted, 80% of Fund rate from Primary Care (day-to-day benefits)	R26 000 per family per year	Yes, subject to authorisation. Services must follow pre-authorised hospitalisation	–
HIV management				
HIV treatment	100% of Fund rate	Unlimited cover, subject to formularies	Yes	–
Vaccinations				
Pneumococcal vaccinations	100% of Fund rate	Limited to one vaccination per beneficiary per lifetime	For beneficiaries over 65, covered from Insured Benefits. For beneficiaries younger than 65, covered from the Acute, Homeopathic and Naturopathic medication benefit	–

Primary Care (day-to-day benefits), subject to payment from the Medical Savings Account

Primary Care (day-to-day) benefits are first paid from the MSA. Once the MSA is exhausted for the year, benefits are paid as described below. The MSA, available upfront for the year, is equal to 10% of the total annual contribution for the member / member family

Consultations and non-surgical procedures				
General Practitioner, medical specialists, homeopaths, naturopaths and registered private nurse practitioners, including services and fees charged on an outpatient basis	100% of the agreed or Fund rate for GPs and Specialists. Other providers paid at 100% of the Fund rate	M R 2 700 M + 1 R 4 450 M + 2 R 5 200 M + 3 R 5 700 M + 4 + R 6 600	Registered private nurse practitioner's consultations and services include the cost of vaccinations and injection material, e.g. the administering of mumps, measles and rubella (MMR) vaccinations. PMB-related conditions, including the 270 DTPs, in-hospital and ante-natal consultations are not included under this benefit.	Subject to DSP: Discovery GP Network and Premier A or Premier B Specialist Network

Service	Benefit	Limits (Subject to managed care rules and protocols)	Authorisation Requirements	Designated Service Provider (DSP)
Prescribed acute medication				
Acute, homeopathic and naturopathic medication	100% MMAP from MSA, then from Primary Care (day-to-day) limit	M R 5 200 M + 1 R 7 800 M + 2 R 9 000 M + 3 R10 250 M + 4 + R11 500	–	–
Self-medication Over-the-counter (OTC) medication	100% of cost	R250 per prescription per beneficiary per day and available funds from the MSA	Only medicine that a pharmacist is entitled to prescribe and dispense	–
Optical				
Eye tests and tonometry tests	100% of Optical Assist Tariff from MSA	1 eye test and 1 tonometry test per beneficiary per year	Tests must be performed by a registered optometrist	–
Spectacles, lenses, frames and contact lenses Includes cover for hardening, tinting, reflective lens coating and refractive eye surgery	100% of Optical Assist Tariff from MSA and simultaneously accrues to the optical limit	Single member R4 750 Family R9 500 The above includes a frame sub-limit of R1 500 per beneficiary per year every two years from date of last service	Sunglasses, spectacle cases, solutions or kits for contact lenses are excluded	–
Paramedical and associated healthcare services				
Acupuncture	80% of Fund rate	Limited to R1 725 per family per year		–
Chiropractic treatment	80% of Fund rate	Limited to R3 150 per family per year Any one consultation limited to the rate at which the Fund will reimburse a GP consultation	Includes the cost of treatment and X-rays	–
Dietetics	80% of Fund rate	Limited to R1 050 per family per year		–
Non-surgical prostheses (for which a benefit is not provided elsewhere in this Schedule)	80% of cost	Limited to R3 150 per family per year		–
Audiology and speech therapy,	80% of Fund rate	Limited to R3 150 per family per year		–
Occupational therapy	80% of Fund rate	Limited to R3 150 per family per year		–
Physiotherapy, biokinetics	80% of Fund rate	Limited to R3 150 per family per year		
Private nursing and registered private nurse practitioners, including frail / hospice care	80% of Fund rate	Limited to R26 000 per family per year	Subject to case management and prior approval Includes private nursing/frail care/ hospice treatment prescribed by a medical practitioner, excludes general care	–
Podiatry / Chiropody	80% of Fund rate	Limited to R2 100 per family per year	Must be prescribed by a medical practitioner	
Clinical Psychology: consultations, therapy, treatment	PMB: 100% of Fund rate Non-PMB: 80% of lesser of claimed or Fund rate	Limited to R8 600 per family per year, subject to Prescribed Minimum Benefits		–

Service	Benefit	Limits (Subject to managed care rules and protocols)	Authorisation Requirements	Designated Service Provider (DSP)
Dentistry				
Basic dentistry	100% of Fund rate	M R 3 750 M + 1 R 4 800 M + 2 R 5 900 M + 3 R 7 200 M + 4 + R 8 400		–
Preventative Screening				
Faecal occult blood test for male prostate screening	100% of Fund rate	Limited to R1 100 per beneficiary per year from the MSA	Available for male beneficiaries 50 years and older	–
Cervical cytology used to detect pre-cancerous and cancerous processes in the cervix	100% of Fund rate	Limited to R1 100 per beneficiary per year from the MSA	Available to female beneficiaries who are between the ages of 21 and 65 years	–
HPV Screening after abnormal test results is received after a cervical cytology screening test (abnormal PAP result)	100% of Fund rate	Limited to R560 per beneficiary per year from the MSA	Only available to female beneficiaries who have received an abnormal test result after having undergone a cervical cytology screening test	–
Mammography using low-dose x-rays to detect cancer early	100% of Fund rate	Limited to R2 225 per beneficiary per year from the MSA	Available to all female beneficiaries who are 40 years or older	–
Health risk assessment which includes: ■ Blood pressure test ■ Blood glucose test ■ Total serum cholesterol test	100% of Fund rate	Subject to available funds in the MSA	Paid once for either the basket of tests or any one of these tests	–
Smoking cessation				
Smoking cessation	100% of Fund rate	Limited to R730 per beneficiary per month from the MSA	MSA expended will be reimbursed subject to a negative nicotine test result	–

SPECIAL FEATURES

Substance abuse focus

All Engen Medical Benefit Fund members have access to South African National Council on Alcoholism and Drug Dependence (SANCA) approved facilities as in-patients for drug and alcohol rehabilitation. Please contact the Client Service Department for confidential support and a referral to an appropriate treatment facility, should you be in need of assistance. Daily limits and annual limits apply and pre-authorisation is compulsory.

Oncology Programme

Members registered on the Oncology Programme have access to chemotherapy, medicines and materials, radiation in- and out-of-hospital and PET scans. All Oncology treatment allocates to a threshold of R210 000, whereafter non-PMB treatment pays at 80% of the Fund Rate only.

If the treatment is PMB-related, the Fund will continue to pay for any authorised treatment that may still be necessary.

HIV/AIDS management programme

It has been demonstrated that by proactively managing HIV and AIDS, those who have been diagnosed as HIV positive, can live a healthy and fulfilling life. When you register for our HIV Programme you are covered for the care that you need. You can be assured of confidentiality at all times. Call us on 0800 001 615 or email hiv@engenmed.co.za to register.

Emergency medical evacuations – ER24

If you ever find yourself in a situation where you require emergency transport for medical reasons, you are in the very best hands. The Engen Medical Benefit Fund ambulance benefits, which are covered under insured benefits, include medically appropriate emergency transport response services provided by ER24. This benefit is available by contacting 084 124.

Self service facilities

The Engen Medical Benefit Fund website has been specifically developed for the benefit of members, and by registering on the site, you are able to review your monthly statements, claims and personal information on-line.

To register, simply visit www.engenmed.co.za and register by entering your membership number and identification or passport number.

ADMINISTRATIVE REQUIREMENTS

Claims administration

To qualify for benefits, a claim must be submitted to the Fund by not later than the last day of the fourth month, following the month in which the service was rendered. If you believe a claim has been rejected in error, you have 60 days to report the error and resubmit the claim failing which the claim will be classified as stale.

As the member of the Fund you are responsible for monitoring and reviewing your monthly statement and for acting promptly where a claim is not reflecting, or has not been paid. This will ensure that such claims do not become stale. Claims submitted after they have become stale, will not be paid by the Fund (in line with Regulation 6 of the Medical Schemes Act No.131 of 1998).

Members who pay cash for any services received, should remember to submit the claim with the receipt as proof of payment, using the appropriate contact details of the Fund as provided in this Member Guide, or as communicated by the Fund from time-to-time. Members will be reimbursed at the relevant Fund rate (refer to the Benefit Schedule for details) and you may request the Fund to pay differences between claimed amounts and benefit amounts from your Accumulated Medical Savings Account (AMSA).

Members are responsible for ensuring the Fund is informed of any changes in their banking details.

Please note: changing your banking details with your Human Resources (HR) Department does not update your banking details with the Fund.

Payment of claims is always subject to Fund Rules, rates and limits, and Managed Care Protocols and Guidelines may apply.

Remember to obtain pre-authorisation at least 48 hours prior to a planned event or within 24 hours following an emergency

Membership statements

Claims notification will be sent electronically where email details are available. Member statements will also be available on the Fund's website **www.engenmed.co.za**

Medical Savings Account (MSA)

- All members contribute 10% of their total monthly contribution into their Medical Savings Account (MSA). For example, if your total Fund contribution is R1 000, an amount of R100 (10% of R1 000) will be allocated to your MSA and R900 towards the risk pool.
- If you have a positive balance in your MSA at month-end, you will receive interest on that amount.
- If you resign from the Fund, your MSA balance will be kept for a 4 month period to settle any claims that were incurred before resignation. Any remaining positive MSA balance will be paid out to you in the 5th month after your resignation, or be transferred to your new medical scheme.
- On termination of membership, the Fund may use your MSA to offset any debt you owe to the Fund which may include outstanding contributions.
- The Fund advances 12 months of MSA to members effective 1 January of each year. Overdrawn MSA (i.e. if you have used an amount from your advanced MSA that exceeds the amount you have contributed at the time of your resignation) will have to be repaid if you resign from the Fund.
- Payments from your MSA will be made at 100% of the Fund rate, subject to funds being available at the date on which a claim is processed.
- If you have MSA available at the end of the financial year (31 December) the positive balance will be carried over to the next year.
- In the unfortunate event of your death, the MSA balance due to you will be transferred to your dependants should they decide to continue membership of the Fund or, in the absence of such dependants, paid into your estate.

WHAT THE FUND DOES NOT COVER

There are certain medical expenses the Fund does not cover. We call these exclusions.

Exclusions are placed on benefits to protect all members of the Fund from unnecessary events and treatments that may be abused or cause the general cost of the Fund's contributions to become unaffordable.

The Fund will not cover the direct or indirect consequences of the following, except as regulated in the Prescribed Minimum Benefits:

- Cosmetic procedures, for example, otoplasty for jug ears; removal of portwine stains; blepheroplasty (eyelid surgery); removal of keloid scars; hair removal; nasal reconstruction (including septoplasties, osteotomies and nasal tip surgery); and healthcare services related to gender reassignment
- Treatment for obesity
- Treatment for infertility, subject to Prescribed Minimum Benefits
- Frail care (care not related to a medical condition)
- Experimental, unproven or unregistered treatment or practices
- CT angiogram of the coronary vessels and CT colonoscopy
- The purchase of the following, unless prescribed:
  - Applicators, toiletries and beauty preparations;
  - Bandages, cotton wool and other consumable items such as dental floss, toothbrushes or toothpaste eye solutions or kits for contact lenses;
  - Patented foods, including baby foods;
  - Tonics, slimming preparations and drugs;
  - Household and biochemical remedies;
  - Anabolic steroids;
  - Multivitamins and;
  - Sunscreen agents.

Unless otherwise decided by the Fund, benefits in respect of these items, on prescription, are limited to one month's supply for every prescription or repeat thereof.

- Costs of search and rescue
- Any costs that another party is legally responsible for
- Facility fees at casualty facilities (these are administration fees that are charged directly by the hospital or other casualty facility), unless stated differently for specific benefits
- Costs related to participation in reckless activities where, based on an objective test for reasonable behavior, the Beneficiary is deemed to be risking injury recklessly, such activities as solo-mountaineering, speed contests and extreme endurance marathons
- Willfully, self-inflicted injuries, except PMB, subject to clinical review
- Bleaching of vital teeth, metal inlays in dentures and front teeth
- Examination for insurance, school camps, visa, employment or executive purposes
- Accommodation in old age homes, spas or resorts
- Healthcare appointments not kept
- Telephone consultations
- Travelling costs, except emergency medical transportation as authorised
- Sunglasses or spectacle cases
- Accommodation and/or treatment in headache or stress relief clinics.

IMPORTANT TERMINOLOGY

Co-payment

A co-payment is a fee that members are required to pay directly to the service provider if there is a difference between the cover provided by the Fund and the cost charged by the service provider. Co-payments will also apply if you do not make use of appointed DSPs.

Designated Service Providers (DSP)

Designated Service Providers are healthcare professionals with whom the Fund has made special arrangements to provide members with effective and cost-efficient services.

These healthcare professionals will not request upfront payment from members as their claims are paid in full.

Where the use of DSP is indicated, members must make use of their services. If members choose not to use the DSP services, claims from non-DSP providers will be paid up to the Fund rate only, and co-payments will apply.

The following are DSPs:

- the Discovery GP Network;
- the Premier A and B Specialist Networks;
- ER24 for emergency medical transportation.

You can find information about a DSP near you on www.engenmed.co.za

Emergency medical condition

An emergency medical condition means any sudden and unexpected onset of a health condition that requires immediate medical or surgical treatment, where failure to provide such treatment would result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part, or would place the person's life in serious jeopardy.

MMAP (Maximum Medical Aid Price)

MMAP (Maximum Medical Aid Price) is a reference price model which serves as a guide to determine the maximum medical scheme price that schemes will reimburse for a pharmaceutical product that is interchangeable with other more cost-effective alternatives.

Co-payments that may result from MMAP pricing can be avoided by using alternative products that are less expensive, such as generic medicine. The Engen Medical Benefit Fund Medicine reimbursement rate is based on MMAP the use of the most appropriate alternative should always be discussed with your treating practitioner or pharmacist.

Fund rate

The Fund rate is the rate at which the Fund will pay for medical services as approved by the Board of Trustees. This rate is based on the Discovery Health rate.

Priority emergencies

There are instances where treatment at a DSP out-patient or emergency department is classified as an emergency although it may not be a PMB. The Fund will pay for such emergencies from the insured (risk) benefit and not from your MSA.

Preferred Providers

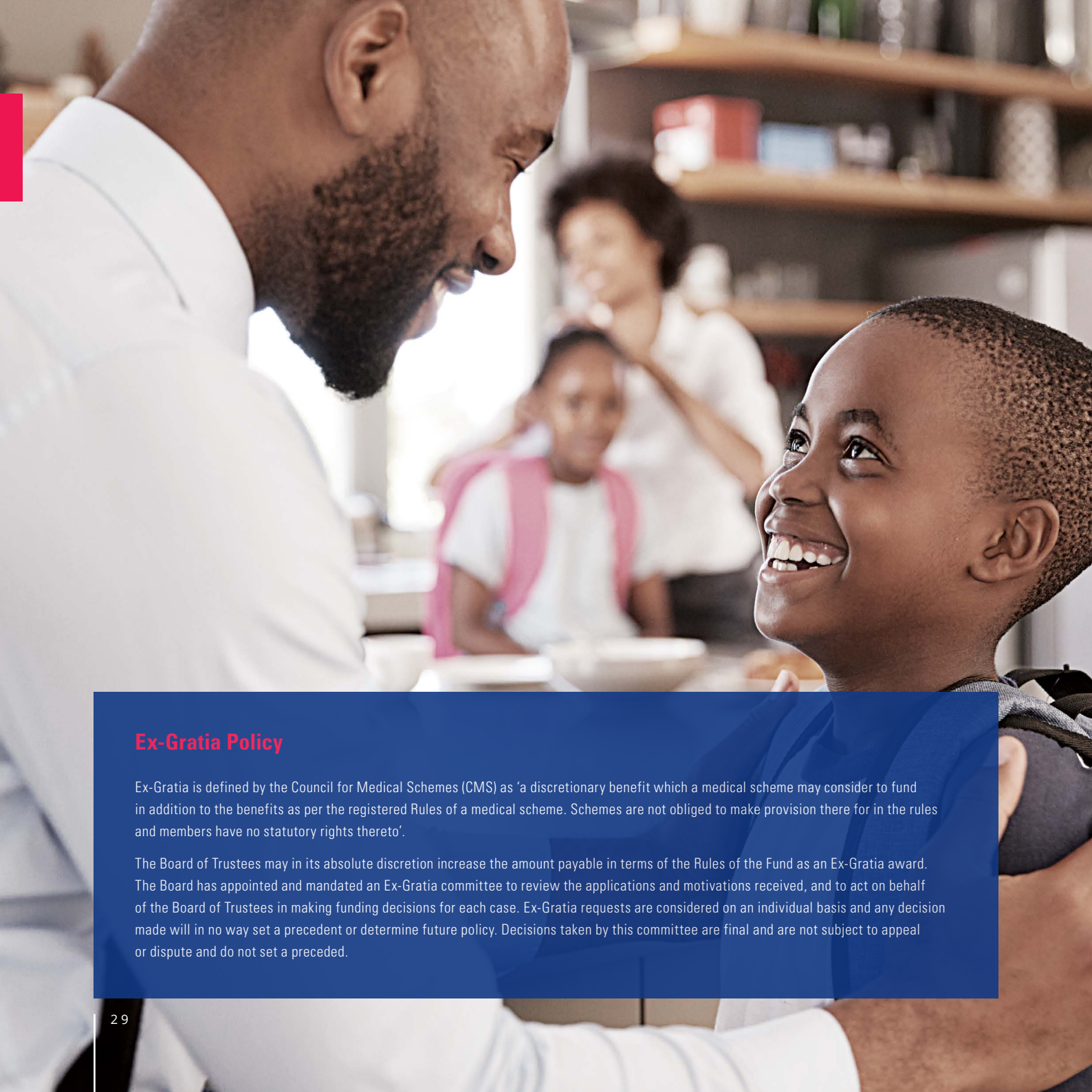
Preferred Providers are healthcare professionals with whom the Fund has made special arrangements to provide members with effective and cost-efficient services.

These healthcare professionals will not request upfront payment from members. The Fund does not restrict members to utilise the services of these Preferred Providers.

Rather we recommend their use, where they are available, to optimise benefits and minimise co-payments.

Prescribed Minimum Benefits (PMBs)

Prescribed Minimum Benefits are defined in the regulations of the Medical Schemes Act, No. 131 of 1998, as being the minimum level of benefits that are available to all medical scheme members and their dependants. The diagnosis,medical management and treatment for these benefits are not limited and are paid according to specific codes, treatment plans and conditions. Members are required to use the services of the Fund's appointed Designated Service Providers for PMBs. A total of 270 diagnoses and 26 chronic conditions are listed as PMBs.



Ex-Gratia Policy

Ex-Gratia is defined by the Council for Medical Schemes (CMS) as 'a discretionary benefit which a medical scheme may consider to fund in addition to the benefits as per the registered Rules of a medical scheme. Schemes are not obliged to make provision there for in the rules and members have no statutory rights thereto'.

The Board of Trustees may in its absolute discretion increase the amount payable in terms of the Rules of the Fund as an Ex-Gratia award. The Board has appointed and mandated an Ex-Gratia committee to review the applications and motivations received, and to act on behalf of the Board of Trustees in making funding decisions for each case. Ex-Gratia requests are considered on an individual basis and any decision made will in no way set a precedent or determine future policy. Decisions taken by this committee are final and are not subject to appeal or dispute and do not set a preceded.

COMPLAINTS AND APPEALS PROCESS

If you are not satisfied with the manner in which your claims were processed or wish to lodge a complaint, the process you need to follow is:

1. Contact the Fund's Client Service Department during office hours and try to resolve your query.
2. If the result is not considered to be satisfactory by you, you may ask that it be escalated to more senior resources in the Administrator's Service Team, such as a Team Leader or Manager.
3. If you are not satisfied, you may in writing request the Principal Officer of the Fund to attend to the matter. You can send the query to the normal email or postal addresses of the Fund, but address it to the Principal Officer.
4. Should you not accept the outcome of the escalation process to the Principal Officer, you may lodge a complaint in writing, for the attention of the Fund's Disputes Committee, c/o The Principal Officer, (the details are available on the website). The Disputes Committee will meet to decide on your complaint or dispute, and determine the procedure to be followed. You have the right to be heard at these proceedings, either in person or through a representative.
5. If you are still dissatisfied after the decision made by the Disputes Committee, you may take your appeal further by approaching the Council for Medical Schemes (CMS) for resolution:

Council for Medical Schemes
Block A Eco Glades 2 Office Park
420 Witch-Hazel Street
Ecopark Centurion 0157

Telephone: 012 431 0500

Fax: 012 431 7544

Customer care call number: 0861 123 267

Email address: complaints@medicalschemes.com

CONTRIBUTIONS – 1 July 2018 to 30 June 2019

Contributions for children are limited to a maximum of four children, without limiting the number of child dependants that may be registered on the Fund. Penalties may be applied to a late joiner, in line with the Regulations to the Medical Schemes Act (Act 197 of 1998).

Income Category	Principal Member	Adult Dependant	Child Dependant
R0 – R4 800	R2 070	R1 827	R 630
R4 801 – R5 850	R2 678	R1 951	R 826
R5 851 – R8 400	R3 222	R2 532	R 896
R8 401 – R10 500	R3 306	R2 593	R 912
R10 501 – R12 500	R3 427	R2 763	R 928
R12 501 – R14 700	R3 552	R2 935	R 978
R14 701 – R15 350	R3 623	R2 986	R 993
R15 351 – R16 850	R3 755	R3 105	R1 041
R16 851 – R21 700	R3 924	R3 243	R1 084
R21 701+	R3 995	R3 303	R1 107

CONTACT DETAILS

Client Service Department

For all your general enquiries (claims, membership, information, etc.)
Phone: 0800 001 615
Fax: 011 539 2766
service@engenmed.co.za

Ambulance and emergency services

Phone: 084 124

Member claim submission

Postal address:
Claims Department PO Box 652509
Benmore 2010
claims@engenmed.co.za
Fax: 0860 329 252

Claims may also be placed in Discovery Health claims collection boxes which may be found at all offices of the Administrator and at most hospitals and rooms of other healthcare professionals.

Maternity registration

auths@engenmed.co.za

Appliance and prostheses authorisations

auths@engenmed.co.za

Oncology registrations and authorisation

oncology@engenmed.co.za

Website queries

webinfo@engenmed.co.za

Chronic medication and renal dialysis registrations and queries

chronicqueries@engenmed.co.za
CIB_APP_FORMS@engenmed.co.za

HIV registration and authorisation

hiv@engenmed.co.za

Hospital authorisation

auths@engenmed.co.za

Escalated complaints

service@engenmed.co.za

Reporting fraud

Report irregular or fraudulent claims.

Email: forensics@discovery.co.za

To stay anonymous, call our Fraud Hotline on 0800 004 500
or email: discovery@tip-offs.com

When sending through a report, please include your membership number and the details of the claim you are querying. If you have any general inquiries on your claims or policy, kindly email service@engenmed.co.za.

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