2018

MEMBER GUIDE

NEDGROUP
MEDICAL AID SCHEME

nmas.medscheme.com

WE'RE HERE TO HELP

If you prefer the 24-hour SELF-HELP facility

1. Call 0860 100 080
2. When the following menu is read out, choose option number 1, "For Benefits, Claims and Membership related enquiries please press 1".
3. You will then be prompted to enter your membership number, "Please enter your membership number followed by the # key".
4. The system will recognise your medical scheme membership number and offer you the appropriate menus.

For enquiries about the BENEFITS available to you, MEMBERSHIP, or other GENERAL QUESTIONS and issues

- Use Nedchat
- Email nedgroup.enquiries@medscheme.co.za (benefit and general enquiries) or nedgroupregistry@medscheme.co.za (enquiries about membership only)
- Call 0860 100 080 (or 011 671 6833)
- Fax 0860 111 784/011 758 7041

To submit a CLAIM or follow up on the payment of claims

For new claims:

- Scan your account(s) and send via NedChat, or email to nedgroup.newclaims@medscheme.co.za, or
- Fax your accounts to 0860 111 784

To follow up on claims:

- View your claims online on the logged-in Member Zone
- Call 0860 100 080
- Email nedgroup.enquiries@medscheme.co.za

To get AUTHORISATION for a hospital admission

- Email nedgroup.authorisations@medscheme.co.za
- Call 0860 100 080
- Fax 0860 21 22 23 or 021 466 1913

To check whether your provider is on the GP or Specialist NETWORK, or to find one who is

- Email nedgroup.enquiries@medscheme.co.za
- Call 0860 100 080
- Login to the Member Zone to access the provider look-up tool

In an EMERGENCY, or for the 'Ask a Nurse' HELPLINE

Call 084 124

To find out where your nearest Network Pharmacy is for preventative SCREENING TESTS AND VACCINES (under your Wellness Benefits), contact ScriptPharm Risk Management

- Call 011 100 7557
- Email nedgroup@scriptpharm.co.za
- Visit www.scriptpharm.co.za

To register for the CHRONIC MEDICINE Benefit, update your chronic medication or resolve any queries related to medicines for the chronic conditions covered by the Scheme, contact ScriptPharm Risk Management

- Call 011 100 7557
- Fax 086 679 1579
- Email nedgroup@scriptpharm.co.za
- Visit www.scriptpharm.co.za

To obtain a copy of your TREATMENT PLAN, or have it updated

- Call 0860 100 080
- Email nedgroupapmb@medscheme.co.za

To confirm whether you qualify for the BACK AND NECK REHABILITATION Programme and to find your closest DBC Centre

- Call 0860 100 080
- Email nedgroup.enquiries@medscheme.co.za
- Visit www.dbcclinic.com

To contact the ONCOLOGY Management Programme (for CANCER patients)

- Call 0860 100 572
- Fax 021 466 2303
- Email cancerinfo@medscheme.co.za

For the HIV and AIDS Management Programme, contact Aid for AIDS

- Call 0860 100 646 / 021 466 1700
- Fax 0800 600 773
- Email afa@afadm.co.za
- Visit www.aidforaids.co.za (or www.aidforaids.mobi on a smartphone)
- SMS (call me) 083 410 9078

To report suspected FRAUD

- Call 0800 112 811
- Email fraud@medscheme.co.za

To claim for medical services you received OUTSIDE SOUTH AFRICA

Email foreign.hos@medscheme.co.za

WHERE YOU CAN FIND HELP, AT A GLANCE

The Scheme offers various channels to help you with a range of services. See below which channels offer which services:

Service/query	Call Centre	Member Zone (via website) and app	NedChat	Walk-in Centres
Membership applications	✓		✓	✓
Option changes	✓		✓	✓
Adding/removing dependants	✓		✓	✓
Membership certificates	✓	✓	✓	✓
Contribution enquiries	✓		✓	✓
Tax certificates	✓	✓	✓	✓
Member claims statements	✓	✓	✓	✓
Claims submissions	✓		✓	✓
Claims and benefit enquiries	✓	✓	✓	✓
Hospital pre-authorisation requests	✓	✓	✓	✓
Disease authorisations	✓	✓	✓	✓
General Scheme information	✓	✓	✓	✓
Processing of refunds	✓		✓	✓
Membership cards	✓		✓	✓
Checking Scheme Tariff/Medical Scheme Rate (MSR)	✓	✓ Via look-up tool	✓	✓

NEDCHAT

NedChat is an innovative downloadable mobile application that allows you to raise any important medical scheme questions you may have on the site during office hours. Skilled consultants attend to your queries in a personal, one-on-one capacity, without the need for phone calls. You are also able to obtain hospital authorisations using NedChat. You can find NedChat on the logged-in Nedbank member zone via our website, nmas.medscheme.com.

SCHEME APP

Use our responsive member app to -

- access your latest benefit limits,
- see and update beneficiary details,
- check service provider claims,

- and lots more!

GET THE APP ON YOUR SMARTPHONE!

You can download our free Scheme smartphone app from the Android and iOS App Stores.

PERSONAL HEALTH RECORD

Personal Health Record (PHR) is a simple, easy-to-use app that gives you and your doctor access to your complete health record anywhere, any time... plus great lifestyle tools to live better.

You can use it to find information on your condition, surgical procedures and medication.

You can also use it to:

- View your medical history including immunisations and allergies.
- Track your health measurements such as blood pressure results and blood sugar levels.
- Earn reward badges for healthy behaviour.
- View your doctor appointments and hospital admissions.
- See how healthy you are with a Health Risk Assessment.
- Connect a wearable device and track your activity and calories burned.

GET THE APP ON YOUR SMARTPHONE!

You can download our free PHR smartphone app from the Android and iOS App Stores.

WALK-IN CENTRES

You are welcome to visit the following walk-in centres of the Scheme's administrator, Medscheme.

Bloemfontein	Shop C7, 1st Floor, Middestad Centre, Cnr Charles & West Burger Street
Cape Town	Ground Floor, Icon Building, Cnr Lower Long Street and Hans Strijdom Avenue
Durban	102 Stephen Dlamini Road, Musgrave
Kathu	6 Rietbok Street
Klerksdorp	Shop 11, Medicover Building, 22 Knowles Street, Witkoppies
Kimberley	Shop 17, Southey Street
Lephalale (Ellisras)	Bosveld Boulevard Park, Shop 6, Cnr Chris Hani and Joe Slovo Street, Onverwacht
Nelspruit	Union Square Unit G2, 44 Mostert Street
Polokwane	Shop 2, Ground Floor, Shoprite Checkers Centre, Cnr Hans van Rensburg & Grobler treets
Port Elizabeth	Block 6, Greenacres Office Park, 2nd Avenue, Newton Park
Pretoria	Nedbank Plaza, Shop 17, Ground Floor, 361 Steve Biko Street, Arcadia
Roodepoort	Flora Centre, Entrance 2, Shop 21 & 22, Cnr Ontdekkers and Conrad Road, Florida North
Secunda	Grand Palace, Unit A2, 2302 Heunis Street
Vereeniging	Ground Floor, 36 Merriman Avenue

CONTENTS

IN SUMMARY

IN THIS SECTION

- Welcome to the inner circle!
- What our members say
- Five Plans offer different benefits at different costs
- Wondering what Plan to choose?
- Your benefits for 2018
- Employee contributions for 2018
- How to save money and make the most of your benefits?
- Co-payments, penalties or out-of-pocket expenses you can expect

WELCOME TO THE INNER CIRCLE!

Nedgroup Medical Aid Scheme ensures that your health remains your wealth.

In life, there is no greater asset than your health. Anybody who has experienced a health scare can testify that any other problem suddenly becomes incomparably small once a health risk becomes apparent. That's why a high quality medical scheme or hospital plan is no longer a nice-to-have, but a must have.

Our only goal is to provide the Nedbank Group and Old Mutual Insure staff, both past and present, with the best possible value for money benefits. As a restricted membership medical scheme, we have several factors that count in our favour, and therefore benefit you in the long run. Let's look at only a few of these...

One goal and one goal only: improving the health of our members

As a medical scheme with exclusive membership for our participating employers, we are not profit driven. We simply want to ensure that you, our current and retired colleagues, and your dependants have great medical cover and the support you need to live a healthy life.

Savings are passed on directly to you

Unlike open schemes, we don't have to spend thousands, even millions, on marketing to attract new members. This is just one of the ways in which we save... and thus pass the savings on to you.

In fact, recent benchmarking by independent consultancy firm Willis Towers Watson shows that our benefits for 2017 were comparable with those offered by eight top open-membership schemes, but our contributions were 24% lower!

We look for reasons to pay claims, not the other way around

Open schemes usually apply strict conditions around the payment of benefits. Although they are required to cover benefits according to their rules, paying more than what is legally required may have a negative impact on their surplus levels and related profitability. Generally they do not pay ex gratia claims.

Our objective is breaking even and maintaining our solvency ratio, not making a profit. We pay claims within our rules and the Scheme offers ex-gratia assistance to our members through a managed governance process.

Bells and whistles... we've got them, too!

Open schemes are in competition with each other for the same member pool, and often add extra benefits to make their offering more attractive... gym memberships and the like.

We're excited to announce that from 2018, with our new partner Sanlam Reality, we will also be able to offer you a lifestyle rewards programme where you can pay a minimal monthly fee and enjoy extras like heavily discounted gym fees, movies, flights and much, much more! More details on Sanlam Reality's extensive offering will be shared with you soon...

DID YOU KNOW...

One of the ways we put our members first is by allowing them to upgrade to a Plan with enhanced oncology benefits if they unexpectedly discover that they (or a loved one) need cancer treatment.

"As members of the Nedgroup Medical Aid Scheme ourselves, we know how important it is to have a medical scheme that is there for you when you need it most. With a Board of Trustees made up entirely of employees and pensioners, like you, we are driven to offer our members the best value for their contributions and to support them in their journey towards living healthier and happier lives."

Howard Stephens, Chairman
Julia le Roux, Principal Officer

"I wish to place on record my appreciation of my management and staff of Nedbank and of the Nedgroup Medical scheme, the consultants Zoey and others for the care and concern that has been given to me and is still being given to me. You all have taught me that friendly caring is really the jewel of being human."

Dheepak Ramchuran

"Both my wife and I were admitted to hospital earlier this year - I had a heart by-pass operation and my wife got away with a couple of stents. Looking back now, we realise how privileged we were to receive medical treatment in a top class hospital by top class medical practitioners. All of this backed up by a top class Medical Aid Fund, supported by a top class administrator. I have never experienced customer service of such high standard in my entire life!"

Hendry & Lettie Smith

"I am so proud to be a member of this incredible medical aid scheme. Nedgroup is the best medical aid ever, and the team is very helpful/polite and efficient, I do not have enough words to express my appreciation for their assistance for the past 28 years."

Shanaz Mohamed

FIVE PLANS
OFFER DIFFERENT BENEFITS AT DIFFERENT COSTS

To satisfy different member needs, our five Plans range from higher-cost options that offer more comprehensive cover, to lower-cost options that offer lower cover.

TRADITIONAL PLUS HAS BEEN RESTRUCTURED AND RENAMED!

PLATINUM

Flexibility for a healthy family with a higher income who wants excellent cover for everyday services benefits such as GP consultations.

From R4 695 pm*

COMPREHENSIVE

Cover for higher healthcare needs, especially chronic conditions, with a savings allocation allowing more flexibility for everyday services benefits.

From R3 869 pm*

TRADITIONAL

Cover for medium healthcare needs, especially chronic conditions, with sub-limits on everyday services benefits.

From R3 417 pm*

SAVINGS

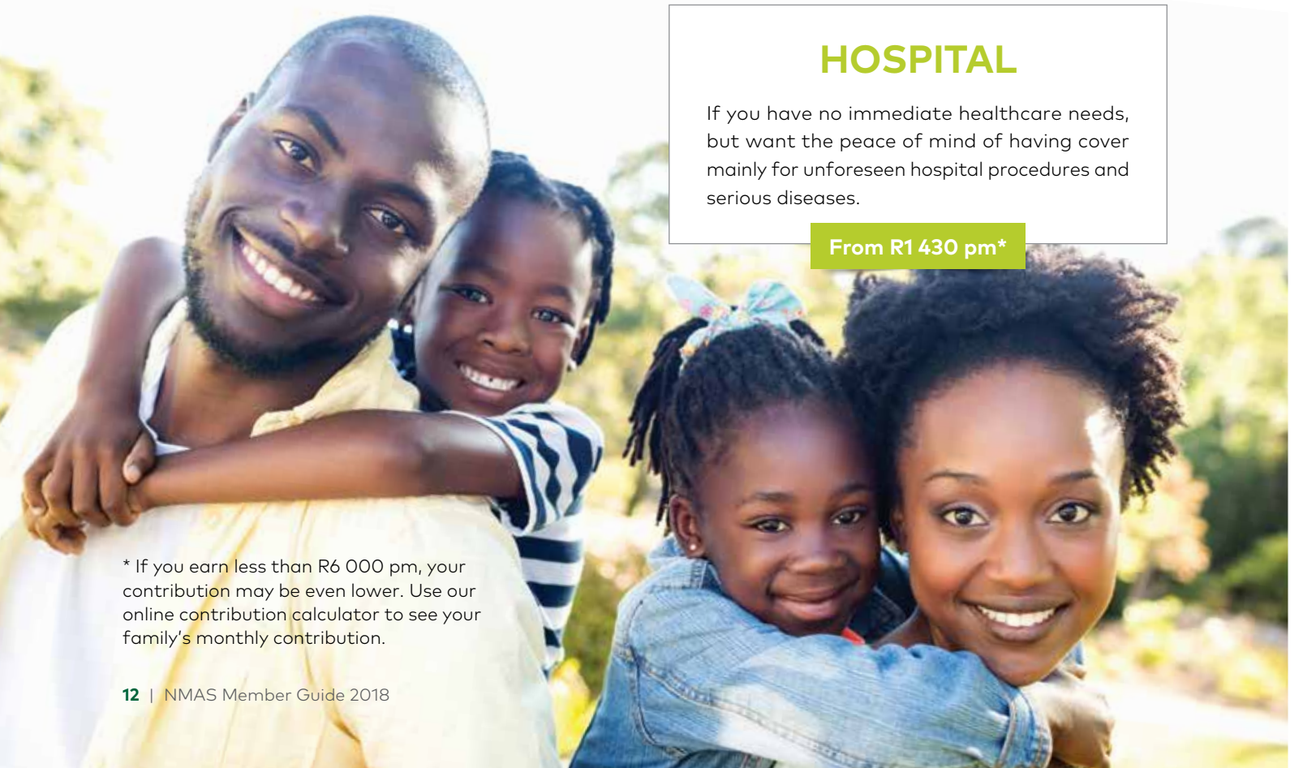
Maximum flexibility for a generally healthy family who is happy to have everyday services covered from an annual savings allocation.

From R2 038 pm*

HOSPITAL

If you have no immediate healthcare needs, but want the peace of mind of having cover mainly for unforeseen hospital procedures and serious diseases.

From R1 430 pm*



* If you earn less than R6 000 pm, your contribution may be even lower. Use our online contribution calculator to see your family's monthly contribution.

THE SAME ...

ALL OUR PLANS OFFER:

- Unlimited **Hospital and trauma cover** (with sub-limits on certain benefits)
- **Emergency transport and telephonic support** by ER24
- Preventative screening tests and vaccines through our **Wellness** benefits
- Access to various **Managed Care Programmes**
- Cover for all Prescribed Minimum Benefits (PMB) **chronic conditions**

... BUT DIFFERENT

THE PLANS DIFFER MAINLY IN HOW THE FOLLOWING ARE COVERED:

Everyday services benefits		Non-PMB chronic conditions
Offers the highest benefits, paying up to 3 x Medical Scheme Rate (MSR).	PLATINUM	Covers PMB and approved non-PMB conditions from a set benefit limit, then from Routine Medical Benefit, then covers PMB unlimited.
Covers certain benefits from a personal medical savings account, allowing more flexibility.	COMPREHENSIVE	Covers approved non-PMB conditions from a set benefit limit; PMB conditions unlimited.
Covers listed benefits up to pre-set sub-limits.	TRADITIONAL	Covers approved non-PMB conditions from a set benefit limit; PMB conditions unlimited.
Covers all benefits from funds available in the personal medical savings account.	SAVINGS	Covers both PMB and approved non-PMB from a set benefit limit, then covers PMB unlimited.
No cover for everyday services.	HOSPITAL	Cover only for PMB conditions and Major Depression.

WONDERING
WHAT PLAN TO CHOOSE?

Weigh up your needs with what you can afford...

YOUR NEEDS

- How healthy are you and your loved ones? What were your medical expenses during the previous benefit year, and do you anticipate any medical procedures or any need for high-cost drugs during the next benefit year?
- Do you prefer to pay less for a Plan that does not cover much in the way of day-to-day medical needs, or would you rather pay more and have a Plan that offers more comprehensive cover for day-to-day medical needs?
- Do you or any of your loved ones suffer from a chronic disease that would require chronic medicine or treatment? If so, is it a condition that is covered by all the Plans, or only by the higher-cost Plans (or not at all)?
- Would you be willing to consult with a network service provider to access additional everyday services benefits and avoid co-payments?

WHAT YOU CAN AFFORD

- Use our handy calculator tool to calculate your family's monthly contribution rate for each Plan to make sure that you can afford the Plan you select. Before moving to a lower-cost Plan, make sure that you will still have good enough cover for your medical needs.

Remember that you can only change Plans once a year and that is before the start of the benefit year on 1 January. No Plan changes are allowed during the year, except for a Plan upgrade to access enhanced oncology benefits.

YOUR BENEFITS FOR 2018

IMPORTANT!
This is an overview only – please see the more detailed chapters in this member guide for specific amounts and rates, as well as conditions that may apply.

HOSPITAL AND TRAUMA BENEFITS

All Plans offer unlimited cover for major medical expenses (but with sub-limits on certain procedures and benefits). *

Claims are paid at Medical Scheme Rate or cost or medicine price, whichever is the lesser. Remember that conditions such as pre-authorisation, co-payments and case management may apply – see the *Hospital and Trauma Benefits* chapter in this guide for more information..

CALL 084 124

IN AN EMERGENCY

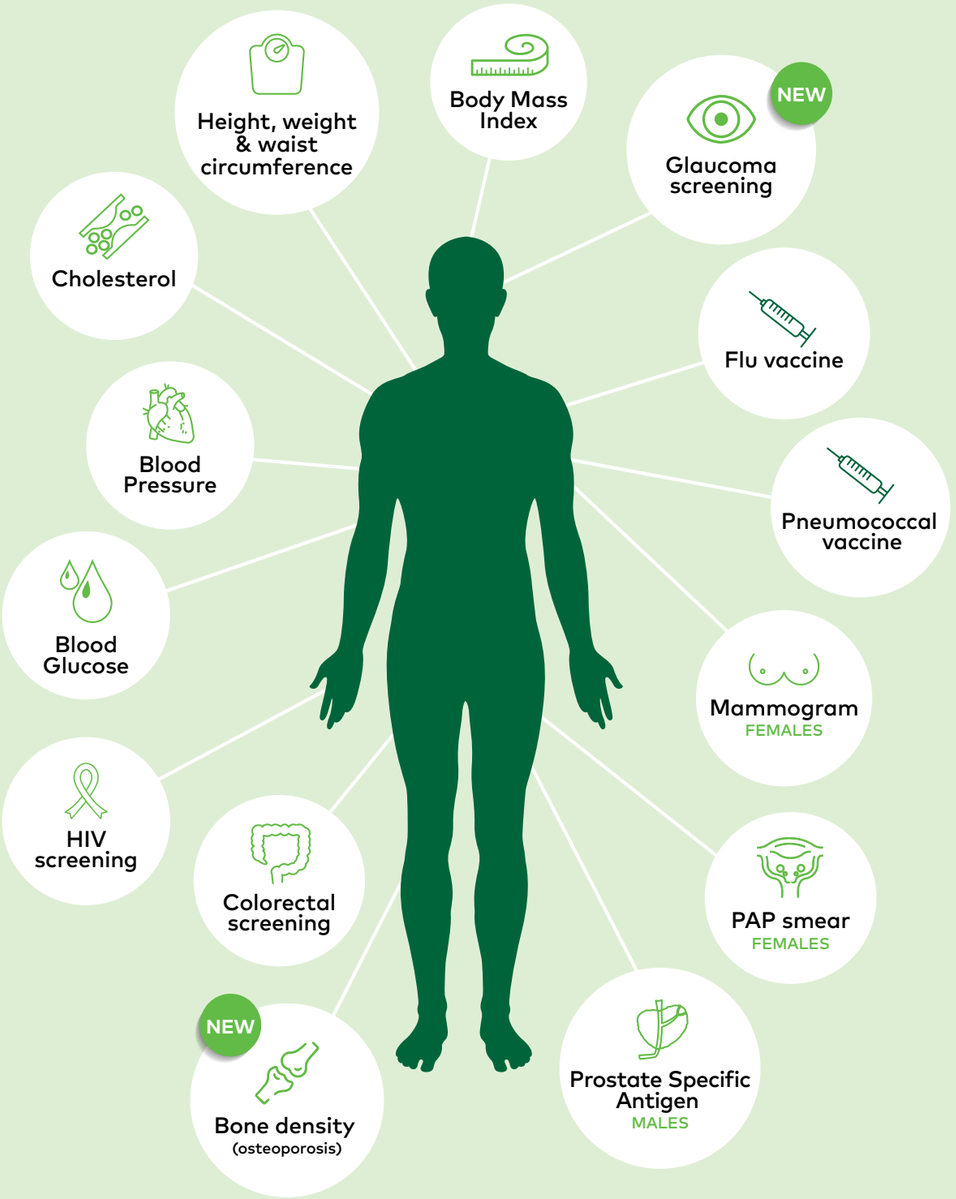
You and your loved ones have access to emergency medical transportation (if authorised by ER24) 24 hours a day, 7 days per week, in South Africa, Lesotho, Swaziland, Zimbabwe, Botswana, Namibia, Mozambique and Angola. (Call +27 102 053 038 if outside the borders of South Africa.)

FOR MEDICAL ADVICE

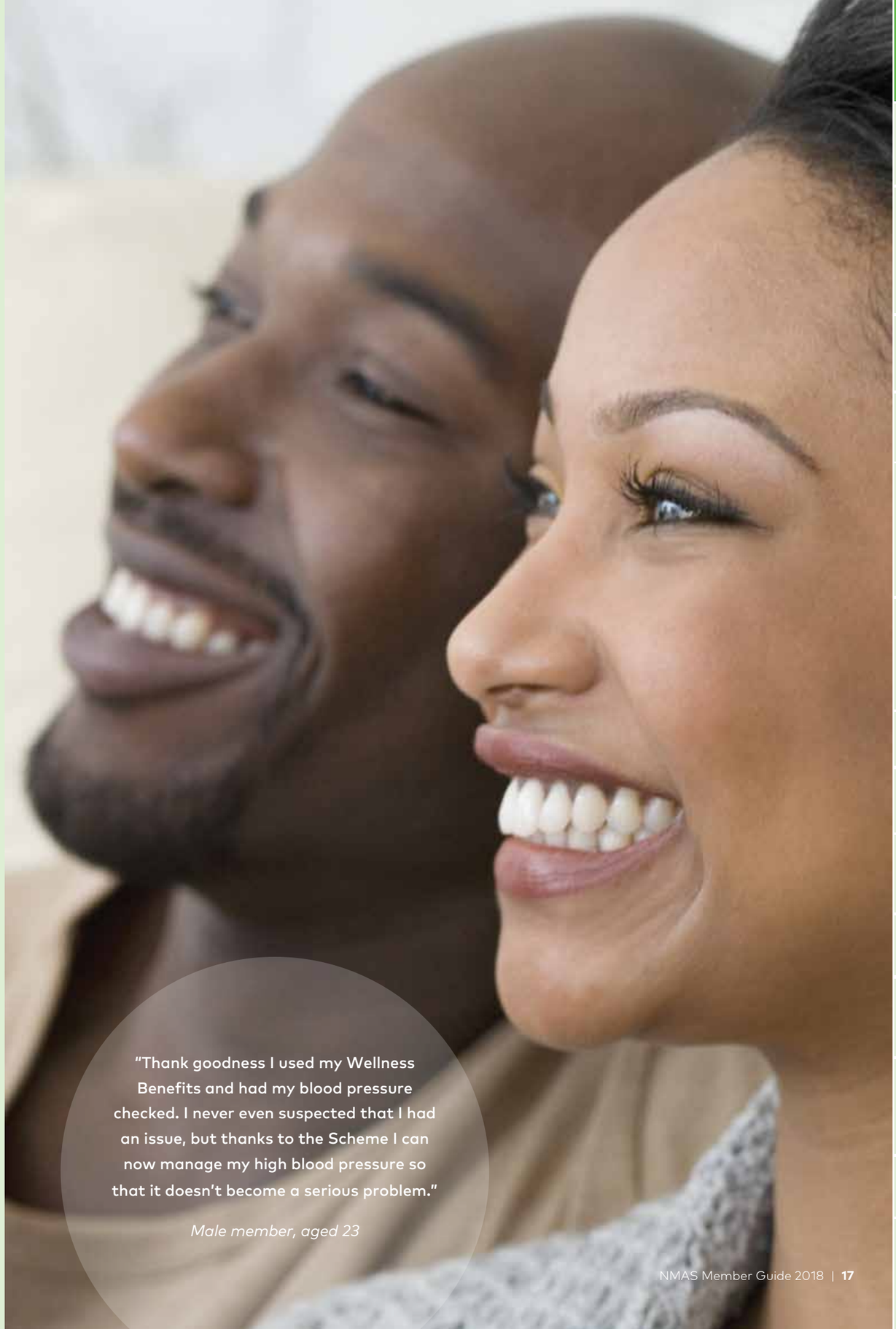
ER24 also has an "Ask the Nurse" medical advice and information line. Although it is not possible to make an accurate diagnosis over the phone, this can help you decide whether you need an ambulance, see your doctor, or simply go to the pharmacy.

WELLNESS BENEFITS

To help you and your loved ones prevent disease, all Plans offer screening tests and vaccinations.

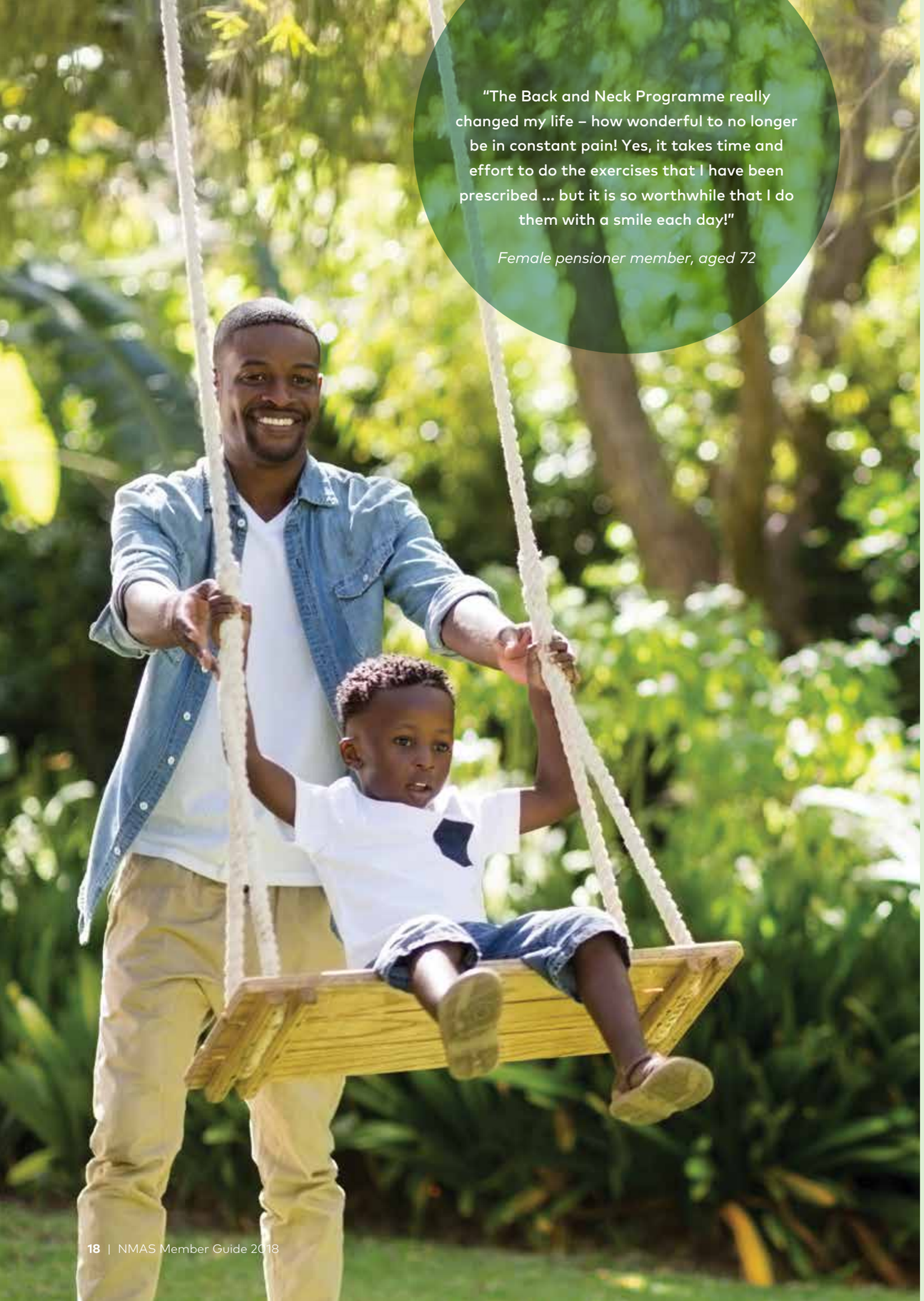


Remember that certain benefit limits and conditions apply, and that the Wellness Benefits do not include the consultation cost itself, as this is payable from your available Everyday Services Benefits – see the *Wellness Benefits* chapter in this guide for more information.



"Thank goodness I used my Wellness Benefits and had my blood pressure checked. I never even suspected that I had an issue, but thanks to the Scheme I can now manage my high blood pressure so that it doesn't become a serious problem."

Male member, aged 23

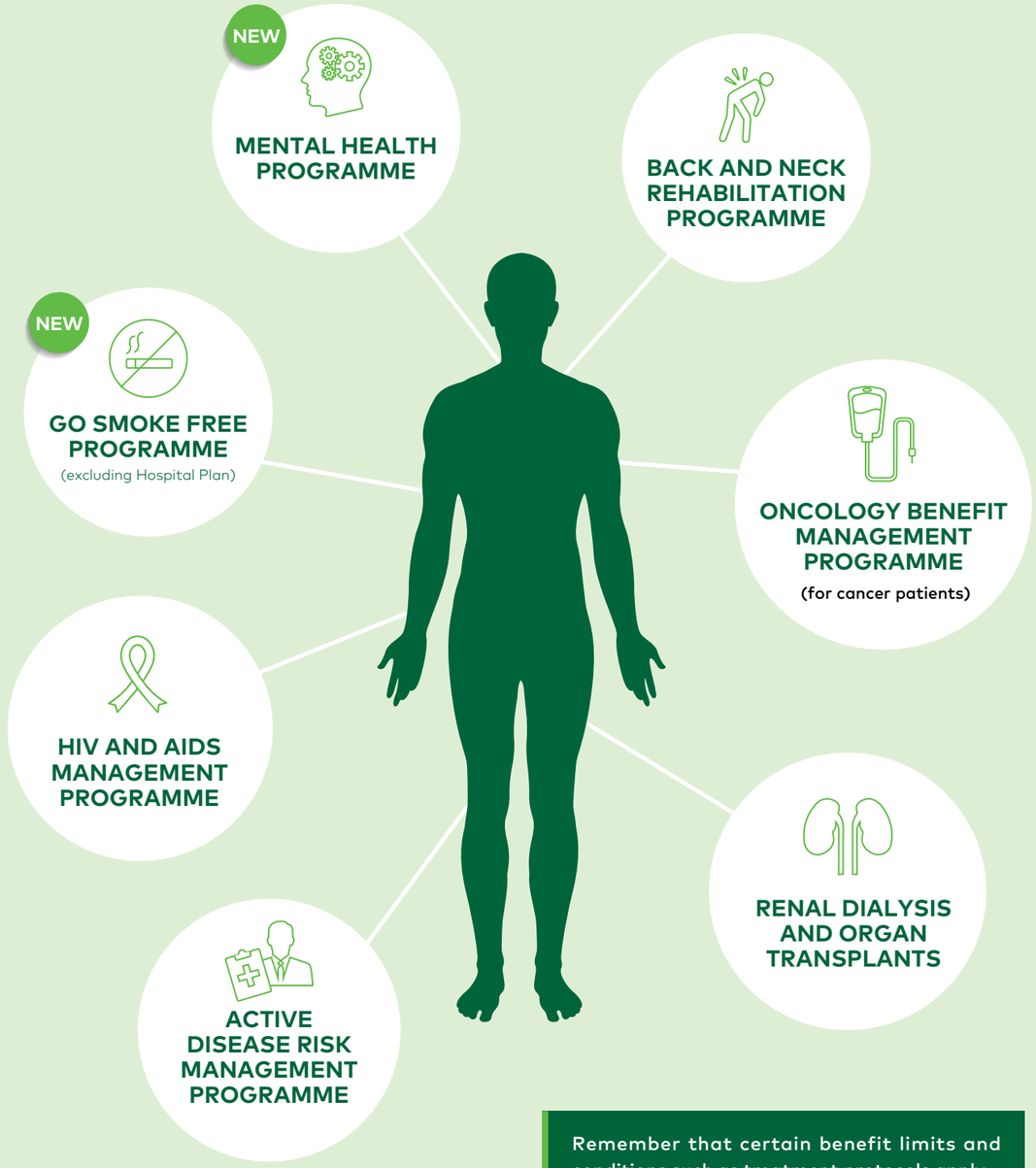


"The Back and Neck Programme really changed my life – how wonderful to no longer be in constant pain! Yes, it takes time and effort to do the exercises that I have been prescribed ... but it is so worthwhile that I do them with a smile each day!"

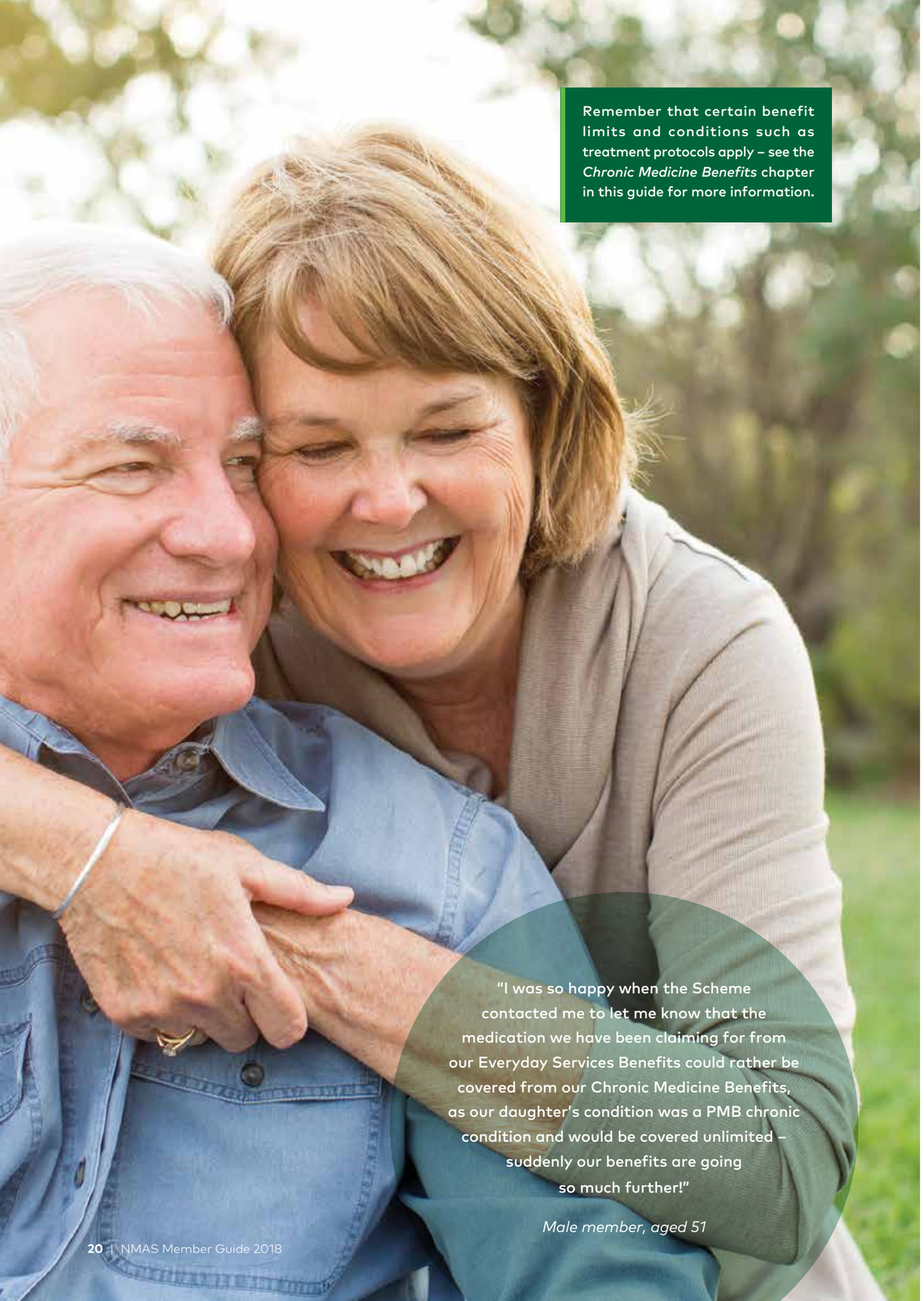
Female pensioner member, aged 72

MANAGED CARE PROGRAMMES

Qualifying members have access to the following programmes, at no additional cost:



Remember that certain benefit limits and conditions such as treatment protocols apply – see the *Managed Care Programmes* chapter in this guide for more information.



Remember that certain benefit limits and conditions such as treatment protocols apply – see the *Chronic Medicine Benefits* chapter in this guide for more information.

"I was so happy when the Scheme contacted me to let me know that the medication we have been claiming for from our Everyday Services Benefits could rather be covered from our Chronic Medicine Benefits, as our daughter's condition was a PMB chronic condition and would be covered unlimited – suddenly our benefits are going so much further!"

Male member, aged 51

CHRONIC MEDICINE BENEFITS

CONDITIONS COVERED

All Plans offer treatment for the official **PMB chronic conditions**, as well as for Major Depression.

All Plans except Hospital Plan offer treatment for a number of **additional Scheme-approved chronic conditions**.

HOW BENEFITS ARE PAID

It is important to understand the different ways in which the Plans cover chronic medicine (for example, although **Platinum Plan** is a higher-cost plan with richer day-to-day benefits, it is typically not suited to members with both PMB and non-PMB chronic conditions).

		Once the chronic medicine benefit limit is exhausted	
PLATINUM	All chronic medicine benefits (both PMB and non-PMB) are first covered from a set chronic medicine benefit limit (R10 280 per family per year for 2018).	All chronic conditions are covered from available Routine Medical Benefit limit until depleted, then...	PMB conditions are covered unlimited.
SAVINGS	All chronic medicine benefits (both PMB and non-PMB) are first covered from a set chronic medicine benefit limit (R10 280 per family per year for 2018).	Non-PMB conditions are covered from available savings.	+ PMB conditions are covered unlimited.
TRADITIONAL COMPREHENSIVE	A set chronic medicine benefit amount is used to cover non-PMB conditions (R10 280 per family per year for 2018).	PMB conditions are covered separately, and unlimited.	
HOSPITAL	A set chronic medicine benefit amount is used to cover Major Depression only (R4 015 per family per year for 2018).	PMB conditions are covered separately, and unlimited.	

THE OFFICIAL PMB CONDITIONS:

Addison's disease, Asthma, Bipolar mood disorder, Bronchiectasis, Cardiac failure, Cardiomyopathy disease, Chronic renal disease, Chronic obstructive pulmonary disease (emphysema), Coronary artery disease (angina pectoris and ischaemic heart disease), Crohn's disease, Diabetes insipidus, Diabetes mellitus type 1 & 2, Dysrythmias, Epilepsy, Glaucoma, Haemophilia, HIV/AIDS, Hyperlipidaemia (high cholesterol), Hypertension (high blood pressure), Hypothyroidism, Multiple sclerosis, Parkinson's disease, Rheumatoid arthritis, Schizophrenia, Systemic lupus erythromatosis and Ulcerative colitis.

ADDITIONAL SCHEME-APPROVED CHRONIC CONDITIONS:

Acne (cystic nodular), Allergic rhinitis (if beneficiary has asthma or is under 12 years), Alzheimer's disease, Anxiety (if linked to another approved psychiatric chronic condition), Attention deficit syndrome (if prescribed by a specialist and under the age of 18 years), Behcet's Disease, Eczema, GORD (with the necessary motivation and/or gastroscopy report), Gout, Hypofunction of the pituitary gland, Hypotension, Insomnia (sleep disorders) (if linked to another approved psychiatric chronic condition), Macular Degeneration, Migraine prophylactics (prevention), Obsessive Compulsive Disorder, Osteoarthritis, Osteoporosis, Paget's Disease, Psoriasis and Sjögren's Disease.

EVERYDAY SERVICES BENEFITS

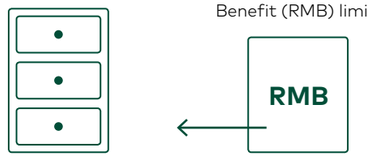
All Plans except Hospital Plan offer a range of Everyday Services Benefits.

PLATINUM

Benefits are paid at up to 3 x MSR.

Sub-limits are available for certain benefits.

Other specific benefits are covered from the Routine Medical Benefit (RMB) limit.



Once these sub-limits are depleted, the available RMB limit can also be used to cover the above benefits.

Once your sub-limits and RMB are depleted, you will be liable for payment.

COMPREHENSIVE

15% of your monthly contribution is allocated to your PMSA. Benefits with sub-limits are paid at MSR, while benefits payable from PMSA are covered at cost.

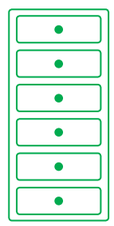
Sub-limits are available for certain benefits.

Other specific benefits are covered from your Personal Medical Savings Account (PMSA).

Once your sub-limits and/or PMSA (whichever is applicable to the specific benefit) are depleted, you will be liable for payment.

TRADITIONAL

Benefits are paid at MSR.



Sub-limits are available for certain benefits.

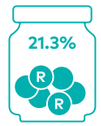
Once your sub-limits are depleted, you will be liable for payment.

SAVINGS

21.3% of your monthly contribution is allocated to your PMSA. Benefits with sub-limits are paid at MSR, while benefits payable from PMSA are covered at cost.

Most of the listed benefits are covered from your Personal Medical Savings Account (PMSA).

Sub-limits are available for certain maternity benefits only.



Once your sub-limits and/or PMSA (whichever is applicable to the specific benefit) are depleted, you will be liable for payment.

Remember that certain benefit limits and conditions apply – see the *Everyday Services Benefits* chapter in this guide for more information.

ANNUAL PMSA AMOUNT (AVAILABLE UPFRONT)

Add up the amounts per beneficiary to calculate the total available for your family.

TIP Use our handy online calculator!

COMPREHENSIVE

If you earn R4 500 pm or less	Member: R 6 139 Adult: R4 787 Child (max 2): R1 352
If you earn between R4 500 and R6 000 pm	Member: R 6 681 Adult: R5 211 Child (max 2): R1 494
If you earn more than R6 000 pm	Member: R 6 820 Adult: R5 316 Child (max 2): R1 540

SAVINGS

If you earn R6 000 pm or less	Member: R 4 669 Adult: R4 029 Child (max 2): R1 432
If you earn more than R6 000 pm	Member: R 5 117 Adult: R4 989 Child (max 2): R1 702

ROUTINE MEDICAL BENEFIT LIMIT

PLATINUM

Member: R16 920
Member +1: R28 450
Member +2: R30 160
Member +3: R36 660

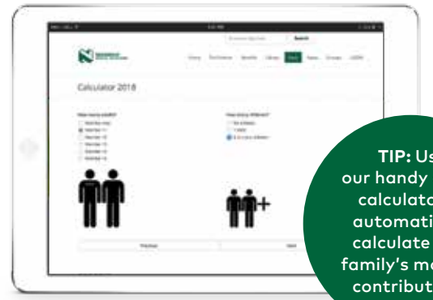
This benefit can also be used to pay for certain other services, once you have used up those limits.

	PLATINUM	COMPREHENSIVE	TRADITIONAL	SAVINGS
Consultations: General Practitioners, Homeopaths and Specialist consultations	✔ Payable from Routine Medical Benefit.	✔ Covered from available PMSA.	✔	✔ Covered from available PMSA.
Optical benefits: Eye tests, lenses, contact lenses and fittings	✔ Additional sub-limits available. Once exhausted, payable from Routine Medical Benefit limit.	✔ Sub-limits available, with frames covered from available PMSA.	✔	✔ Covered from available PMSA.
Maternity benefits: Antenatal visits Ultrasound scans Antenatal classes	✔ Additional sub-limits available.	✔	✔	✔ Additional sub-limits available.
Dentistry: Basic dental services and advanced dentistry	✔ Additional sub-limits available. Once exhausted, payable from Routine Medical Benefit limit.	✔	✔	✔ Covered from available PMSA.
Medicines: Prescribed medicine (acute) Pharmacy advised therapy (PAT)	✔ Payable from Routine Medical Benefit.	✔ Covered from available PMSA.	✔	✔ Covered from available PMSA.
Pathology	✔ Payable from Routine Medical Benefit.	✔	✔	✔ Covered from available PMSA.
Radiology (X-rays)	✔ Payable from Routine Medical Benefit.	✔	✔	✔ Covered from available PMSA.
Supplementary health services (for example, chiropody, chiropractic services, speech therapists, biokinetics)	✔ Payable from Routine Medical Benefit.	✔ Covered from available PMSA.	✔	✔ Covered from available PMSA.
Physiotherapy	✔ Payable from Routine Medical Benefit.	✔ Covered from available PMSA.	✔	✔ Covered from available PMSA.
Psychology	✔ Payable from Routine Medical Benefit.	✔	✔	✔ Covered from available PMSA.
Medical appliances (including CPAP)	✔ Payable from Routine Medical Benefit.	✔	✔	✔ Covered from available PMSA.
Wheelchair and associated appliances	✔ Additional sub-limit available.	✔	✔	✔ Covered from available PMSA.
Hearing aids	✔ Payable from Routine Medical Benefit.	✔	✔	✔ Covered from available PMSA.
Oral contraceptives	✔ Additional sub-limits available, including for Mirena device.	✔ Covered from available PMSA.	✔ Payable from Prescribed medicine (acute) sub-limit.	✔ Covered from available PMSA.

EMPLOYEE CONTRIBUTIONS FOR 2018

VALUE-ADD

- Even if you have more children under age 23, you only pay for two.
- A child over age 23 who is physically or mentally disabled and financially dependent on you, qualifies for child rates.
- A child over age 23 who is financially dependent on you can be registered as an additional adult dependant.



TIP: Use our handy online calculator to automatically calculate your family's monthly contributions.

	1 January 2018 - 31 March 2018 (same amounts as from April 2017)			1 April 2018 - 31 March 2019		
	Member	**Adult**	**Child (max 2)**	**Member**	**Adult**	**Child (max 2)**
PLATINUM						
All income levels	R4 315	R3 366	R1 033	R4 695	R3 662	R1 124
COMPREHENSIVE (includes 15% allocation to PMSA)						
R0 – R4 500.99 pm	R3 202	R2 497	R705	R3 484	R2 717	R767
R4 501 – R6 000.99 pm	R3 486	R2 719	R779	R3 793	R2 958	R848
R6 001 + pm	R3 556	R2 774	R803	R3 869	R3 018	R874
TRADITIONAL						
Up to R6 000.99 pm	R3 080	R2 402	R676	R3 351	R2 613	R735
R6 001 + pm	R3 141	R2 450	R729	R3 417	R2 666	R793
SAVINGS (includes 21.3% allocation to PMSA)						
Up to R6 000.99 pm	R1 718	R1 479	R525	R1 869	R1 609	R571
R6 001 + pm	R1 873	R1 838	R623	R2 038	R2 000	R678
HOSPITAL						
Up to R6 000.99 pm	R1 058	R921	R334	R1 151	R1 002	R363
R6 001 + pm	R1 314	R1 294	R451	R1 430	R1 408	R491

Contributions for active employees are based on Total Guaranteed Package (TGP).

HOW TO SAVE MONEY AND MAKE THE MOST OF YOUR BENEFITS

This is how you can save the Scheme and yourself money:

- **Use the Scheme's pharmacy network** to avoid unnecessary co-payments.
- **Use a doctor/specialist on the network**, to avoid unnecessary co-payments.
- **Consider paying in cash** and then claiming back to get discounts (unless you are registered on the Chronic Medicine Management programme).
- **Get a quote** from the doctor before undergoing any procedure and check with the Contact Centre how much will be paid.
- Ask for **generic medicine** whenever possible.
- **Think twice** about undergoing elective surgery procedures.
- If your doctor recommends a particular line of treatment and you feel uncertain about whether it is necessary, ask for a **second opinion**.
- If an operation is scheduled for the afternoon or evening, **arrange for hospital admission after 12pm**.
- **Maintain a healthy lifestyle**, as prevention is always the better option.
- Make healthier choices to avoid or better **manage lifestyle-related chronic conditions**.
- Use the screening tests and vaccines offered as part of your **Wellness Benefits** to catch potential lifestyle diseases early.

Co-payments, penalties or out-of-pocket expenses you can expect

In an effort to manage escalating healthcare costs and over-utilisation of benefits, the Scheme has implemented certain co-payments that would apply under certain circumstances. For ease of reference, this section gives an overview of all the co-payments that you may incur. Depending on your decisions, you may incur one or a combination of these.

HOSPITALISATION

If you need to be admitted to hospital for a non-emergency...	... you will have to pay	What you can do to avoid additional costs:
and your admitting practitioner is not part of the Nedgroup GP or Specialist Networks, your claims will be covered at **Medical Scheme Rate**, and...	• the difference between what you are charged by the medical service provider and **Medical Scheme Rate** (on ALL Plans), PLUS • a **co-payment of R2 500**, usually after claims are settled (on all Plans except **Platinum**).	Make sure that your admitting practitioner is on the Nedgroup Network, as your hospital claims will then be covered up to **2 x Medical Scheme Rate** and you will not have a **R2 500 co-payment** on hospital bills.
and you do not contact the Scheme before you are admitted to hospital to pre-authorise your admission (unless it is a valid emergency), ...	• a penalty of **R500** (and even run the risk of not having your hospital claims covered).	Always pre-authorise a hospital admission, as well as in-hospital tests such as MRI, radio-isotope or CAT scans, at least three days beforehand. In an emergency, the Scheme must be notified on the first working day after the admission.

LAPAROSCOPIC SURGERY AND OTHER PROCEDURES WITH CO-PAYMENTS

Laparoscopic procedures are more expensive, and the procedure may in general be performed as an open procedure. The Scheme, like many other medical schemes, funds these procedures with a co-payment, rather than only cover open procedures.

If you have any of the following procedures*...	... you will have a co-payment of	What you can do to avoid additional costs:
Upper GI endoscopy (gastroscopy)	**R500**	If performed in a doctor's rooms, no co-payment will apply.
Laparoscopic appendectomy	**R2 500**	The alternative, if you do not want to incur the co-payment, would be to undergo open surgery.
Laparoscopic hernia repair	**R2 500**	
Laparoscopic hysterectomy	**R2 500**	
Laparoscopic radical prostatectomy	**R2 500**	
Laparoscopic pyeloplasty	**R2 500**	
Knee arthroscopy	**R2 500**	
Balloon sinuplasty	**R2 500**	
Non-emergency spinal fusion surgery, if you live reasonably close to a DBC Centre and decline participation in the Back and Neck Rehabilitation Programme before surgery	**R5 000**	The Scheme's Back and Neck Rehabilitation Programme.

*These co-payments will not apply if the procedure is in accordance with Prescribed Minimum Benefits. Please see the *Prescribed Minimum Benefits* chapter in this member guide for more information.

CHRONIC MEDICINE BENEFITS

If you claim for a medicine that is ...	... then	What you can do to avoid co-payments or additional costs
not approved on the chronic medicine programme (benefit) or is not an approved formulary generic	The claim will be not be processed and paid from the chronic benefit. It may be covered from a different benefit or you may be liable to pay for the medication.	• Apply for the chronic medicine programme before claiming any chronic related medicine. • Ensure that your application form is accompanied by relevant supporting documentation and a copy of a valid doctor's prescription. Please note clinical entry criteria and formularies are applied, which will determine the outcome of your chronic application
not listed on the Chronic Medicines Formulary or is not the approved item(s) on your chronic authorisation decision letter	The claim for the medication will be rejected and you will be liable to pay for the medication.	If you do not want to incur this cost, use medicine on the Chronic Medicines Formulary. This list of cost-effective medicines is based on local and international studies, and complies with the criteria developed by the Council for Medical Schemes. Members should take their chronic decision letter with them to their pharmacy provider, to ensure that the correct product is claimed.
changed in terms of the strength or dosage or medicine type	The claim for the medication will be rejected and you will be liable to pay for the medication.	Send any prescription updates to the chronic medicine department for review and for authorisation updates before claiming any new medication deemed to be chronic.
for a chronic condition that is not on the list of PMB chronic conditions, or on the list of additional Scheme approved conditions (which are Plan-specific)	The claim will be paid from your available Everyday Services Benefits (from the acute medicine sub-limits, where applicable), not from your Chronic Medicine Benefits.	You can apply for an *ex gratia* payment, which will then be considered by the Scheme's *ex gratia* committee. Please note, however, that *ex gratia* applications are only granted in exceptional and deserving cases.

See the *Chronic Medicine Benefits* chapter in this member guide for more information.

MANAGEMENT OF PRESCRIBED MINIMUM BENEFITS (PMB) CONDITIONS

If you ...	... the following will apply:	What you can do to minimise your costs and make your benefits go further.
are diagnosed with a PMB condition and choose to consult with a GP or specialist that is not on the Nedgroup Network	• Your claims for consultations will be covered at **Medical Scheme Rate** and be paid from your available Everyday Services Benefits (except for **Hospital Plan**). • If your Everyday Services Benefits become exhausted, the service will be covered from your PMB benefit, with a 25% co-payment that you will need to cover from your own pocket. • If you are admitted to hospital for a PMB condition, - you will incur a **R2 500 admission co-payment** (unless you are on **Platinum Plan**), and - your hospital-related claims will only be paid at **Medical Scheme Rate** and you will be liable for the difference.	Choose a GP or specialist on the Nedgroup Networks, as your PMB-related accounts will then be paid from the PMB benefit at a Scheme-agreed rate, and you will not be liable for any co-payment on your specialist's claim, should you be admitted to hospital.

PHARMACY CLAIMS

If you claim for ...	... then	What you can do to minimise your costs and make your benefits go further.
dispensed by a non-Nedgroup Network Pharmacy	For PMB chronic medication, only 75% of the medicine cost will be covered from the chronic medicine benefit. There will be a 25% co-payment at the point of sale, which you will be liable for. For non-PMB chronic medication, in other words medication used to treat Scheme-approved additional chronic conditions (which are Plan-specific), you will be liable for 100% of the cost at the point of sale.	Use a Nedgroup Network Pharmacy for all your PMB and non-PMB chronic medication – refer to the website for a pharmacy locator or call the chronic medicine department for a Nedgroup Network Pharmacy provider in your area.
pharmacy-based Wellness Benefits such as screening tests or flu vaccines from a pharmacy that is not a Nedgroup Network Pharmacy	Your benefit will be covered from your Everyday Services Benefits, instead of from your Wellness Benefits, unnecessarily depleting your Everyday Services Benefits.	Use one of the Nedgroup Network Pharmacies for pharmacy-based Wellness Benefits – see the *Wellness Benefits* chapter in this guide for more information.

ONCOLOGY CONSULTATIONS

If you claim for ...	... you will to pay	What you can do to minimise your costs and make your benefits go further.
a consultation with a non-ICON oncologist	The difference between what is charged and the cover of Medical Scheme Rate	Use the Scheme's DSP for oncology treatment, Independent Clinical Oncology Network (ICON), as consultations are covered at a negotiated fee. ICON is a dedicated network of oncologists committed to the comprehensive management of members with cancer.

1

WELCOME

IN THIS SECTION

Why have a medical scheme?

You never know when you or one of your family members may need medical care, which could cost a substantial amount. Fortunately, as a member of the Nedgroup Medical Aid Scheme, you can enjoy peace of mind knowing that you and your family are protected by the comprehensive benefits available on the various Plans offered by your medical scheme.

How can this Member Guide help me?

This guide will give you all the information on the benefits that you are entitled to as a member, irrespective of the Plan you choose. It also contains information on the various Plans, to help you choose the one that suits you best, plus information on claims processes, chronic medication and more. Use the side tabs and colour coding to find the information you need, when you need it.

What are some of my responsibilities as a member?

- Understand how the Scheme and specific Plans work by reading this Member Guide and all communication sent to you by the Scheme.
- Keep the Scheme up to date on any changes to your membership details.
- Check whether the correct contributions are deducted from your salary/pension or bank account. (Child dependants 23 years or older will pay the adult dependant contribution.)
- Check all accounts from service providers as well as your statements and claims advices from the Scheme to make sure that all your details are correct and that your claims have been processed correctly. This will also help to identify fraud.
- Inform the Scheme before you are admitted to hospital or within 24 hours of an emergency admission to hospital.
- File all your documentation regarding the Scheme so that you can refer to it if necessary.
- Keep your membership card in a safe place so that no-one else can use it fraudulently.
- Choose a Plan that best suits your needs. Although HR and Medscheme as administrator can offer you information, neither of these parties is allowed to offer you financial advice such as which Plan to choose.

Abbreviations used in this guide:

DBC	Document Based Care (provider of the Back and Neck Rehabilitation Programme)
DSP	Designated Service Provider
MRI	Magnetic Resonance Imaging
MSR	Medical Scheme Rate
PET	Positron Emission Tomography
PMB	Prescribed Minimum Benefits
PPR	Private Provider Rates
PMSA	Personal Medical Savings Account
RMB	Routine Medical Benefit
SEP	Single Exit Price (for medicines)
TTO	To-take-out (medicine to take home from hospital)

2

EVERYDAY SERVICES BENEFITS

IN THIS SECTION

What will be paid from Everyday Services Benefits?

Everyday Services Benefits typically cover medical treatment that you receive out of hospital or as an outpatient at a hospital. Unlike the services and procedures covered under Hospital and Trauma Benefits, these are expenses that occur more frequently. Examples include visits to your doctor or dentist, as well as prescribed medicines.

The services you receive before being admitted to hospital are covered by your Everyday Services Benefits, even if these services are directly related to your hospital admission. Similarly, any follow-up services after you have been discharged from hospital also fall under Everyday Services Benefits. (However, there is a sub-limit under Hospital and Trauma Benefits for physiotherapy treatment after hospitalisation, if approved by the Case Manager.) Please refer to the tables that follow for more information.

Anti-malaria tablets and contraceptives (excluding condoms) are covered under Everyday Services Benefits. Vaccines, other than those covered under the Wellness Benefit, are only covered under the **Savings** and **Platinum** Plans from available benefits. Child immunisation vaccinations are subject to the acute medication benefit on all plans, except the **Platinum Plan**. Please refer to the tables below for more information. In addition, you may claim from your Everyday Services Benefits for prescribed vitamins and treatments for pregnancy-related anaemia as well as other supplements prescribed during pregnancy.

VALUE-ADD

Additional out-of-hospital benefits that will be covered separately

There are a number of out-of-hospital benefits that you have access to on all Plans (unless otherwise specified), that are covered from your Hospital and Trauma Benefits. These include:

- Services in doctors' rooms
- Nursing services
- Specialised Radiology
- Dental implants / building up of teeth (not available on the **Hospital Plan**); covered at Medical Scheme Rate
- Oncology: PET scans, social worker, specialised drugs (PMB only on the **Savings** and **Hospital** Plans)
- Other specialised drugs (cover for Multiple Sclerosis only on the **Savings** and **Hospital** Plans)
- Artificial limbs and artificial eyes
- Home Oxygen Therapy
- Stoma care products

You can read more about these benefits in the Hospital and Trauma Benefits chapter of this member guide.

How do the different plans cover Everyday Services claims?

PLEASE NOTE

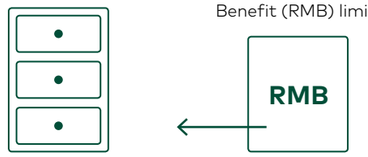
- Member +3 benefit limits will also apply to families with more than three dependants.
- Unless stated otherwise, the benefit limits shown below apply to the benefit year running from 1 January to 31 December.
- If there is a shortfall between the benefit covered by the Scheme and the actual cost of the service, you will need to pay this difference at the point of sale.
- The **Hospital Plan** does not offer any of the benefits below, and therefore does not form part of the comparison in this chapter.

PLATINUM

Benefits are paid at up to 3 x MSR.

Sub-limits are available for certain benefits.

Other specific benefits are covered from the Routine Medical Benefit (RMB) limit.



Once these sub-limits are depleted, the available RMB limit can also be used to cover the above benefits.

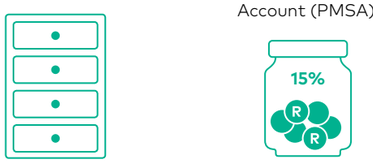
Once your sub-limits and RMB are depleted, you will be liable for payment.

COMPREHENSIVE

15% of your monthly contribution is allocated to your PMSA. Benefits with sub-limits are paid at MSR, while benefits payable from PMSA are covered at cost.

Sub-limits are available for certain benefits.

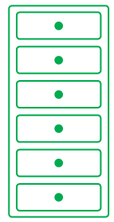
Other specific benefits are covered from your Personal Medical Savings Account (PMSA).



Once your sub-limits and/or PMSA (whichever is applicable to the specific benefit) are depleted, you will be liable for payment.

TRADITIONAL

Benefits are paid at MSR.



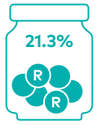
Sub-limits are available for certain benefits.

Once your sub-limits are depleted, you will be liable for payment.

SAVINGS

21.3% of your monthly contribution is allocated to your PMSA. Benefits with sub-limits are paid at MSR, while benefits payable from PMSA are covered at cost.

Most of the listed benefits are covered from your Personal Medical Savings Account (PMSA).



Sub-limits are available for certain maternity benefits only.

Once your sub-limits and/or PMSA (whichever is applicable to the specific benefit) are depleted, you will be liable for payment.

ANNUAL PMSA AMOUNT (AVAILABLE UPFRONT)

Add up the amounts per beneficiary to calculate the total available for your family.

TIP Use our handy online calculator!

COMPREHENSIVE

If you earn R4 500 pm or less	Member: R 6 139 Adult: R4 787 Child (max 2): R1 352
If you earn between R4 500 and R6 000 pm	Member: R 6 681 Adult: R5 211 Child (max 2): R1 494
If you earn more than R6 000 pm	Member: R 6 820 Adult: R5 316 Child (max 2): R1 540

SAVINGS

If you earn R6 000 pm or less	Member: R 4 669 Adult: R4 029 Child (max 2): R1 432
If you earn more than R6 000 pm	Member: R 5 117 Adult: R4 989 Child (max 2): R1 702

RMB ROUTINE MEDICAL BENEFIT LIMIT

PLATINUM

Member: R16 920
Member +1: R28 450
Member +2: R30 160
Member +3: R36 660

The Routine Medical Benefit benefit can also be used to pay:

- **Chronic medicine** (PMB and non-PMB) – Once the chronic limit has been exceeded, you may submit claims under this benefit.
- **All refractive procedures** – Claims will be paid from this benefit once you have exceeded your limit under the Hospital and Trauma Benefit.
- **Procedures out-of-hospital** not covered under the Hospital and Trauma benefits

	PLATINUM	COMPREHENSIVE	TRADITIONAL	SAVINGS
General Practitioners, Homeopaths and Specialists consultations Visits, consultations, outpatients, procedures out of hospital not covered under Hospital and Trauma Benefits	Payable from Routine Medical Benefit limit.	Covered from available PMSA.	Member: **R2 240** Member +1: **R4 135** Member +2: **R4 510** Member +3: **R5 530**	Covered from available PMSA.
Optical benefits • **Eye tests** • **Lenses, contact lenses and fittings** Eye tests are unlimited (payable from this benefit limit and, once exceeded, payable from the Overall Annual Limit). Lenses, contact lenses and fittings are paid up to the available sub-limits.	**R4 915** per beneficiary Once the limit is exhausted, this benefit will be paid from the Routine Medical Benefit limit.	Member: **R2 535** Member +1: **R3 955** Member +2: **R4 170** Member +3: **R4 885** A sub-limit of **R955** for frames for the 2-year cycle starting Jan 2017	Member: **R2 535** Member +1: **R3 955** Member +2: **R4 170** Member +3: **R4 885** A sub-limit of **R955** for frames for the 2-year cycle starting Jan 2017	Covered from available PMSA.
Maternity benefits • **Antenatal visits** • **Antenatal classes** • **Ultrasound scans** • **Child Vaccinations**	**R7 520** combined maternity benefit per family per year. Once the limit is exhausted, this benefit will be paid from the Routine Medical Benefit limit. **2 x 2D or 3D** scans per family At a private clinic: **R5 380** per family per year Medication cost only, excluding facility fee or nursing consultations	**R2 915** per family **R1 505** per family **2 x 2D** scans per family	**R2 915** per family **R1 505** per family **2 x 2D** scans per family	**R2 915** per family **R1 505** per family **2 x 2D** scans per family
Dentistry benefits • **Basic dental services** Removal of teeth and roots, removal of wisdom teeth, exposure of teeth for orthodontic reasons and suturing of traumatic wounds, diagnosis and treatment of oral and associated conditions, plastic dentures.	**R8 050** per beneficiary per year for Basic and Advanced dentistry. Once the limit is exhausted, this benefit will be subject to the Routine Medical Benefit limit.	**R3 195** per beneficiary Once the limit is exceeded, claims will be paid from Advanced dentistry limit.	**R3 195** per beneficiary Once the limit is exceeded, claims will be paid from Advanced dentistry limit.	Covered from available PMSA.
• **Advanced dentistry** Inlays, bridgework, crowns excluding gold content, mounted study models, metal base partial dentures, orthodontics, periodontists, prosthodontists and dental technicians.		Member: **R4 260** Member +1: **R7 740** Member +2: **R7 980** Member +3: **R9 520**	Member: **R4 260** Member +1: **R7 740** Member +2: **R7 980** Member +3: **R9 520**	Covered from available PMSA.

	PLATINUM	COMPREHENSIVE	TRADITIONAL	SAVINGS
Medicines: • **Prescribed medicine (acute)** • **Antenatal vitamins prescribed during pregnancy** – excluding calcium supplements and Omega preparations	Payable from Routine Medical Benefit limit.	Covered from available PMSA.	Member: **R3 355** Member +1: **R5 230** Member +2: **R5 510** Member +3: **R6 460** Paid at **Medicine Price or Medicine Price List**, whichever is the lesser.	Covered from available PMSA.
• **Pharmacy advised therapy (PAT) -** Medicines supplied by a registered pharmacist without a prescription from a medical practitioner or dentist. Benefit excludes the pharmacy's administration fee. The funding of compound analgesics, for example, Myprodol®, Stilpane® and Syndol® will be restricted to a maximum supply of one hundred tablets or capsules per year. If your condition requires medication in excess of this limit, you, your doctor or pharmacist can contact the Scheme on 0860 100 080. He/she will be transferred to a clinical agent who will consider a verbal motivation.	Payable from Routine Medical Benefit limit.	Covered from available PMSA.	**R1 340** per family, subject to the prescribed medicine limit.	Covered from available PMSA.
Pathology	Payable from Routine Medical Benefit limit.	Member: **R2 015** Member +1: **R2 565** Member +2: **R2 605** Member +3: **R2 855**	Member: **R2 015** Member +1: **R2 565** Member +2: **R2 605** Member +3: **R2 855**	Covered from available PMSA.
Radiology (X-rays)	Payable from Routine Medical Benefit limit.	**R2 685** per family	**R2 685** per family	Covered from available PMSA.
Supplementary health services 23 practice areas including applied kinesiology, audiometry/audiology, autologous donation of blood, biokinetics, chiropody, chiropractic services, clinical technology, dieticians, naturopaths, occupational therapy, orthoptic treatment, podiatry, remedial therapy, speech therapists, and social workers	Payable from Routine Medical Benefit limit.	Covered from available PMSA.	Member: **R1 985** Member +1: **R3 665** Member +2: **R3 995** Member +3: **R4 905**	Covered from available PMSA.
Physiotherapy Physiotherapy following hospitalisation is covered under the Hospital and Trauma Benefits, provided it is pre-authorised by the Case Manager before discharge from hospital. See the *Hospital and Trauma Benefits* chapter in this guide for more information.	Payable from Routine Medical Benefit limit.	Covered from available PMSA.	**R3 180** per family	Covered from available PMSA.

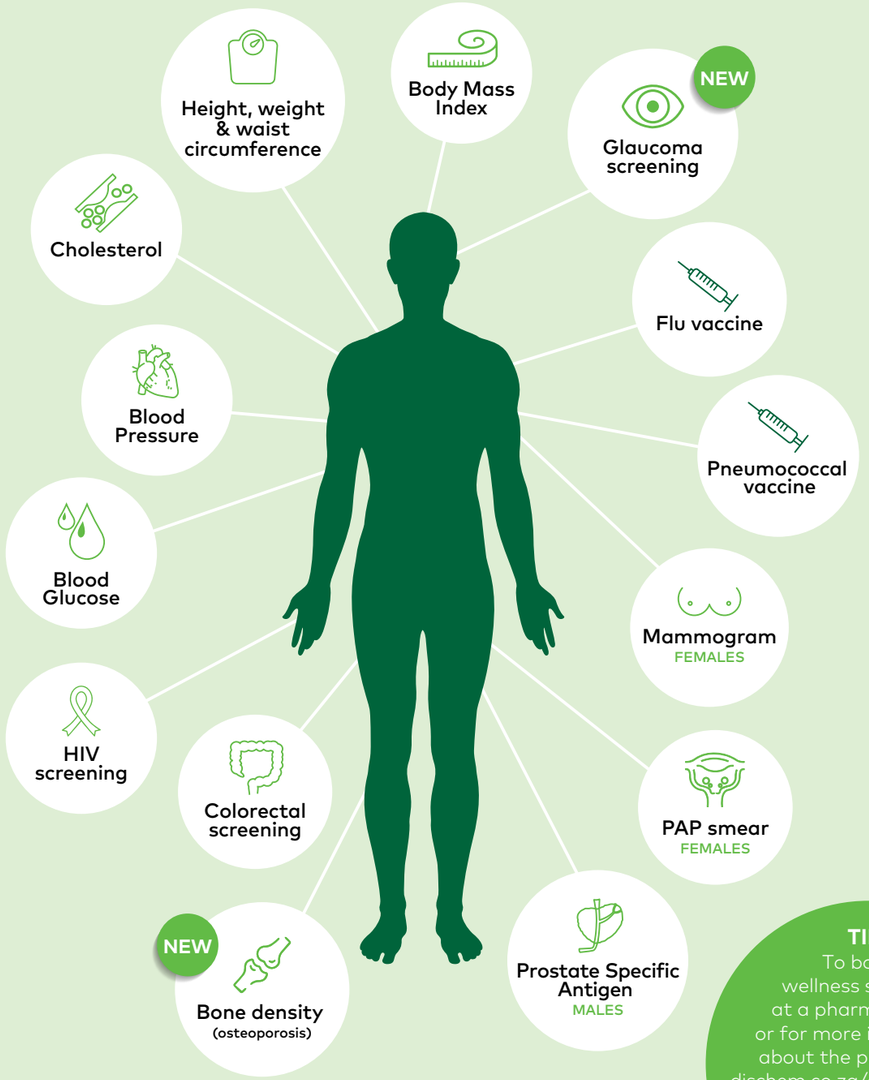
	PLATINUM	COMPREHENSIVE	TRADITIONAL	SAVINGS
Psychology There is a difference in the benefits you receive for treatment by a psychiatrist and a psychologist. A psychiatrist is a medical specialist who may use psychotherapy as well as medication to treat patients. The consultation or treatment by a psychiatrist will be deducted from the General Practitioners and Specialists limit, where applicable. Psychotherapy by a clinical psychologist, who is not a specialist, will be deducted from the Psychology limit, where applicable.	Payable from Routine Medical Benefit limit.	**R5 960** per family	**R5 960** per family	Covered from available PMSA.
Medical appliances Not forming an integral part of an operation, for example, baumanometer, all orthopaedic braces, and crutches, as well as CPAP equipment. Maintenance and repairs are not covered by the Scheme, unless a full quote is received and pre-authorised by the Scheme. Approval for moulded insoles is subject to motivation from a relevant specialist. The frequency of the benefit will be subject to the Scheme's clinical protocols.	Payable from Routine Medical Benefit limit.	**R4 165** per family	**R4 165** per family	Covered from available PMSA.
Wheelchair and associated appliances Can be purchased or hired, if approved before acquisition.	**R11 890** per family	**R11 890** per family	**R11 890** per family	Covered from available PMSA.
Hearing aids This benefit covers the cost of the repair of the devices, subject to the quote being submitted to the Scheme and being approved. A registered provider must submit the claim. The cost of batteries is excluded.	Payable from Routine Medical Benefit limit.	**R33 130** per family for beneficiaries 6 years and younger every 2 years **R22 670** per family for beneficiaries 7 years and older Benefit available per beneficiary every 2 years, starting 1 January 2017.	**R33 130** per family for beneficiaries 6 years and younger **R22 670** per family for beneficiaries 7 years and older Benefit available per beneficiary every 2 years, starting 1 January 2017.	Covered from available PMSA.
Oral Contraceptives Products must be prescribed for contraception and not for the treatment of acne or skin conditions, unless otherwise specified as per managed care protocols.	**R3 090** per beneficiary for the Mirena device, with a **R1 800** sub-limit for oral contraceptives, subject to managed care protocols. The cost of a GP or gynaecologist consultation will be covered from the Routine Medical Benefit.	Covered from available PMSA.	Payable from Prescribed medicine (acute) sub-limit.	Covered from available PMSA.

3

WELLNESS BENEFITS

IN THIS SECTION

- Why should I go for screening tests?
- What is available under the Wellness Benefits?



TIP:
To book a wellness screening at a pharmacy clinic, or for more information about the process, visit dischem.co.za/stay-well-clinic for Dis-Chem or clicks.co.za/clinicBooking for Clicks Pharmacies.

Why should I go for screening tests?

Having screening tests done is one of the most important things you can do for your health. Screenings are medical tests that check for diseases before there are any known symptoms. Screenings can help doctors find diseases early, when the diseases may be easier to treat. Do bear in mind, though, that screening tests are only indicative. For a more accurate diagnosis of a chronic condition, your doctor may refer you for more extensive blood tests to determine whether you require chronic medication. For more information on chronic medicine benefits, read the Chronic Medicine Benefits chapter of this member guide.

What is available under the Wellness Benefits?

The following Wellness Benefits are available to members on ALL Plans: NEW

WELLNESS SCREENING

You have access to the Nedgroup Network Pharmacy Screening Programme, allowing you and your dependants to visit a participating Nedgroup Network pharmacy clinic or attend a Scheme Wellness event, so that a qualified nurse can give you advice on how to improve your health. Another advantage of these screening tests is that members with potentially high risks in terms of their health may be identified at an early stage.

You will be covered for the following diagnostic tests (two sets of tests at R150 per set of tests including VAT per beneficiary per year), to the value of R300 including VAT per beneficiary per year. (You will have the flexibility to choose to have all the tests at one encounter, either at a Wellness event or at a NedgroupNetwork Pharmacy, or to have multiple individual tests over the benefit year, subject to the benefit limit shown above.)

- Blood sugar
- Blood pressure
- Cholesterol
- Measurement of height, weight and waist circumference
- Body Mass Index calculation

HIV SCREENING

You also have the following HIV tests and services available on all Plans:

- Pre-testing counselling,
- Testing and post-test counselling,

- limited to **2 tests** per beneficiary per year and subject to the preferred provider negotiated rate.

Your monthly statement will reflect any claims received and paid once this benefit has been accessed. The claims are paid from your HIV Benefit and not from your Everyday Services Benefits.

VACCINATIONS

The following vaccinations are covered under the Wellness Benefits:

- One flu vaccine per beneficiary per benefit year.
- One pneumococcal vaccine per member or beneficiary aged 65 or over per lifetime.

PLEASE NOTE
ONLY the vaccines are covered under this benefit, whereas any consultation fees will be paid from the Everyday Services Benefits limit (for applicable Plans) or, in the case of **Savings Plan** members with insufficient savings or **Hospital Plan** members, from the member's own pocket.

CANCER SCREENING TESTS

- **Pap smear** (usually performed by a GP or gynaecologist) – limited to one test per female beneficiary per benefit year.
- **Prostate Specific Antigen** (a blood test to screen for prostate cancer) – limited to one test per male beneficiary over age 50 per benefit year.

WHERE CAN I ACCESS THE PHARMACY-BASED BENEFITS?
To find out where the nearest participating Nedgroup Network Pharmacy is, you may contact:

ScriptPharm Risk Management
Telephone: 011 100 7557
Email: nedgroup@scriptpharm.co.za
Website: www.scriptpharm.co.za

- **Mammogram** (performed at a radiology practice) – limited to one test per female beneficiary over age 40 per benefit year.
- **Colorectal screening** (where a sample of your stool is screened by a pathologist) – limited to one test per beneficiary over age 50 per benefit year.

PLEASE NOTE
ONLY the tests are covered under this benefit; whereas any consulting fees will be paid from the Everyday Services Benefits limit (for applicable Plans) or, in the case of **Savings Plan** members with insufficient savings in their PMSA, from the member's own pocket.

OTHER SCREENING TESTS

NEW **Glaucoma screening** (performed at an optometrist/ophthalmologist) – limited to one test per beneficiary over age 55.

NEW **Bone density screening** (performed at a radiology practice) – limited to one test per beneficiary over age 65 every two years.

Your monthly statement will reflect any claims received and paid once this benefit has been accessed.

The claims are paid from your Wellness Benefit and not from your Everyday Services Benefits. Any medical expenses not covered under the Wellness Benefit will be paid from your Everyday Services Benefits.

TIP:
If you would like information on where you can access the screening tests that are not offered at pharmacy clinics, please call 0860 100 080.

4

CHRONIC BENEFITS

IN THIS SECTION

What is a chronic condition?

A chronic condition is one that requires on-going, long-term or continuous medical treatment. However, the Scheme's chronic medicine benefit does not necessarily cover all these conditions.

Which basic chronic conditions are covered by all Plans?

PRESCRIBED MINIMUM BENEFITS (PMB) CHRONIC CONDITIONS

There are 26 PMB chronic conditions that must be covered in terms of the regulations governing medical schemes, referred to as the PMB Chronic Conditions – see PMB Chronic Conditions listed in the table below. To manage the risk and ensure that appropriate standards of health are applied, treatment algorithms were developed for these PMB Chronic Conditions. These algorithms, which have been published in the Government Gazette, can be regarded as benchmarks, or minimum standards, for treatment. This means that the treatment your medical scheme must cover is not allowed to be inferior to the published algorithms.

If you have one or more of the 26 PMB chronic conditions and meet the clinical entry criteria, your medical scheme will cover your chronic medication and issue a PMB treatment plan indicating your cover for any GP consultations and relevant tests. The Scheme may make use of protocols, formularies (list of specified medicines) and Designated Service Providers to manage this benefit.

The Scheme also covers Diagnosis and Treatment Pairs (DTP). A DTP links a specific diagnosis to a treatment and therefore broadly indicates how each of the approximately 270 PMB conditions should be treated.

Where the DTP includes chronic medicine as the appropriate treatment, the DTP will be covered by the Scheme (subject to protocols, formularies and the use of DSPs). The following conditions are part of the DTP list:

- Deep vein thrombosis
- Hormone replacement therapy
- Hypofunction of the pituitary gland
- Hyperthyroidism
- Hypoparathyroidism

To better understand this benefit, it helps to be familiar with the following terms and what they mean:

Chronic Medicine Formularies

A formulary is a list of cost effective evidence-based medicines that the Scheme will cover for the treatment of your chronic condition. These lists are compiled by the ScriptPharm Risk Management and are reviewed quarterly.

Reimbursement is subject to clinical guidelines and protocols. The Scheme applies a Standard Formulary and an Advanced Formulary as part of the guidelines.

The Standard Formulary, applicable to the **Hospital** and **Savings** Plans, contains a list of medicines that provide cover for the listed chronic conditions.

The Advanced Formulary, applicable to the **Platinum**, **Comprehensive** and **Traditional** Plans, provides access to a wider range of medicines than the Standard Formulary.

If you choose to use a medicine that is not on your Plan's formulary, and you do not have a motivation for this non-formulary medicine (which would then be reviewed and considered for approval), you will have to pay for it from your own pocket. The formularies are updated throughout the benefit year. Any products that are removed from the formulary will be communicated to you during the year. It is important for you to discuss changing to an alternative medicine with your treating doctor, or the medication will be covered from your available Everyday Services Benefits and thereafter will be for your own account.

PMB CHRONIC CONDITIONS

1. Addison's disease
2. Asthma
3. Bipolar mood disorder
4. Bronchiectasis
5. Cardiac failure
6. Cardiomyopathy disease
7. Chronic renal disease
8. Chronic obstructive pulmonary disease (emphysema)
9. Coronary artery disease (angina pectoris and ischaemic heart disease)
10. Crohn's disease
11. Diabetes insipidus
12. Diabetes mellitus type 1 & 2
13. Dysrythmias
14. Epilepsy
15. Glaucoma
16. Haemophilia
17. HIV/AIDS*
18. Hyperlipidaemia (high cholesterol)
19. Hypertension (high blood pressure)
20. Hypothyroidism
21. Multiple sclerosis
22. Parkinson's disease
23. Rheumatoid arthritis
24. Schizophrenia
25. Systemic lupus erythromatosis
26. Ulcerative colitis

Other Scheme approved chronic conditions

The Scheme covers the following approved chronic conditions on the **Platinum**, **Comprehensive**, **Traditional** and **Savings** Plans.

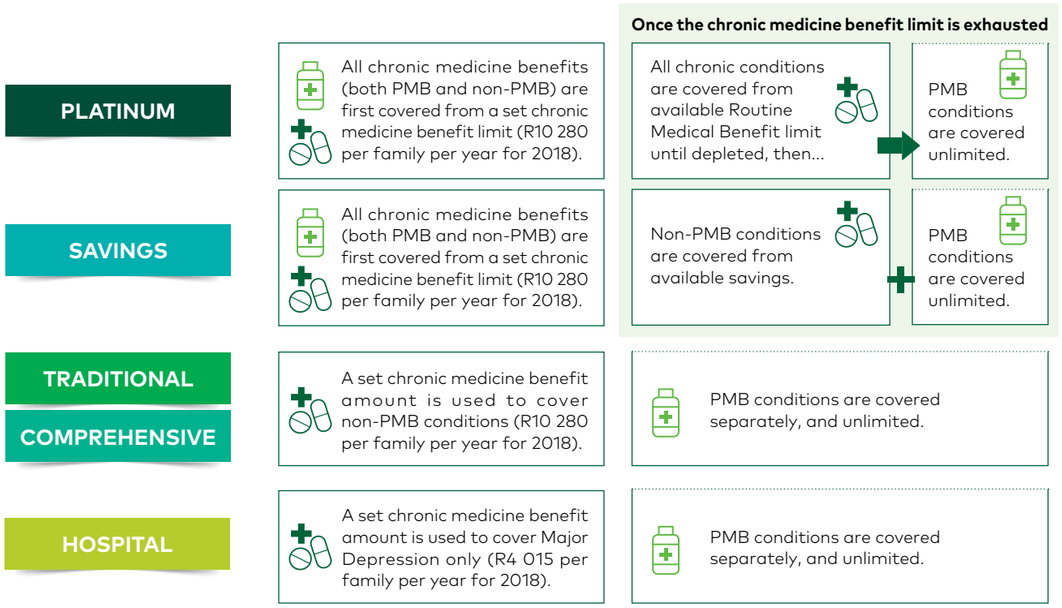
OTHER SCHEME-APPROVED CHRONIC CONDITIONS

1. Acne (cystic nodular)
2. Allergic rhinitis (if beneficiary has asthma or is under 12 years)
3. Alzheimer's disease
4. Anxiety (if linked to another approved psychiatric chronic condition)
5. Attention deficit syndrome (if prescribed by a specialist and under the age of 18 years)
6. Behcet's Disease
7. Eczema
8. GORD (with the necessary motivation and/or gastroscopy report)
9. Gout
10. Hypofunction of the pituitary gland
11. Hypotension
12. Insomnia (sleep disorders) (if linked to another approved psychiatric chronic condition)
13. Macular Degeneration
14. Major Depression
15. Migraine prophylactics (prevention)
16. Obsessive Compulsive Disorder
17. Osteoarthritis
18. Osteoporosis
19. Paget's Disease
20. Psoriasis
21. Sjögren's Disease

* Please refer to *HIV and AIDS management programme* in the *Managed Care Programmes* chapter of this member guide for more information on benefits available.

How are chronic medicine benefits covered under each Plan?

It is important to understand the different ways in which the Plans cover chronic medicine (for example, although **Platinum Plan** is a higher-cost plan with richer day-to-day benefits, it is typically not suited to members with both PMB and non-PMB chronic conditions).



	PLATINUM	TRADITIONAL COMPREHENSIVE	SAVINGS	HOSPITAL
26 PMB chronic conditions Subject to pre-authorisation and approval of the chronic medicine	**100% of medicine price** for PMB and non-PMB chronic medicine subject to **R10 280** per family per year, provided it is obtained from a DSP (Nedgroup Network pharmacy). Thereafter, chronic medicine claims will be paid from Routine Medical Benefit. Once Routine Medical Benefit is depleted, **100% of cost** for chronic medication for the 26 PMB chronic conditions paid from PMB benefit, provided it is obtained from a DSP (Nedgroup Network pharmacy). Advanced Medicine Formulary applies. No further benefit for other Scheme-approved chronic conditions.	**100% of cost** for chronic medication paid from PMB benefit, provided it is obtained from a DSP (Nedgroup Network pharmacy). Advanced Medicine Formulary list applies.	**100% of medicine price** for PMB and non-PMB chronic medicine, limited to **R10 280** per family per year provided it is obtained from a DSP (Nedgroup Network pharmacy). Once chronic medicine benefit limit for PMB and non-PMB chronic medicine is depleted, **100% of cost** for chronic medication for 26 PMB chronic medicine paid from PMB benefit, provided it is obtained from a DSP (Nedgroup Network pharmacy). Once chronic medicine benefit limit is depleted, other scheme-approved chronic medicines will be covered from your available savings provided it is obtained from a Nedgroup Network pharmacy. Once your savings is depleted, you will be liable for payment from your own pocket. Standard Medicine Formulary list applies.	**100% of cost** for chronic medication paid from PMB benefit, provided it is obtained from a DSP (Nedgroup Network pharmacy). Standard Medicine Formulary list applies.
Other Scheme-approved chronic conditions Subject to pre-authorisation and approval of the chronic medicine		**100% of medicine price**, limited to **R10 280** per family per year, provided it is obtained from a DSP (Nedgroup Network pharmacy). Chronic medicine obtained from a pharmacy outside of the network will be paid from your Everyday Services Benefit. Once your Everyday Services Benefit is depleted, you will be liable for payment from your own pocket.		Cover for Major Depression only. **100% of medicine price**, limited to **R4 015** per family per year provided it is obtained from a DSP (Nedgroup Network pharmacy).
Once benefits for other Scheme-approved Chronic Conditions for the year have been exhausted, additional costs are covered as follows				
	From your Routine Medical Benefit limit. If no more benefits are available, you will have to pay in full at the point of sale.	From your Prescribed Medicines limit. If no more benefits are available, you will have to pay in full at the point of sale.	From your Personal Medical Savings Account, if there are funds available. Otherwise you will need to pay in full at the point of sale.	Other than for Major Depression, no benefit for other Scheme-approved Chronic Conditions. You will need to pay in full at the point of sale.
Medical Management of 26 PMB chronic conditions	**100% of cost** at DSP paid from PMB benefit, subject to the Scheme's treatment protocols. If you choose a GP or specialist outside of the network, your claims will first be paid from your Everyday Services Benefit and thereafter be covered by the PMB benefit with a co-payment of 25% that you will need to cover from your own pocket. Nedgroup GP and Specialist network is the DSP for medical management of the 26 PMB chronic conditions.		**100% of cost** at DSP paid from PMB benefit, subject to the Scheme's treatment protocols. If you choose a GP or specialist outside of the network, your claims will be covered by the PMB benefit, with a co-payment of 25% that you will need to cover from your own pocket. Nedgroup GP or specialist network is the DSP for the medical management of the 26 PMB chronic conditions. PMB standard level of care treatment plan applies.	
DSP for chronic medicine	Nedgroup Network Pharmacies managed by ScriptPharm is the DSP for chronic medication.			

How do I apply for the Chronic Medicine Benefit?

Should you or one of your dependants be diagnosed with a chronic condition for which you are currently not registered on the Chronic Medicine Management programme, you should follow the steps below to apply for this benefit:

- Check the PMB and other Scheme-approved Chronic Conditions list to ensure that your condition is covered on your selected Plan. Refer to *Which basic chronic conditions are covered by all Plans?* for a full list of conditions covered.
- Complete a chronic medicine benefit application form. Application forms can be obtained from the ScriptPharm (ScriptNet) website at www.scriptpharm.co.za or call ScriptPharm on 011 100 7557 to request an application form and it will be faxed, emailed or posted to you.
- Take note of the instructions on the application form and ensure that both you and your doctor(s) sign the application form.
- Certain diseases require additional test results, motivation and supporting documentation and in some cases a specialist must complete the application form.
- All completed applications should be posted, faxed or emailed (see details below).
- Incomplete application forms will cause a delay in processing your application.
- Do not submit the original prescription. It must be presented to your pharmacist to obtain the medication, once approval has been obtained.

YOUR APPLICATION WILL BE PROCESSED AS FOLLOWS:

- Clinical Entry Criteria will be applied, which means that your application must meet certain clinical criteria before chronic medicine benefits will be authorised. ScriptPharm pharmacists, supported by medical advisers, will review your application to ensure that the most appropriate and cost-effective medication is authorised. The use of cost-effective medication ensures cost containment without compromising the quality of care.
- Medicines will be covered in full, without co-payments, if they are listed on the Chronic Medicines formulary. This list of cost-effective medicines is based on local and international studies, and complies with the criteria developed by the Council for Medical Schemes.
- Chronic medicines will be approved from the date of receipt of the prescription/application, provided that the application is fully completed and includes all supporting documentation. The Scheme will not backdate chronic medicine authorisations prior to the date of receipt of the prescription/ application.
- You will receive a confirmation letter indicating the outcome of your chronic medicine benefit application. Please read this letter and note the end date of the chronic medicine authorisation. The confirmation letter, together with a valid prescription, must be presented at a Nedgroup Network Pharmacy. Pharmacies will not dispense your chronic medication without a valid prescription.

PLEASE NOTE

The turnaround time will be a maximum of five (5) working days for your application to be processed. Incomplete application forms may result in your request being rejected. In the event that the application is referred to the medical advisor, this may result in a longer turnaround time for your application to be processed.

OTHER CHRONIC DISEASES

Authorisation for other chronic conditions, for example, medicines associated with the treatment of anaemia due to renal failure, organ transplant, life-sustaining conditions and major medical/post-hospitalisation medication, will continue to be managed by Medscheme.

Should you be diagnosed with one of the 270 medical conditions listed as PMB conditions, but that is not on the list of PMB chronic conditions, please contact ScriptPharm Risk Management:

Postal address:
ScriptPharm Risk Management
Postnet Suite No 230, Private Bag X19
Garden View, 2047

Telephone: 011 100 7557

Fax: 086 679 1579

Email: nedgroup@scriptpharm.co.za

Business hours: Monday to Friday 08:00 – 16:30

PLEASE NOTE

Even if your authorisation letter states that it is an 'ongoing' authorisation, it is still important for you to send in an updated prescription every six months, or after every visit to your doctor that relates to your approved chronic condition.

What if my prescription (medicine/dosage) changes?

If you need new, additional medication or have a change in your current medication strength and/or dosage for a registered condition, it is your responsibility to send these prescription changes/updates directly to ScriptPharm for your authorisation to be amended appropriately.

If the required changes are dosage related and are urgent, your medical practitioner or pharmacist may contact ScriptPharm to process your requested change. Please note that telephonic authorisations initiated by your medical practitioner or pharmacist should only be used in the case of an emergency. Unprocessed authorisation changes will result in your claims being rejected or being processed from your Everyday Services Benefit, or your Personal Medical Savings Account, or from your own pocket. Certain medicines require additional information for approval, and your doctor will be asked to submit this information. Please note that a copy of a valid prescription must be sent to ScriptPharm within seven working days following the telephonic authorisation.

If you have any queries, please call 011 100 7557. Alternatively, you may fax or post a copy of your new prescription to ScriptPharm. Please ensure that your membership number and details are clearly indicated on the prescription.

When a prescription changes, you should include the following information and submit the request to ScriptPharm:

- Membership number
- Member's initials and surname
- Patient's initials and surname
- Patient's contact details; for example, telephone number, fax number, postal address and/or email address.

How do I obtain an additional month's supply of chronic medication?

If you are travelling and require an additional month's supply of chronic medication, please supply the following information two weeks before departure:

A completed **"Extended supply"** application form (obtainable from ScriptPharm's (ScriptNet) website) with a copy of your air tickets/itinerary attached.

If you don't supply this information, there could be a delay in processing your request. Applications must be received for review at least two weeks before your date of departure.

Who are the Scheme's Designated Service Providers for chronic medication?

You must obtain your authorised chronic medication for PMB and other Scheme-approved chronic conditions from the Scheme's Designated Service Providers (DSPs).

The Nedgroup Pharmacies network has been identified as the Scheme's DSP for chronic medication.

To find out where the nearest Pharmacy to you is, you may contact:

ScriptPharm Risk Management

Telephone: 011 100 7557

Email: nedgroup@scriptpharm.co.za

Website: www.scriptpharm.co.za (click on Locate a Nedgroup Pharmacy)

COURIER PHARMACIES

If you do not live within a reasonable distance of a Nedgroup Network Pharmacy, you may use one of the following courier pharmacies as your DSP.

PHARMACY DIRECT

Postal address: PO Box 7344, Centurion, 0046

Telephone: 086 002 7800

Fax: 0866 11 4000/1/2/3

Email: care@pharmacydirect.co.za

Please call me: 083 690 8934

DIS-CHEM DIRECT

Postal address: Private Bag X 21, Northriding, 2162

Telephone: 011 589 2788

Fax: 086 641 8311

Email: direct@dischem.co.za

CLICKS DIRECT MEDICINES

Postal address: PO Box 30480, Wibsey, 1717

Telephone:

- General enquiry service: 0861 444 405
- Accounts enquiry service: 0861 444 407

General fax line: 0861 44 44 14

Accounts fax line: 0861 44 44 12

Email: clicksdirectmedicines@dirmed.co.za

Web: www.clicksdirectmedicines.co.za

5

HOSPITAL AND TRAUMA BENEFITS

IN THIS SECTION

What are Hospital and Trauma benefits?

Hospital and Trauma Benefits generally cover major medical expenses that you would incur when undergoing surgery or while admitted in hospital, as well as specified procedures performed in the doctors' rooms (see *What services in doctors' rooms are covered?* below). Services not included will fall under the Everyday Services Benefits and are paid from the appropriate limit.

A visit to a hospital's Emergency Room does not qualify to be paid from your Hospital and Trauma Benefit, unless the incident is of such a serious nature that you are admitted to a ward in the hospital itself for further treatment. You may, however, submit a motivation to the Principal Officer for consideration.

PLEASE NOTE
Various hospital groups have introduced a set of tariff codes to levy a facility fee for accessing the emergency units. If you make use of the emergency unit, a separate fee will be charged over and above the cost of treatment. The tariffs are based on the severity of the emergency admission – the higher the priority of admission, the higher the facility fee charged.

What is our overall annual limit?

All members have access to unlimited Hospital and Trauma Benefits **at Medical Scheme Rate (MSR), no matter which Plan they belong to**. There are, however, sub-limits for certain services, depending on the Plan that you are on. Refer to the tables below for the sub-limits that apply to Hospital and Trauma Benefits under the various Plans.

What services in doctors' rooms are covered?

Provided you obtain a pre-authorisation number, certain procedures that are undertaken in doctors' rooms will be covered under your Hospital and Trauma Benefits at cost or **Medical Scheme Rate**, whichever is the lesser. **These include but are not limited to:**

- Bone marrow biopsy
- Colonoscopy
- Cystoscopy
- Functional endoscopy of sinuses
- Gastroscopy
- Hysteroscopy
- Intravenous therapy
- Keloids (subject to motivation)
- Laser to scars (subject to motivation)
- Flexible sigmoidoscopy
- Surgical biopsies (needle biopsies) (subject to motivation)
- Tonsillectomy (laser)
- Upper GI endoscopy
- Vasectomy
- Stitching of wounds
- Excision and repair
- Drainage of subcutaneous abscess & avulsion of nail
- Circumcision-clamp
- Excision of lymphoma
- Biopsy of skin

Any other minor procedures will be considered if adequately motivated.

Contact the Call Centre to confirm whether your in-room procedure, if not listed above, is covered.

You can still authorise your treatment on the first working day after the procedure, if your circumstances do not allow you to do so beforehand. These procedures are more cost effective when performed in a doctor's room and will be paid from the hospital and trauma benefit provided the procedure is authorised.

What treatments by a practitioner while in hospital are covered?

- If you are diagnosed and need to be admitted to hospital, it will be to your advantage if the admitting practitioner is part of the Nedgroup GP and Specialist Network, as you will obtain cover of up to 2 x Medical Scheme Rate. In addition, you will NOT be required to make a co-payment on the hospital claim. (In the case of members on the **Platinum Plan**, no co-payment will apply if a non-Network provider is used.)
- If your treating practitioner is not part of the Nedgroup GP and Specialist Network, all accounts will be covered at Medical Scheme Rate. In addition,

IMPORTANT!
If you are on any Plan other than **Platinum** and you are admitted to hospital by a GP or specialist who is not on the Nedgroup network, you will incur a R2 500 co-payment.

you will be required to make a co-payment on the hospital claim (unless it was an emergency case). No co-payment on the **Platinum Plan**.

- If you are referred to a specialist, you should check with your administrator whether the specialist is part of the Nedgroup specialist network, **as you will probably not be in a position to change your specialist at the time of requesting pre-authorisation or admission.**

To find out whether the practitioner is on the Nedgroup GP and specialist network, please contact Medscheme on 0860 100 080, or log onto the Member Zone via nmas.medscheme.com.

How does pre-authorisation before hospitalisation work?

- The purpose of pre-authorisation is not only to enable the Scheme to manage the exorbitant cost of hospitalisation, but also to ensure that our members receive the most appropriate and effective treatment available.

IMPORTANT!
You need to pre-authorise any admission to hospital, or you will incur a penalty of R500 (unless it was an emergency).

- Before you are admitted to hospital, other than for an emergency, you need to notify the Scheme at least three working days before the admission date. This is known as pre-authorisation.
- It is recommended that you obtain authorisation at least ten days before being hospitalised for a procedure where an implant or an internal prosthesis will be necessary, for example, a knee replacement (quote to be provided).
- Pre-authorisation is also required for MRI, radio-isotope and CAT scans. If you need these procedures, please follow the process in the table below.
- If you do not inform the Scheme of a planned stay in hospital, you will be charged a penalty of **R500.** The Scheme could also call for medical evidence explaining why the treatment took place in hospital and reserve the right not to pay for these medical expenses.

PLEASE NOTE
An authorisation is confirmation that the claims will be paid at Scheme tariff or the negotiated tariff, provided you are a registered beneficiary and your contributions are fully paid up at the time of receipt of the claims. If your provider charges more than the Scheme tariff or the negotiated tariff, you will be liable for the difference between the amount charged by the treating provider and the amount paid by the Scheme. It is recommended that you obtain a quote from the treating provider (if you select a non-network specialist) and confirm the Scheme tariff. This will enable you to negotiate with the treating provider specifically on the tariff (if you select a non-network specialist) prior to the procedure. Any shortfalls will be for your account.

To pre-authorise, please follow the process below (your GP/specialist or the hospital can also do this on your behalf)

- Contact Hospital Benefit Management on 0860 100 080 (or email nedgroup.authorisations@medscheme.co.za three working days before being admitted to hospital (ten days for implants or internal prostheses).
- In the case of an emergency, you must arrange to notify Medscheme on the first working day after being admitted.
- Please make sure that you have the following information on hand when calling:
  - your membership number
  - name and date of birth of patient
  - the name and the practice number of the hospital
  - the proposed treatment or procedure/tariff code (ICD10 code) and CCSA code
  - the planned date of admission to the hospital
  - name and practice number of the doctor who wishes to admit you to hospital and
  - contact person's details while you are in hospital
- The consultant will confirm the benefits available for the procedure and whether your hospital admission is approved.
- You will receive a pre-authorisation number, which the hospital will require when you are admitted. If your hospitalisation is postponed, you will need to update your pre-authorisation. If you are re-admitted to hospital, you will need to pre-authorise again.

- If you/your dependants are scheduled to undergo an operation in the afternoon, you should ask your doctor to admit you/them after 12:00. In this way the Scheme can avoid incurring unnecessary hospital costs.

THE PROCESS AFTER YOU ARE ADMITTED

The hospital must obtain approval from the Scheme (via the Case Manager) for stays that exceed the number of days that were initially pre-authorised.

On the day of discharge, patients should arrange to leave the hospital before 12:00. In this way the Scheme can avoid incurring unnecessary hospital costs.

What services and procedures are covered during hospitalisation?

- Services and procedures are usually covered at cost or **Medical Scheme Rate** (MSR), whichever is the lesser.
- See the tables further down for the full list of the services and procedures that are covered, as well as the sub-limits that apply.
- Any services provided in the hospital that are not related to the admitting diagnosis will not be covered (in other words, diagnostic tests not related to the reason for admission).
- For the Scheme to consider covering the additional medical services that were not authorised or approved at pre-authorisation stage, a clinical motivation from the member or treating provider will need to be submitted to the Scheme. The request will be considered and evaluated in accordance with the Scheme's evidence based managed care protocols and the member will be informed of the outcome. Any additional medical services which do not meet the Scheme's evidence based managed care protocols will be for your account.

DENTISTRY

- Hospitalisation will only be considered for basic dentistry procedures performed on beneficiaries who are 7 years or younger . In this case, the Hospital and the Anaesthetist will be paid from the Hospital and Trauma benefit and the Dental Practitioner will be paid from Everyday Services Benefit if your Plan has that benefit. **PLEASE NOTE: There is no cover for the Dental Practitioner on the Hospital Plan and any such claim will be for the member's own account.**
- All dental-related cases requiring surgery, which do not fall within the surgical class of tariffs, need to be motivated by the attending dental practitioner.
- **Orthodontic treatment** for persons over the age of **21 is excluded** from this benefit **for all Plans.**

LAPAROSCOPIC SURGERY AND OTHER SURGERIES WITH A CO-PAYMENT

- Laparoscopic procedures are more expensive, and the procedure may in general be performed as an open procedure. The Scheme has therefore decided, like many other medical schemes, to fund these procedures with a co-payment, rather than only cover open procedures.
- Members who undergo the following procedures will therefore be liable for the co-payments shown below (excluding PMB level of care):

PROCEDURE	CO-PAYMENT
Laparoscopic appendectomy	**R2 500**
Laparoscopic hernia repair	**R2 500**
Laparoscopic hysterectomy	**R2 500**
Laparoscopic radical prostatectomy	**R2 500**
Laparoscopic pyeloplasty	**R2 500**
Knee arthroscopy	**R2 500**
Upper GI endoscopy (gastroscopy)	**R500** (If performed in a doctor's rooms, no co-payment will apply.)
Balloon sinuplasty	**R2 500**

PSYCHIATRIC SERVICES

- This benefit covers hospitalisation and all associated accounts, for example, psychiatrist, psychologist, anaesthetist, general practitioner, occupational therapist, social worker, physiotherapist, pathology, radiology and medication.
- It also covers consultations with a psychiatrist on an outpatient basis in the place of hospitalisation, provided that this has been pre-authorised and approved.
- The Scheme covers a maximum of three days' hospitalisation for beneficiaries admitted by a GP or specialist physician.
- If a patient is not admitted to a registered psychiatric facility, the psychiatrist must arrange for a transfer to an accredited facility as soon as it is possible to do so. Alternatively the patient must be discharged.
- A psychiatrist must assess these admissions as appropriate.
- The Scheme does not pay for sleep therapy, since it is not recognised as therapeutic by the Association of Psychiatrists.

INTERNAL PROSTHESES

These are manufactured substitutes that are surgically implanted for a diseased or missing part of the body, or used to improve the function of a diseased or damaged organ.

PLEASE NOTE
The cost of prostheses may be more than what is covered by the Scheme, in which case you will be liable for the difference. Discuss the various alternatives with your service provider and ask for quotes that are more aligned with your benefit limit.

MATERNITY BENEFITS
See our new *Maternity Benefits* chapter later in this member guide.

How does pre-authorisation by a case manager work?

Before you receive the treatment, you need to contact the Scheme and apply for the specific benefit. This applies to the following benefits – physiotherapy following an admission, home oxygen, hyperbaric oxygen therapy and renal dialysis.

PLEASE MAKE SURE THAT YOU PROVIDE THE FOLLOWING INFORMATION TO THE CASE MANAGER:

- your membership number
- name and date of birth of patient
- the proposed treatment or tariff code (ICD10 code)
- the quotation and/or treatment plan
- name and practice number of the doctor
- clinical motivation

PLEASE NOTE
The Scheme may from time to time contract with or pilot with credentialed specific provider groups (networks) or centres of excellence in order to ensure cost effective and appropriate care. Beneficiaries are entitled to benefits from contracted networks appointed as the Scheme's DSP for PMB benefits and other benefits. The Scheme reserves the right to not fund, partially fund or impose a co-payment for services acquired outside of these networks provided reasonable steps are taken by the Scheme to ensure access to the network.

Services and procedures covered during hospitalisation

The following services and procedures are covered at **cost or Medical Scheme Rate**, whichever is the lesser, unless otherwise stated. When multiple procedures are done, modifier 0005 is/could be applicable to the procedure (which reduces the chargeable amount); this means the treatment is paid at a sliding scale. The first procedure will be paid at Medical Scheme Rate (MSR), the second procedure at 0.75 x MSR, the third procedure at 0.5 x MSR and the fourth and subsequent procedures at 0.25 x MSR. It is recommended that you obtain a quote from your doctor (if you select a non-network specialist) and confirm the Scheme tariff. This will enable you to negotiate with your doctor to charge medical scheme rates or to give you a discount, if he or she has opted not to bill medical scheme rates. Any shortfalls for a non-network specialist (other than an emergency) will be for your account.

	SERVICE CATEGORY	BENEFIT
	Unlimited cover for major medical expenses, subject to the pre-authorisation and case management process and, for cases over R500 000, subject to the Medical Advisor's approval. Certain sub-limits apply.	
1	**Co-payments** (refer to the last section in the *In Summary* chapter)	Laparoscopic procedures listed under *Laparoscopic surgery and other surgeries with a co-payment* in the section above will attract a co-payment of **R2 500** for all admissions, except for PMB related conditions. Where the admitting doctor is not on the Nedgroup specialist network (except for emergencies), the account will attract a hospital co-payment of **R2 500** (except for members on the **Platinum Plan**). **R5 000** co-payment on spinal fusion surgery if you live within a reasonable distance of a DBC centre and declined following the Back and Neck Programme before choosing to undergo the surgery. (This co-payment will not apply to emergency admissions.)
2	**Private and Public Hospital accommodation** To avoid incurring unnecessary hospital costs: • On the day of discharge, you should arrange to leave the hospital before 12:00. • If scheduled to undergo an operation in the afternoon, you should ask your doctor to admit you after 12:00.	**Medical Scheme Rate** for accommodation in: • a general ward • theatre • recovery rooms • intensive care unit • high care unit • specialised intensive care Benefits for private or isolated wards are paid at general ward rates, unless there is an acceptable medical reason and pre-approval is obtained from the Case Manager. You will be responsible to pay the difference. **Medical Scheme Rate** for operating theatres. The benefit for nursing homes applies to registered facilities only and for short-term episodes of acute care only, in the place of hospitalisation and excludes frail care and long-term care.
	• **Facility fees** (refer to *What are Hospital and Trauma benefits?* at the beginning of this chapter.	**Platinum Plan**: Paid from Routine Medical benefit limit. **Savings** and **Comprehensive** Plans: Paid from Personal Medical Savings Account. **Other Plans**: No benefit; for member's own account.
	• **Medicine on discharge (TTO)**	Limited to **R540** per beneficiary per admission, and must be supplied on the day of discharge from hospital.
3	**Nursing services**	**100% of cost** with a **sub-limit of R17 010** per family per year in a registered facility only and subject to pre-authorisation. **This benefit covers home services by a registered nurse, pre- and post-confinement treatment by a registered midwife, and is for short-term episodes of acute care only** in the place of hospitalisation. Items such as laundry, telephone calls, hairdressing, etc. will not be covered under this category. Only necessary medical services will be covered.
4	**Prescribed Medication** (Nursing homes/Hospice)	Medication provided may be covered from either the Everyday Services Benefits, or Personal Medical Savings Account, where applicable. Prescribed (acute) medicines will not be covered on the **Hospital Plan**, except for Major Depression and those conditions covered under Prescribed Minimum Benefits. **PLEASE NOTE:** ***You must apply for this benefit and it must be pre-authorised by the Case Manager.***
5	**Hospices**	**Cost or Medical Scheme Rate**, whichever is the lesser, limited to **R31 510** per family per year. The medication will be subject to your Prescribed medicine (acute) sub-limit.
6	**Maternity** • **Confinement in hospital**	**Cost or Medical Scheme Rate,** whichever is the lesser, subject to the overall annual limit. As per clinical guidelines and protocols. Further days will require motivation by the attending doctor and approval by a Case Manager.
	• **Midwife delivery**	Society for Private Nurse Practitioners' tariffs, including pre-and-post confinement costs, if a gynaecologist is not used.
	• **Confinement in a registered birthing unit**	**Cost or Medical Scheme Rate,** whichever is the lesser, subject to the overall annual limit. Including 4 x post-natal midwife consultations per event. **Platinum Plan**: **Tariff** agreed with the hospital group for private wards for confinement.
7	**Ambulance services**	**Tariff** agreed with the Scheme's preferred provider, ER24.

8	**General practitioners & medical specialists in hospital**	The Scheme has appointed a Nedgroup GP and Specialist Network as our Designated Services Provider. If you are referred to a specialist, please check with your administrator whether the specialist is part of the Nedgroup Specialist Network. **Scheme negotiated tariff** for a network specialist or **Medical Scheme Rate** for the specialist who is not part of the Nedgroup Specialist Network for the following services: • surgery • procedures in hospital • anaesthesia • applicable portion of assistant's fees at operations • hospital visits
	• **Dental practitioners in hospital**	**Platinum Plan**: Paid from Routine Medical Benefit limit **Comprehensive Plan**: Paid from Everyday Services Benefit limit **Traditional Plan**: Paid from Everyday Services Benefit limit **Savings Plan**: Paid from Personal Medical Savings Account **Hospital Plan**: No benefit; for member's own account.
9	**Radiology and Pathology** General Radiology and Pathology (in hospital)	**Medical Scheme Rate** subject to the overall annual limit.
	• **Specialised Radiology** (in and out of hospital) MRI scans, radio-isotope scans and CAT scans (wherever the service is provided – excluding PET scans), subject to pre-authorisation.	**Medical Scheme Rate** up to a maximum of **R17 290** per family per year
	• **Ultrasound scans** (in and out of hospital – other than pregnancy scans)	**Medical Scheme Rate** up to a maximum of **R6 660** per family per year.
10	**Maxillofacial and oral surgery**	**Medical Scheme Rate** subject to submission and approval of a quotation.
11	**Dental implants or Building up of Teeth** (In and out of hospital)	**Hospital Plan**: No benefit; for member's own account. **Platinum**, **Comprehensive**, **Traditional** and **Savings** Plans: **Medical Scheme Rate**, with a sub-limit of **R14 610** per family per year for the cost of implant placements and implant components or the building up of a tooth. Please note: The building up of a lost tooth refers to the actual implant and implant components. The structure that is placed on the implant refers to the crown – in this case the implant-supported crown. A crown is categorised as advanced dentistry and will therefore be payable from your available Everyday Services Benefits. Hospital-related costs such as accommodation, specialist fees, theatre fees as well as associated services are subject to the normal Hospital and Trauma Benefit limits. A dental treatment plan will be required for every phase of treatment and needs to be submitted to the Scheme and approved before the procedure.
12	**Orthognathic surgery** (Functional correction of malocclusions)	**Platinum**, **Comprehensive**, and **Traditional** Plans: Limited to and included in the overall annual limit. **Savings Plan**: Paid from Personal Medical Savings Account. **Hospital Plan**: No benefit; for member's own account. Includes all services rendered, including the cost of special investigations, hospitalisation, all general and specialist dental practitioners, their assistants and anaesthetists as well as the cost of materials, all implant components, plates, screws and bone or bone-equivalent in respect of the orthognathic surgery procedure.
13	**Physiotherapy** • **In hospital**	**Medical Scheme Rate**, subject to the overall annual limit.
	• **After hospitalisation, if linked to the hospital admission**	This benefit must be pre-authorised by the Case Manager before discharge from hospital. It is limited to a maximum of ten appointments and treatment within 30 days of discharge from hospital or within a reasonable period of discharge.
14	**Physical Rehabilitation**	**Medical Scheme Rate** with a sub-limit of **R72 290** per family per year, subject to approval by the Case Manager. This benefit will only be allowed for the following non-progressive conditions: acute disablement as a result of a stroke, spinal cord injury or brain injury (where injury refers to a lesion relating to the above only and is caused by trauma, infection, surgery, bleeding or infarction). This benefit includes all associated accounts.

15	**Mental health** • **Psychiatric treatment**	**Negotiated tariff** up to a maximum of 21 days per beneficiary per year or **outpatient psychotherapy, up to 15 days' contact sessions**. This benefit is subject to pre-authorisation. This benefit covers all related costs.
	• **Treatment and accommodation for substance abuse**	**Negotiated tariff** up to a maximum of 21 days per beneficiary per year. This benefit is subject to pre-authorisation. This benefit covers all related costs.
16	**Oncology** (Including approved, related medication, MRI, CAT and radio-isotope scans as well as chemotherapy, radiotherapy, oncologists' consultations, mammograms, radiology and pathology fees)	The Scheme has appointed the Nedgroup Oncology Network as our Designated Service Provider for oncology. If you are referred to a provider for oncology related treatment, please check with your administrator whether the provider is part of the Nedgroup Oncology Network. **Medical Scheme Rate** for non-DSP, or **negotiated tariff** for DSP, with the following sub-limits, provided the patient enrols on the Oncology Benefit Management Programme. **Platinum**, **Comprehensive**, and **Traditional** Plans: **R593 820** per family per year (with ICON Protocols) **Savings** and **Hospital** Plans: **R464 970** per family per year (with ICON Protocols) A 12-month care plan must be submitted to the Case Manager, and is subject to approval by the Case Manager in terms of the Scheme's managed care protocols for the diagnosis. The care plan should include the date of diagnosis, the area concerned, any prior surgery or treatment, new treatment requests, as well as approximate costs. • The cost of a mammogram will be covered if it forms an integral part of the care plan, submitted by your oncologist. • Vitamins, antibiotics, alternative medicine, sleeping tablets, anti-anxiety and medicines for depression will not be covered. • Medicines must be registered with and approved by the Medicines Control Council for the specific diagnosed condition. **Platinum**, **Comprehensive** and **Traditional** Plans: Herceptin 12-month course of treatment will be covered as per clinical protocols and guidelines for adjuvant treatment of early breast cancer. Post active treatment period: a period of 12 months following the active treatment period.
	• **Social worker – Oncology treatment**	**Medical Scheme Rate or cost**, whichever is the lesser, for consultations with a social worker, up to a sub-limit of **R2 970** per family per benefit year on referral from the Nedgroup Oncology Network for terminal cases.
	• **PET scans**	**Medical Scheme Rate** with a sub-limit of **R30 000** per family per year, subject to the approval of the Case Manager.
	• **Brachytherapy** (Including seeds, disposables and equipment. Subject to the Oncology Managed Healthcare Programme.)	**Medical Scheme Rate** with a sub-limit of **R45 320** per family per year.
	• **Specialised drugs for Oncology** (Subject to the relevant managed healthcare programme and to its prior authorisation. The Oncology Specialised Drug List is a continuously evolving list of drugs used for the treatment of cancers and certain haematological conditions. This list includes but is not limited to targeted therapies, for example, biologicals, tyrosine kinase inhibitors and other non genericised chemotherapeutic agents. Subject to a published list.)	**Platinum**, **Comprehensive**, and **Traditional** Plans: **Medicine price** with a sub-limit of **R200 570** per year, subject to the Overall Oncology Benefit (with ICON Protocols). **Savings** and **Hospital** Plans: PMB (ICON Protocols) A member on the **Hospital** or **Savings** Plans will have the choice to upgrade to a plan with enhanced Oncology benefits within 60 days of the member or one of his/her dependants being diagnosed with cancer or having to undergo Oncology treatment. Any request to upgrade after 60 days will require motivation and approval by the Scheme.

17	**Non-Oncology specialised drugs** (The non-oncology specialised drug list is a continuously evolving list of high cost drugs used for the treatment of chronic conditions. This list includes but is not limited to biological drugs (biological therapy for inflammatory arthritides, inflammatory bowel disease, chronic demyelainating polyneuropathies, chronic hepatitis, botulinum toxin, palivizumab). Unless otherwise stated, for any other diseases where the use of the drug is deemed appropriated by the managed health care organisation, drugs will be funded from this benefit. Subject to a published list.)	**Platinum**, **Comprehensive**, and **Traditional** Plans: **Medicine price** with a sub-limit of **R180 090** per family per year, subject to application and approval under the Scheme's managed care protocols. **Savings** and **Hospital** Plans: PMB only
18	**Macular degeneration drugs**	**Platinum**, **Comprehensive**, and **Traditional** Plans: **Medicine price** with a sub-limit of **R56 580** per family per year, subject to a motivation received from the provider and subsequent approval. **Savings** and **Hospital** Plans: PMB only
19	**Internal prostheses (devices surgically implanted)** Including all accompanying temporary or permanent devices used to assist with the guidance and alignment of these internal prostheses and devices. Patients may pre-authorise 10 working days prior to admission for a joint replacement or spinal fusion operation. We encourage you to consider using ICPS (Improved Clinical Pathway Services), a group of orthopaedic surgeons that specialise in performing hip and knee replacements according to standardised clinical care pathways, for knee and hip replacements. 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 and to ensure the best health outcomes. Call us on 0860 100 080 and ask for the details of an ICPS orthopaedic surgeon closest to you.	**Cost** for specific prosthesis applied for, subject to the relevant managed healthcare programme and to prior authorisation. The following specific sub-limits apply per beneficiary per year (unless stated otherwise): ***Cardiac system:*** • Cardiac pacemakers: **R72 940** per beneficiary per year. • Cardiac stents (including the carrier) and drug eluting-balloons. **R30 330** per stent per beneficiary, limited to 3 x stents. • Cardiac valves: **R42 960** per valve per year, limited to 2 x valves. • Cardiac Resynchronisation Therapy (CRT): **R50 410**. ***Central nervous system:*** • Neuro-stimulation (ablation devices for Parkinson's): **R48 040**. • Vagal stimulator (for intractable epilepsy): **R40 530**. ***Endovascular devices:*** • Aorta stent grafts: **R124 800** per stent (including the delivery system), limited to 1 stent. • Carotid stents: **R21 170** • Detachable platinum coils: **R52 680** • Embolic protection devices: **R52 530** • Endovascular aneurysm repair (EVAR) stent grafts: **R123 250** • Peripheral arterial stent grafts: **R43 510**. ***Orthopaedic prostheses and devices including cement and antibiotic cement:*** • Elbow replacements: **R46 530** per elbow • Total hip replacement: **R55 130** per hip • Total knee replacement: **R60 950** per knee • Total shoulder replacement: **R53 010** per shoulder • Spinal instrumentation: **R65 520** • Bone lengthening devices: **R47 270** • Other approved spinal implantable devices and intervertebral discs: **R52 680** ***Opthalmic system:*** • Intraocular lenses: **R3 360** per lens, limited to 2 lenses. ***Any other prostheses not listed above:*** • **R59 180**, subject to Case Management approval. The following prostheses are also covered by the Scheme: Cables, Plates: screws, orthopaedic staples, K-wires and rods, Staples (bones), Exo-skeletal apparatus, Cardiac and rings, Silicone bands (intra-ocular surgery), Ventriculo-peritoneal/ Pleural shunt, Tension-free vaginal tapes/slings, Coral implants, Bone Cement, Aortic grafts, Artificial sphincter (M), Aortic modular stents (M), Hepatic stents, Breast prosthesis (M). The items above indicated by an "M" must be motivated by a medical practitioner.
20	**Blood transfusions**	**Cost** (cost of material, apparatus and operator's fee).

21	**Perfusion services**	**Medical Scheme Rate** (cost of material, apparatus and clinical technologist's fee).
22	**Organ Transplant / donor services** • **Organ transplant**	**Cost, subject to Prescribed Minimum Benefits.** Proposed transplants need to be pre-authorised. An application, together with the relevant treatment plan, which the patient must obtain from his/ her doctor, should be submitted, after which the relevant Case Manager will contact the patient. **Medicine price** for anti-rejection drugs, subject to pre-authorisation, provided that drugs from a preferred provider are used.
	• **Organ donors**	Subject to pre-authorisation, the benefit is only available to live donors who are beneficiaries of the Scheme. A donor belonging to the Scheme will also be covered when donating to a recipient who is not a member of the Scheme.
23	**Corneal grafts**	**Cost, limited to R31 710**, subject to the relevant managed healthcare programme and to pre- authorisation, as well as approval by the Scheme before starting work-up for transplantation.
24	**Renal dialysis** (Including related pathology, scans and consultations.)	**Medical Scheme Rate** **PLEASE NOTE:** *A 12-month treatment plan must be submitted to the Case Manager and is subject to approval in terms of the Scheme's managed care protocols. This plan should include the following information:* • date of diagnosis • area concerned • any prior surgery or treatment • ICD10 code • tariff code • doctor's practice number • new treatment requested • the approximate cost Subject to pre-authorisation for the related medication from a preferred provider.
25	**HIV/AIDS Benefit**	Benefits are unlimited, subject to approval for medication and medical management. Mother-to-child, accidental exposure and rape-prophylactics must be pre-authorised by the HIV/AIDS Care Manager. For a rape case, the hospital will provide a three-day "starter kit" of anti-retroviral treatment, which will fall under the HIV/AIDS limit. If this medication is required for a further 28 days, the additional benefit needs to be pre-authorised by the Care Manager.
	• **HIV Testing**	It covers the following services: • Pre-testing counselling • Testing and post-test counselling Limited to **2 tests** per beneficiary per year and subject to the preferred provider negotiated rate.
26	**All refractive procedures** (Including excimer laser, radial keratotomy, holmium procedures and LASIK phakic lenses.)	**Medical Scheme Rate** **Platinum**, **Comprehensive** and **Traditional** Plans: **R13 860** per family per year for hospital and associated services. Hospital related costs such as accommodation and theatre fees, as well as associated services, are subject to this limit. Benefits will only be granted if medical reports, as required by the Scheme, are submitted to prove that this operation is necessary, based on medical grounds and within the set refraction limit of the Scheme's guidelines. **Platinum Plan**: Once this limit has been exceeded, claims will be paid from the Routine Medical Benefit. **Savings Plan**: Paid from Personal Medical Savings Account. **Hospital Plan**: No benefit; for member's own account.
27	**Artificial limbs and artificial eyes**	**Cost** according to clinical protocols, subject to the relevant managed healthcare programme and to the following sub-limits: **R75 870** per artificial leg per beneficiary (every 2-3 years for children and every 5 years for adults). **R75 870** per artificial arm per beneficiary (every 2-3 years for children and every 5 years for adults). **R26 450** per artificial eye per beneficiary (every 2 years for a glasseye and every 5 years for an acrylic eye).

28	**Home oxygen therapy** (Subject to the relevant managed healthcare programme and pre-authorisation.)	**Cost** with a sub-limit of **R17 850** per family per year. **PLEASE NOTE:** *You must apply for this benefit and it must be pre-authorised by the Case Manager.*
29	**Hyperbaric oxygen therapy**	**Cost** with a sub-limit of **R58 350** per family per year. **PLEASE NOTE:** *This benefit must be motivated by a specialist and pre-authorised by the Case Manager. It will not be approved for the treatment of strokes, cerebral palsy, diabetic wounds and ulcers. The therapy is used to treat arterial gas embolism, carbon monoxide poisoning, crush injuries, thermal burns and many other conditions.*
30	**Stoma care products**	**Cost** with a sub-limit of **R20 760** per family per year.
31	**Breast reduction**	**Medical Scheme Rate** Subject to submission of a motivation by the treating provider and submission of medical reports as required by the Scheme. Benefits are subject to approval of the procedure by the Scheme's medical advisor on the grounds that patient meets the clinical criteria (such as Body Mass Index) applied by the Scheme in terms of the Scheme's managed care protocols.
32	**Cochlear implants** NEW	**R240 000** per implant for beneficiaries under the age of 7 years **R220 000** for beneficiaries over the age of 7 years Subject to one implant per beneficiary per ear for life. **R120 000** maintenance or replacement of processors per beneficiary every 5 years

PLEASE NOTE

All hospitalisation is subject to the Scheme's contracted managed healthcare programmes, which include the application of treatment protocols, formularies, pre-authorisation and case management.

The Scheme reserves the right not to pay for procedures performed by non-recognised providers (where applicable).

Certain procedures may be associated with a significant learning curve and/or are not taught routinely at local universities and/or require special training and experience, including that aimed at maintenance of expertise, and/or need access to certain infrastructure for quality outcomes. Where such procedures have been identified by the Scheme's managed care provider, recognised providers are those who have been acknowledged by meeting minimum training and practice criteria for the safe and effective performance of such procedures. Recognition occurs as a result of a formal application process by interested providers and adjudication of relevant information against competency guidelines by the managed care provider and/ or appointed credentialing body. Criteria for formal recognition are informed by clinical evidence, clinical guidelines and/or expert opinion.

The Scheme (or contracted managed care company on behalf of the Scheme) may from time to time contract with or credential specific provider groups (networks) or centres of excellence as determined by the Scheme in order to encourage high-quality, cost effective and appropriate care. The Scheme reserves the right not to fund or partially fund services acquired outside of these networks, provided reasonable steps are taken by the Scheme to ensure access to the network.

ER24 (24-hour evacuation & emergency transport)

084 124

Outside borders of South Africa telephone:
+27 102 053 038

Worldwide, there is an increasing trend of using ambulances as a transport mechanism when the patient could have gone in a private vehicle. This has resulted in ambulances not always being available for real emergencies.

Nedgroup Medical Aid Scheme and ER24 have embarked on a stringent programme to decrease the abuse of ambulances and to try to ensure that ambulance transports are reserved for patients who fit the CMS definition for emergencies:

"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."

All ambulance cases will be audited to assess whether the patient was admitted into hospital and /or whether there was a need for specialised emergency care. If the patient was not admitted and did not require specialised care, the ambulance claim may be rejected and the member may be billed for the transportation.

What to do in an emergency situation

You and your registered dependants will have access to emergency medical transportation in South Africa 24 hours a day, 7 days per week, provided that this is authorised by ER24 (the Scheme's DSP for emergency medical services). Services offered by ER24 include:

- 24-hour access to the ER24 Emergency Call Centre
- Dispatch of emergency response
- Medical transportation by ambulance or aircraft as deemed medically necessary
- Authorised inter-hospital transfers

In addition to emergency transportation, you also have access to emergency medical advice and assistance. ER24's operators will guide you through a medical crisis situation, provide emergency advice and arrange for you to receive the support you require – available at all times.

Remember that, in the case of an emergency where you (or your dependants) are admitted to hospital, you must notify the Scheme on the first working day after being admitted (see *How does pre-authorisation before hospitalisation work?* earlier in this chapter for more information).

The Nedgroup Medical Aid Scheme does offer cover for emergency medical assistance outside the borders of South Africa. The cover is limited to Lesotho, Swaziland, Zimbabwe, Botswana, Namibia, Mozambique and Angola.

What else do I need to know if I have to visit an emergency unit?

Medical emergencies are not something you can plan for. However, knowing what to expect in terms of the processes followed at an emergency unit is helpful, as it will allow you to concentrate on your or your loved ones' well-being, should you be involved in a medical emergency.

The first thing you need to be aware of is that you may have to wait for medical attention, and that you should not become anxious about this. The reason for this potential wait is that, when patients arrive at the hospital emergency unit, every patient is assessed and given a score that indicates how severe their condition is. This process is called triage.

According to the triage system, a colour code is assigned to each patient based on this score (which is given according to a checklist of symptoms). Red indicates that very urgent medical intervention is required, while green indicates the least urgent attention required. The colour code therefore reflects how urgently the patient needs treatment. In practice this could mean that some patients who are already waiting for treatment might have to wait a little longer, and that persons arriving later than they have, may be treated first.

The triage system is used internationally to ensure that patients in danger receive immediate attention, rather than having emergency units that operate on a first-come, first-served basis.

A visit to the emergency unit that results in an admission will be covered under the authorisation provided by the Scheme and paid from the Hospital and Trauma Benefit.

Where the visit to the emergency unit does not result in an admission, you will be responsible for the account and may make representations to the Scheme to consider payment of the account. Please note that only where you required urgent treatment will the account be considered by the Scheme.

PLEASE NOTE

Treatment received in a hospital's Emergency Room is not an admission to hospital and is regarded as treatment received out of hospital/everyday services. If approved by the Scheme, the claim is payable from your available Everyday Services Benefit.

Furthermore, if you are transported to hospital by an ER24 ambulance (even though approved), and on examination you are found to be fit enough to return home, you will be responsible for arranging your own transport home.

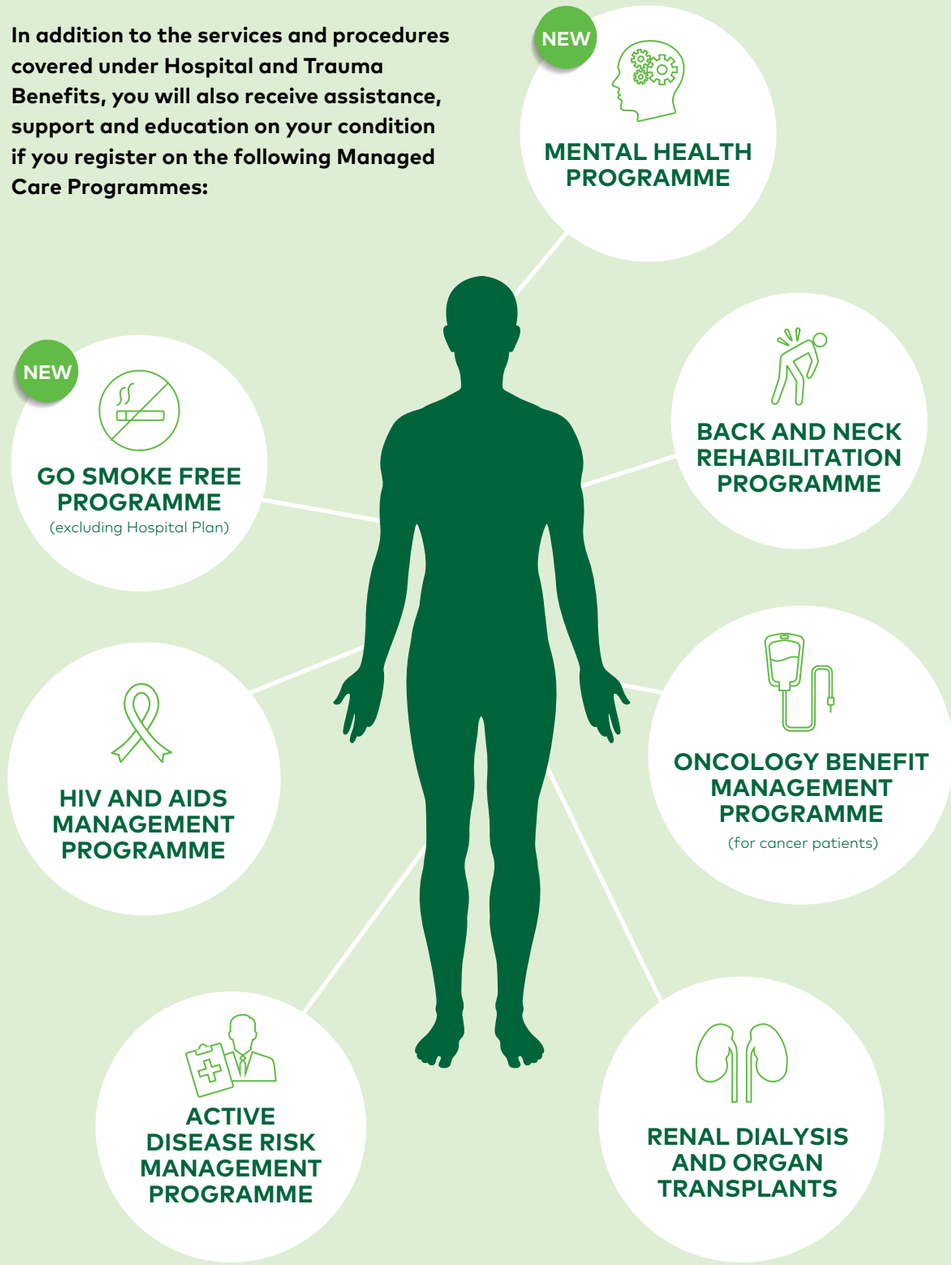
6

MANAGED CARE PROGRAMMES

IN THIS SECTION

- **NEW!** Mental Health Programme
- **NEW!** GoSmokeFree Programme
- Back and Neck Rehabilitation Programme
- Oncology Benefit Management Programme
- HIV and AIDS Management Programme
- Renal Dialysis and Organ Transplant Programme
- Active Disease Risk Management Programme

In addition to the services and procedures covered under Hospital and Trauma Benefits, you will also receive assistance, support and education on your condition if you register on the following Managed Care Programmes:



MENTAL HEALTH PROGRAMME

NEW

The Mental Health Programme provides support for any mental health conditions or substance-abuse issues that you may have. The Mental Health Programme has been built around the principle of providing support to both you and your family practitioner to promote access to the best quality primary mental healthcare that is available.

Did you know that one in three South Africans will suffer from a mental health disorder in his or her lifetime and that a person's physical, social and financial wellbeing is closely tied to their mental health?

HOW DOES IT BENEFIT YOU?

The programme provides effective collaboration between a care manager and family practitioners, psychiatrists, psychologists and other healthcare professionals, who will work together to ensure that you are supported in a way that suits your individual needs. Your adherence and active participation in treatment is required to achieve the desired outcomes and we encourage you to make the most of the opportunities and support that this programme has to offer. While enrolled on the programme you may expect to receive the following support:

- Education for you and your family
- Referral to community support groups
- Support and guidance.

A telephonic helpline is available to any beneficiary suffering from a mental health condition or problems with substance (drug and alcohol) abuse. This will provide you with direct access to a care manager who will assess your eligibility for enrolment on the programme, explain the programme to you as well as inform you about the benefits available to manage your condition.

HOW CAN YOU ACCESS THE BENEFIT?

You may access the programme by either:

Calling 0860 106 155, or

Emailing Nedgroupmentalhealth@medscheme.co.za

Alternatively you may be identified through predictive modelling and contacted by one of the care managers for enrolment on the programme.

WHAT DOES THE BENEFIT CONSIST OF?

When you enrol on the mental health programme, a care template will be triggered which will provide additional benefit to ensure that your team of healthcare professionals may optimally manage your condition. This will be individualised based on your unique requirements, making this a tailored benefit structured specifically for you, ensuring the best possible outcome.

GOSMOKEFREE PROGRAMME (ALL PLANS EXCEPT HOSPITAL PLAN)

NEW

The Scheme is pleased to announce a new programme aimed at helping members who smoke to kick the habit!

Studies show that 70% of smokers would like to give up smoking and 30% go on to attempt to stop each year … yet fewer than 3% successfully quit cold turkey! It has also become clear that the most effective smoking cessation intervention is a combination of behaviour change techniques, medication and support – that is why the GoSmokeFree Stop Smoking Programme uses all these techniques.

HOW DOES IT BENEFIT YOU?

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.

The GoSmokeFree Stop Smoking Programme is available at various pharmacies throughout South Africa using a trained Nursing Sister or Pharmacist, so access to the programme is easy.

HOW WILL THIS BENEFIT BE COVERED?

- **Hospital Plan**: No benefit
- **Savings Plan**: Payable from available PMSA
- **Comprehensive**, **Traditional** and **Platinum** Plans: Payable from Everyday Services Benefits

HOW CAN YOU ACCESS THE BENEFIT?

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

Call 0860 100 080 for more information

BACK AND NECK REHABILITATION PROGRAMME

The DBC back and neck rehabilitation programme consists of up to 12 sessions over a 6-week period. The treatment takes place at specific DBC centres (see below).

The DBC Treatment System was developed in Finland more than 20 years ago and today the DBC network spans treatment providers in more than 22 countries. The DBC system is completely evidence and outcomes based with a current global success rate in excess of 85%* after an average of 3 to 9 weeks' treatment. Every centre in the DBC network provides treatment data to DBC Finland and this data is used for quality control and reporting.

HOW TO ACCESS THE PROGRAMME

You can access the programme in various ways.

The Scheme may refer you to the programme if:

- you request a pre-authorisation for an admission related to back/neck surgery (for example a spinal fusion), pain management (for example a rhizotomy) or specialised radiology (for example an MRI scan), or
- Medscheme's predictive model identifies you as being at risk of a back/neck admission in the next year (if you haven't yet visited one of the accredited centres).

As the list of centres is still limited, the Scheme will only identify and contact members within 30km of a DBC centre and these are the members that we contact, as we often find that members who have to travel more than 30km would decline the Programme.

- Your specialist or GP may refer you to participate in the Programme.
- You may self-refer by contacting the Scheme on 0860 100 080, should you experience chronic, ongoing back or neck pain.

PROGRAMME VS SURGERY – IMPLICATIONS

Apart from the physical trauma of surgery and related anaesthetics, there is also the financial side. Imagine you were advised to undergo spinal fusion, with instrumentation. The average cost of such a procedure would be around R92 000. Together with the associated costs, you would be looking at a total cost of around R134 000. The Scheme may not cover all these costs, and you will have to cover any shortfall. (As an example, a Scheme member had to pay around R52 000 from his own pocket sometime in the past to cover the shortfall on his spinal fusion surgery, as a result of the member selecting a non-network specialist to perform the surgery.)

By contrast, the cost of the DBC Programme is around R12 330, and you will not have to pay any of this from your own pocket.

WHERE ARE THE DBC CENTRES?

There are DBC centres throughout South Africa, with additional centres opening on an ongoing basis. Please call 0860 106 155 or visit www.dbcclinic.com to find the DBC centre closest to you.

ONCOLOGY BENEFIT MANAGEMENT PROGRAMME
(FOR CANCER PATIENTS)

Refer to *16. Oncology* under the table, *Services and procedures covered during hospitalisation* in the *Hospital and Trauma Benefits* chapter in this member guide for benefit limits.

If you are diagnosed with cancer, it will be to your advantage to contact the Oncology Case Manager before starting any treatment. The Oncology Benefit Management Programme will not only help you to manage the high costs associated with treatment, but you will also receive help, support and education on your condition from the Oncology Case Manager.

The Scheme has appointed the Nedgroup Oncology Network as our Designated Service Provider for oncology. If you are referred to a provider for oncology-related treatment, please check with your administrator whether the provider is part of the Nedgroup Oncology Network.

WHY IS IT NECESSARY FOR ME TO REGISTER ON THE ONCOLOGY BENEFIT MANAGEMENT PROGRAMME?

By enrolling in the programme, you will qualify for the annual oncology family benefit limit. It will also ensure that health services related to oncology, such as your doctor's consultations, general and specialised radiology and pathology during follow-up visits to the doctor, will be covered from your oncology benefit. By obtaining authorisation you are also ensuring that your treatment is effectively managed within your available benefits.

This benefit forms part of your Hospital and Trauma Benefits. It is envisaged that in most cases this limit will be sufficient to cover well-managed costs.

If your care plan is not approved, you will not have access to the oncology benefit limit, and all your cancer-related accounts will be paid from your Everyday Services Benefits.

The Oncology Case Manager will address any concerns with the treating oncologist.

- Please submit your care plan to cancerinfo@medscheme.co.za.

If you have any queries regarding the Oncology Benefit Management Programme or your condition, please contact the Oncology Case Manager on 0860 100 572.

UPGRADE TO ACCESS ENHANCED BENEFITS

If you or one of your dependants are diagnosed with cancer or have to undergo oncology treatment and your Plan does not provide adequately for the cancer treatment, you can apply to upgrade to **Traditional**, **Comprehensive** or **Platinum Plan** within two months (60 days) after the date of the first diagnosis of cancer, or having had to undergo oncology treatment.

HOW TO OBTAIN AUTHORISATION FOR ASSOCIATED TREATMENT

1. Surgery/procedures/hospital admissions:

If you need to be admitted to hospital for chemo-therapy or radiotherapy, please contact the Oncology Management Department directly.

Surgery or related procedures are covered from the hospital benefits and not the oncology benefit, so you will need to obtain a pre-authorisation from the Hospital Pre-authorisation Department.

2. Specialised radiology (including PET scans):

If you require specialised radiology, such as CT, MRI or PET scans, you will need an additional authorisation from the Oncology Management Department for it to be covered from your oncology benefit.

When applying for a specialised radiology authorisation, the following information is required:

- membership number
- dependant number
- requesting doctor practice number
- radiology practice number
- codes to be charged and estimated cost
- reason for the scan

If you need an authorisation for a PET scan, your doctor must complete the PET scan form, which is available at all PET scan units.

3. Hospice, private nursing and medical admissions:

If you need services such as home nursing or hospice, you need to contact the Hospital Pre-authorisation Department. You can also contact this department if you have complications such as dehydration or excessive vomiting, or need to be hospitalised for pain control.

4. Social worker:

An Oncology Social Worker Benefit, subject to the Oncology Benefit limit, for the payment of seven sessions with a social worker affiliated to the Nedgroup Oncology Network in the case of terminal cases.

PLEASE NOTE

The account claims process and claims queries are not handled by the Oncology Case Manager. These queries should be directed to the General Enquiries call centre.

HIV AND AIDS MANAGEMENT PROGRAMME

Members and dependants of the Nedgroup Medical Aid Scheme have access to benefits for the treatment of HIV and AIDS. These benefits can be accessed by registering on the HIV and AIDS management programme and all Nedgroup Medical Aid Scheme members are entitled to join.

HIV/AIDS

For most people HIV/AIDS is a frightening disease, but today treatment is available that allows the majority of people living with HIV to lead healthy and productive lives for many years.

ACTION AND INFORMATION

The first step is to find out whether you have been infected with HIV and what you can do to protect your loved ones and stay healthy. Medicines are available to attack the virus, while vitamins, good nutrition and exercise can play a critical role in keeping your body strong and healthy. Starting treatment at the right time ensures the effectiveness of the medicines, improves quality of life and decreases the risk of serious infections or other complications. Our HIV and AIDS management programme can help you access benefits to assist you with the best way of managing HIV/AIDS.

WE CAN HELP YOU TO MANAGE YOUR CONDITION

Our HIV and AIDS management programme is specifically for HIV/AIDS related medicine. This programme is used to pay for medicine to attack the virus, vitamins to boost your immune system and regular monitoring tests.

YOUR CONDITION WILL STAY CONFIDENTIAL

HIV is a sensitive matter and every effort is made to keep your condition confidential. The staff members have all signed confidentiality agreements and are employed in a separate company from the Scheme or the administrator. Staff who manage the HIV and AIDS management programme will not reveal your HIV status to anyone without your permission. The HIV and AIDS management programme uses separate telephone, fax and private mailbag facilities from the Scheme or the administrator. Patients need to use these facilities to maintain confidentiality.

YOU MUST REGISTER ON OUR HIV AND AIDS MANAGEMENT PROGRAMME

If your test shows you are HIV-positive you must register on the HIV and AIDS management programme as soon as possible to make use of this benefit. Telephone in confidence and ask for an application form and the counsellor will also assist you with registering on the HIV and AIDS management programme. Your doctor can also contact us on your behalf.

REMEMBER:
Even if you are not registered on this programme, you are covered for two HIV tests per beneficiary per year.

AFTER YOU HAVE REGISTERED

After you receive the application form, you and your doctor must complete it and return it to the HIV and AIDS management programme by using the confidential, toll-free fax line number on the form. A highly qualified medical team will examine your details and if necessary, discuss an appropriate treatment with your doctor.

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 medicines are working correctly.

WHAT THE HIV AND AIDS MANAGEMENT PROGRAMME OFFERS YOU

The Scheme's HIV and AIDS management programme 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 infection after sexual assault or needle stick injury) at the most appropriate time.
- Treatment to prevent opportunistic infections like certain serious pneumonias and tuberculosis.
- 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 Treatment Support Line.
- Clinical guidelines and telephonic support for doctors.
- Help in finding a registered counsellor for emotional support.

Managed by Aid for AIDS (AfA).

Tel: 0860 100 646
Fax: 0800 60 0773
Email: afa@afadm.co.za
Website: www.aidforaids.co.za
Mobisite: www.aidforaids.mobi
SMS (call me): 083 410 9078

The HIV/AIDS Care Manager will assist with all your questions regarding the condition, its treatment, social issues or any concerns that you may have.

RENAL DIALYSIS AND ORGAN TRANSPLANTS

If you need to undergo renal dialysis or an organ transplant, you must submit a care plan.

A 12-month care plan must be submitted to, and approved by, the Case Manager.

This plan should include the following information:

- date of diagnosis
- the area concerned
- any prior surgery or treatment
- ICD10 code
- tariff code
- practice number of doctor or supplier
- new treatment requested as well as approximate costs.

Please submit your care plan to:

Hospital Benefit Management

Fax: 0860 21 22 23 or 021 466 1913
nedgroup.authorisations@medscheme.co.za

ACTIVE DISEASE RISK MANAGEMENT PROGRAMME

The Nedgroup Medical Aid Scheme Active Disease Risk Management Programme identifies members who are at risk of suffering complications or advancement of their chronic conditions. The programme will assist you to control, manage and monitor your conditions. With your prior consent, your health coach will work together with you and your GP.

If you have been diagnosed or are at potential risk of developing a chronic condition, you may have access to our dedicated health coaches who will be on hand to advise and provide guidance to you. This will be communicated to you by various ways to provide support, information and practical advice to better manage or prevent chronic conditions.

Members registered on the programme will have access to a health line to discuss any chronic conditions confidentially with a health coach, as well as be encouraged to access the YourHealth Portal on the Member Zone. This is an online educational web and mobile health portal that gives members access to a range of resources to assist with better health choices which includes e-tutorials and educational articles, tools and quizzes.

Please note the following

- The health coaches are not able to diagnose or treat health problems over the phone and the advice provided does not replace a visit to your doctor.
- All information regarding your medical condition will be kept strictly confidential.

Active Disease Risk Management Department

Telephone: 0860 106 155
Fax: 0860 106 245
Email: membercare@medscheme.co.za

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PRESCRIBED MINIMUM BENEFITS

IN THIS SECTION

What are PMBs?

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, regardless of the benefit Plan they have selected.

PMBs are fully covered by your medical scheme, provided you follow the guidelines. The cover is related to the diagnosis, treatment and care of:

- any emergency medical condition
- a limited set of 270 Diagnostic Treatment Pairs (DTP) defined in the Regulations and published on the Council for Medical Schemes website
- 26 chronic conditions (defined in the Regulations and published under *Which basic chronic conditions are covered by all Plans?* later in this chapter).

When deciding whether a condition is a PMB, the doctor should look only at the symptoms and not any other factors, such as how the injury or condition was contracted. This approach is called diagnosis-based. Once the diagnosis has been made, the appropriate treatment and care is decided upon, as well as where the patient should receive the treatment (at a hospital, as an outpatient or at a doctor's rooms).

PRESCRIBED MINIMUM BENEFITS						
270 Diagnostic Treatment Pairs (DTP)					26 PMB Chronic Conditions	
Acute Conditions		**Chronic Conditions**		**Hospitalisation**	**Medical management of the condition**	**Medicine for the condition**
Medical management of the condition	Medicine management of the condition	Medical management of the condition	Medicine for the condition			

Why do we have PMBs?

There are two reasons why PMBs are in place:

- To ensure that medical scheme beneficiaries have continuous cover for PMB related conditions. This means that even if a member's benefits for the year run out, the Scheme will continue to pay for the treatment of PMB conditions. These benefits are subject to the medical management treatment protocols.
- To ensure that healthcare is paid for by the correct parties. Medical Scheme members with PMB conditions are treated according to the specified treatments and these have to be covered by their medical scheme, irrespective of where the patient is treated.

Which PMB conditions are covered by the Scheme?

EMERGENCY MEDICAL CONDITIONS

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.

In an emergency it is not always possible to diagnose the condition before admitting the patient for treatment. However, if a doctor suspects that the patient is suffering from a condition which is covered in terms of PMB, the Scheme is required to approve the

treatment. Schemes may request that the diagnosis be confirmed by supplying supporting evidence within a reasonable period of time.

DIAGNOSTIC TREATMENT PAIRS (270 MEDICAL CONDITIONS)

The Regulations to the Medical Schemes Act provide a long list of conditions identified as PMB. The list is in the form of Diagnosis and Treatment Pairs (DTP). A DTP links a specific diagnosis to a treatment and therefore broadly indicates how each of the approximately 270 PMB conditions should be treated.

Here is an example of a DTP as it appears in the Medical Schemes Act:

Code	Diagnosis	Treatment
109A	Vertebral dislocation/fracture, open or closed with injury to spinal cord	Repair/reconstruction; medical management; in-patient rehabilitation up to two months

If your PMB condition is not an emergency or a PMB chronic condition, but is a once-off PMB condition as diagnosed by your doctor, you will be covered as per the Scheme Rules. If you are unsure of whether your diagnosed acute condition is covered as a PMB you can contact the Scheme to clarify this. The administrator will require the ICD10 code to determine whether the condition is an acute PMB condition.

Once the condition has been identified as an acute PMB condition, the administrator will request that you submit your claim/s, together with the ICD10 code, relevant tariff codes, doctor's practice number and any test results (including pathology and radiology) that support the diagnosis.

TO AVOID PMB CLAIMS BEING REJECTED

- Check that your doctor/service provider has included the correct ICD10 code on your account.
- ICD10 codes provide accurate information on your diagnosis and this assists in determining which benefits you are entitled to and how these benefits could be paid.
- Your PMB condition will be identified by the ICD10 code, so if the incorrect code is used, your PMB-related condition will be paid from the wrong benefit.
- ICD10 codes must also be provided on medicine prescriptions and referral notes to other healthcare providers.

IF YOUR PMB CLAIM IS REJECTED

You can contact the Scheme at 0860 100 080 to enquire about the reason for the rejection and process to follow. It is important to check that your practitioner has put the correct ICD 10 and tariff codes on your invoice.

PLEASE NOTE

The Scheme is obliged by law to treat information about members' conditions with the utmost confidentiality. No information pertaining to a member's condition will be disclosed to any other party, including the member's employer or family.

Who are the Scheme's Designated Service Providers for PMBs?

GP OR SPECIALIST VISITS

If you are diagnosed with a PMB condition, it would be to your benefit to make use of the general practitioner or specialist on the Nedgroup GP and specialist network for your medical management where general practitioner or specialist visits are clinically indicated for the condition. If you choose a GP or specialist on the Nedgroup GP and specialist network, your PMB-related account will be paid from the PMB benefit at a Scheme-agreed rate, and you will not be liable for any co-payment on your specialist's claim should you be admitted to hospital. (In the case of members on the **Platinum Plan**, no co-payment will apply if a non-Network provider is used. However, bear in mind that your hospital-related claims will only be paid at Medical Scheme Rate and that you will be liable for the difference.)

Alternatively, you may wish to continue consulting your own practitioner, even if he/she is not part of the network. In such a case the service provider will be covered at Medical Scheme Rate, and paid from your available Everyday Services Benefits (except on the **Hospital Plan**, which does not have Everyday Services Benefits). Thereafter the service will be covered from the PMB benefit for all Plans, with a co-payment of 25% that you will need to cover from your own pocket.

To find out whether the practitioner is on the Nedgroup GP and Specialist Network, please contact Medscheme at 0860 100 080, or log onto www.medscheme.co.za.

The consultant will confirm whether the practitioner is part of the Nedgroup GP and Specialist Network, or provide details of practitioners on the network.

PHARMACIES

Nedgroup Network Pharmacies is the Designated Service Provider (DSP) Pharmacy network for chronic medicine. Members who voluntarily use a non-designated pharmacy service provider for their approved PMB medication, will be liable for a 25%

co-payment at the point of sale at the pharmacy. In other words, the Scheme will only pay 75% of the claim for the approved/authorised medication.

Members who use a non-DSP pharmacy provider for their chronic medicine (the additional 21 conditions which fall outside of the 26 PMB conditions), will have their account paid from their available Everyday Services Benefits. Once the Everyday Services Benefits are depleted, you will be liable for the full account at point of sale at the pharmacy. Chronic medicines will only be paid from your chronic medicine benefit if obtained from a Nedgroup Network pharmacy.

Further to this, the Regulations stipulate that a member's personal medical savings account (for **Savings Plan** members only) may not be used to fund any co-payment costs related to PMB claims. Members must therefore settle the co-payment directly with the service provider.

To apply for authorisation for chronic medicines, please contact ScriptPharm Risk Management on 011 100 7557 Monday to Friday, 08:00 – 16:30 or fax the application form to 0866 791 579 or email nedgroup@scriptpharm.co.za

HOSPITALS

The hospital that your doctor refers you to is the DSP for hospitalisation.

How do I register on the PMB Medical Management Programme?

Please contact 0860 100 080 or email nedgroupapmb@medscheme.co.za.

PLEASE HAVE THE FOLLOWING INFORMATION READILY AVAILABLE BEFORE CALLING:

- Name of member
- Name of beneficiary applying for benefits
- Membership number
- Date of birth or identity number (for member registering on the programme)
- Treating doctor's name and practice number
- Condition to be covered – ICD10 code to be supplied by treating doctor
- Whether you are already registered as a chronic medicine user

If your condition requires basic primary healthcare treatment and/or diagnostic tests, you will be informed of your PMB treatment plan, in writing, once it has been authorised. This communication is triggered if the correct ICD10 and tariff codes are submitted on the claim.

PLEASE NOTE

Treatment Plans for members registered for conditions on the **PMB Chronic conditions** list (in the Chronic Benefits chapter earlier in this guide) will roll over each year and members do not have to re-apply. Members who had a Treatment Plan for any condition that is not on the PMB Chronic conditions list mentioned above must please note that such a Treatment Plan will generally not roll over from one year to the next, and they would have to reapply, if necessary. In either case, Treatment Plans may differ from those of the previous year.

PRESCRIBED MINIMUM BENEFITS - HOW CAN THEY BENEFIT YOU?

Many members and even healthcare providers still don't understand how PMBs work, what benefits PMBs hold, and also what the 'dark side' of PMBs is. The Council for Medical Schemes put together a number of FAQs to help educate members on their rights and responsibilities in terms of PMBs.

WHY ARE SOME CHRONIC ILLNESSES COVERED AND SOME NOT?

The diseases that have been chosen are the most common, they are life-threatening, and are those for which cost-effective treatment would sustain and improve the quality of the member's life.

CAN MY SCHEME INSIST THAT IT WILL ONLY FUND TREATMENT THAT FOLLOWS THE APPROPRIATE PROTOCOL?

Yes. Treatment algorithms (benchmarks for treatment) for all PMB conditions have been published in the Government Gazette. Your scheme may decide for which medicines it will pay for each chronic condition, but the treatment may not be below the standards published in the treatment protocols. If your scheme's cover conforms to that standard and you and your doctor decide that you should rather use different medication, then you may have to pay a co-payment towards the cost of that medicine. Your medical scheme must, however, pay for the treatment if your doctor can prove that the standard medication is ineffective or detrimental to your condition.

Your medical scheme may develop protocols to manage the use of benefits. Such protocols would specify, for example, types of tests, investigations and number of consultations. Members who might need more frequent or extra services than provided for in the protocols, can appeal to their scheme for these to be covered. The scheme's appeal process might include a motivation from the treating doctor that explains the clinical reasons for the additional services.

CAN MY SCHEME REFUSE TO COVER MY MEDICATION IF I NEED, OR WANT, A BRAND OTHER THAN THAT WHICH THE SCHEME SAYS IT WILL PAY FOR?

Yes, the medical scheme may refuse to cover a part of the expenses. Your scheme may draw up what is known as a formulary – a list of safe and effective medicines that can be prescribed to treat certain conditions. The scheme may state in its rules that it will only cover your medication in full if your doctor prescribes a drug on that formulary. Generally speaking, schemes expect their members to stick to the formulary medication.

Often the medicines on the list will be generics – copies of the original brand-name drug – that are less expensive but equally effective. If you want to use a brand-name medicine that is not on the list, your medical scheme may foot only part of the bill and you will have to pay either the difference between the price of the medication you use and the one on the formulary, or a percentage co-payment as registered in the scheme rules.

If you suffer from specific side-effects from drugs on the formulary, or if substituting a drug on the formulary with one you are currently taking affects your health detrimentally, you can put your case to your medical scheme and ask the scheme to pay for your medicine. You can also appeal to the scheme if the formulary drug is ineffective and does not have the desired effect. If your treating doctor can provide the necessary proof and the scheme agrees that you suffer from side-effects, or that the drug is ineffective, then the scheme must give you an alternative and pay for it in full.

CAN MY SCHEME MAKE ME PAY A CO-PAYMENT OR LEVY ON A PMB?

No, your scheme cannot charge you a co-payment or levy on a PMB if you follow the scheme formulary and protocol. However, if your scheme appoints a Designated Service Provider (DSP) and you voluntarily use a different provider, your scheme may charge you the difference between the actual cost and what it would have paid if you had used the DSP or the percentage co-payment as registered in the scheme rules.

CAN SCHEMES STILL SET A CHRONIC MEDICINE LIMIT?

Yes, your scheme can set a limit for your chronic medicine benefit. Any chronic medication you claim for will then reduce that limit, regardless of whether or not it is one of the PMB chronic conditions. However, if you exhaust your chronic medicine limit, your scheme will have to continue paying for any chronic medication you obtain from its DSP for a PMB condition.

Source: www.medicalschemes.com/medical_schemes_pmb/questions.htm

THE 'DARK SIDE' OF PMBS

Unfortunately there is a growing trend of providers 'milking' the PMB system, as they know that the medical schemes must theoretically pay their costs, even if such costs are much higher than the medical scheme rate. Data from various medical schemes indicate that providers are starting to charge more for their services in the case of PMB conditions than for non-PMB conditions. The reality is that providing PMBs is costing medical schemes more and more each year, with the inevitable result of contributions having to be increased by more than usual. This is also why schemes are very strict in how PMBs are covered – should a member simply be able to claim the most expensive medicine for a given PMB condition, costs will soar out of control and medical schemes will either have to charge exorbitant contributions or no longer be financially sustainable.

8

PERSONAL MEDICAL SAVINGS ACCOUNT

(Available on the Comprehensive and Savings Plans.)

IN THIS SECTION

What is a PMSA?

The Personal Medical Savings Account is a savings account held by a member's medical scheme to which a certain percentage of a member's contribution is paid on a monthly basis. These funds can only be used to defray health care expenditure.

From the beginning of each benefit year, the personal medical savings account is credited with a percentage of a member's contribution as determined in the medical scheme rules.

This savings fund is made available upfront to a member; in other words, the full year's savings funds are made available at the beginning of each benefit year.

Please remember that the **Platinum**, **Traditional** and **Hospital** Plans have no PMSA contributions and therefore no PMSA balance. Also remember that if you move to any of the Plans without a PMSA, your PMSA balance will be paid out to you after 6 months, together with the balance of Unit Trusts.

What can the money in my PMSA be used for?

YOU CAN USE THE MONEY IN YOUR PMSA TO PAY FOR:

- Everyday Services, on the **Savings** and **Comprehensive** Plans
- Any services that are deemed medically necessary, but are not covered under the Wellness Benefits and Everyday Services Benefits.
- The difference between the actual cost of a service and MSR, other than PMB.

What are accumulated savings?

If a member does not use all the money in the PMSA in any given year, the accumulated savings are recorded separately.

What can the money in my accumulated savings be used for?

YOU CAN USE THE ACCUMULATED SAVINGS FOR:

- Services that are generally or specifically excluded according to the Rules of the Scheme. These services should be obtained from a registered practitioner, and you must advise the Scheme in writing to ensure that these services are paid from your accumulated savings.
- Claims during a waiting period.
- Any claims that come in after the PMSA and Everyday Services Benefits sub-limits (where applicable) have been depleted on the **Comprehensive** and **Savings** Plans.

YOU CANNOT USE THE MONEY IN YOUR PMSA OR ACCUMULATED SAVINGS TO PAY FOR:

- PMB conditions
- Costs that are higher than the medicine price (for example, the administration fee).

Will the money in my PMSA and accumulated savings earn interest?

Any money in your PMSA and accumulated savings will earn interest at a rate of 50% of the actual average interest rate earned by the Scheme.

Can I withdraw money from my PMSA?

No, the Scheme Administrator will manage your PMSA. When claims have to be settled they will automatically deduct the money from your PMSA.

What happens if I do not have enough money left in my PMSA to settle my claims?

The Scheme will pay these claims up to the available PMSA balance and then from available accumulated savings, whereafter you will be liable to settle the difference directly with your supplier.

Is there a credit facility?

The PMSA offers a credit facility, which means that you can use the credit balance in your PMSA to settle claims, even if you have not made all the monthly contributions to your PMSA.

How will I know what the balance in my PMSA or accumulated savings account is?

For the most up-to-date information on your balances, you can use the telephonic self-help facility (0860 100 080), NedChat or you can view detailed statements of all your transactions, available benefits, and the balance in your PMSA/accumulated savings on the Member Zone and on your monthly member statements.

What will happen to the balance in my PMSA should I decide to change to a Plan that does not have a PMSA allocation?

Your PMSA balance will be paid out to you after six (6) months, to allow the Scheme to settle any claims that may be submitted in the period after you terminate your membership. PMSA is subject to tax implications.

What happens to the money in my PMSA if I am no longer a member of the Scheme?

If your membership of the Scheme ends, for example, if you resign, are retrenched, pass away or transfer to

your spouse's employer-preferred medical scheme, the following will happen:

- Any amounts that have been paid by the Scheme, but which exceed the benefits to which you are entitled, will be recovered from you or your estate.
- The money in your PMSA will be used by the Scheme to pay any non-PMB outstanding claims.
- If there is no money in your PMSA, only the benefit amount will be paid to the service provider. You (or your estate) will be responsible for settling the balance with the service provider.
- The onus is on you, as the member, to notify the Scheme of your new medical scheme, banking and/ or your contact details.

If you have used your upfront PMSA and resigned before the end of the benefit year, the overspent amount must be paid back to the Scheme within 30 days of the termination date.

Six months after your membership of the Scheme has ended , the balance in your PMSA will be calculated and paid out into the banking account recorded by the Scheme, if the following applies:

- If you do not join another medical scheme
- If you join another medical scheme on a Plan that does not have a savings account
- If you join another medical scheme as a dependant
- If you move to a Plan that does not have a PMSA

If you pass away, the balance in your PMSA will be kept by the Scheme to be used by your dependants who become continuation members of the Scheme, if applicable, or be paid to your estate after six months.

If I leave the Scheme for another scheme with a PMSA, can I transfer my PMSA / accumulated savings balance to my new scheme?

If you are joining another medical scheme with a PMSA, we request that you provide us with your new medical scheme details by emailing these to nedgroupregistery@medscheme.co.za. Upon receipt of this information, the Scheme will arrange to transfer the balance of your PMSA to your new medical scheme after the 6th month following your termination date. This option will allow you to not incur any tax on the balance.

9

MATERNITY BENEFITS

IN THIS SECTION

- While you are pregnant
- Giving birth
- Choosing your birth partners and setting
- The case for natural birth
- After birth

Maternity benefits are available for members and their dependants.

- For the birth itself, benefits are paid from Hospital and Trauma Benefits.
- Associated services such as antenatal classes and scans are paid from the Everyday Services Benefits under each Plan (except **Hospital** Plan, which does not offer any Everyday Services Benefits).

For ease of reference, the various benefits and procedures around maternity have been combined in this chapter.

WHILE YOU ARE PREGNANT

	PLATINUM	COMPREHENSIVE	TRADITIONAL	SAVINGS
ANTENATAL CONSULTATIONS	Covered at up to **3 x Medical Scheme Rate**.	Covered at **Medical Scheme Rate**, up to **R2 915** per family per year		
SCANS	**2 x 2D** or **2 x 3D** pregnancy scans per member family per year	**2 x 2D** pregnancy scans per family per year		
ANTENATAL CLASSES • Normal delivery and labour • Breathing exercises • Caesarean section • Pain relief • Breastfeeding • Post-delivery body changes • Care of the baby during the first few weeks It is recommended that you attend antenatal classes between the 25th and 30th week of pregnancy. Most often there are about six to eight classes, each two hours long, presented by a nurse or midwife.	Covered at up to **3 x Medical Scheme Rate**. Your **combined maternity benefit is R7 520** per family per year. Once this limit is depleted, further claims are payable from your available Routine Medical Benefit.	Covered at **Medical Scheme Rate**, up to **R1 505** per family per year.		
ANTENATAL VITAMINS (excluding calcium supplements and Omega preparations)	Payable from Routine Medical Benefit, at **Medicine Price List**.	Payable from the Prescribed medicine (acute) benefit sub-limit at **Medicine Price List** (MPL) for the **Traditional Plan** and at cost from PMSA for the **Comprehensive** and **Savings** Plans.		

REMEMBER TO PRE-AUTHORISE YOUR HOSPITAL ADMISSION

by contacting Hospital Authorisations on 0860 100 080. This is usually done around 12-14 weeks; usually when you book your bed at the hospital.

The Scheme's YourHealthPortal offers moms-to-be a very handy tool, offering weekly bite-sized emails with interesting information about:

- what is happening in your body that week,
- how your baby would be developing during that week, and
- what you need to do (if anything).

There is also a wide range of more general articles around pregnancy and babies on the Portal – simply type an appropriate search term to access this information.

HOW TO REGISTER:

Visit the Scheme's website at nmas.medscheme.com and log in to the Member Zone. Go to the YourHealthPortal. View 'Programmes' and click on 'Pregnancy Pogramme' to access this tool. (You would need to deregister to stop these emails if you deliver before your due date or if your pregnancy comes to an unexpected end.)

GIVING BIRTH

CONFINEMENT IN HOSPITAL	**Covered at cost or Medical Scheme Rate**, whichever is less. As per clinical guidelines and protocols. Further days will require motivation by the attending doctor and approval by a Case Manager.
MIDWIFE DELIVERY	Society for Private Nurse Practitioners' tariffs, including pre-and-post confinement costs, if a gynaecologist is not used.
CONFINEMENT IN A REGISTERED BIRTHING UNIT	**Covered at cost or Medical Scheme Rate**, whichever is less. 4 x post-natal midwife consultations per event are also covered. For **Platinum Plan at the tariff agreed** with the hospital group for private wards for confinement will be covered.

UPDATE YOUR PRE-AUTHORISATION

On the day of your admission or within one working day, update your hospital authorisation by contacting Hospital Authorisations on 0860 100 080. Remember that if you do not pre-authorise your stay in hospital, you will have to pay a penalty on your hospital account.

Choosing your birth partners and setting

Whether you choose a gynaecologist, a general practitioner, or a registered midwife to help you with your birth will depend on a number of factors, including what kind of experience you want, where you plan to give birth, whether your pregnancy is normal or high risk, and what your medical scheme will pay for. Many women prefer the peace of mind of a gynaecologist, especially if they expect higher risk pregnancies and deliveries. For others, the personal touch of a midwife is more what they are looking for. Some combine these options, by opting for a midwife, but with a gynaecologist as a back-up. Some women also employ a doula – someone whose primary focus is on the physical and emotional comfort of the mother during the birth process. This can also be a close friend or sister who has already gone through the birth process herself and has the temperament needed for this role.

THE CASE FOR NATURAL BIRTH

Emergency Caesarean sections have saved the lives of countless mothers and babies who would have died, had they not received this lifesaving intervention. However, is it really the best option for you and you baby if there is no emergency?

Since the 17th century, midwives and surgeons have experimented with Caesarean section in situations where the mother and/or child were in danger. The operation was risky back then and there was no guarantee of survival. But today the procedure is safer and immensely popular.

It's become so prevalent in fact, that in South Africa, C-section rates in the private sector stand at over 70%, according to 2014 information by the South African Council for Medical Schemes. This is worrying as the World Health Organisation recommends an ideal 10-15% Caesarean section rate worldwide. The C-section rate exceeding the WHO recommendation is a worldwide trend.

WHY ARE SO MANY WOMEN CHOOSING C-SECTION?

A prospective mother's anxiety is often a motivating factor when choosing C-section. The media and society in general feeds this fear of something that used to be normal: natural childbirth. In contrast, we have casual attitudes towards surgery and have lost our fear of medical procedures, even though surgery is also risky. We simply do not have enough education on the positives of natural childbirth.

In an environment where patients are increasingly suing their healthcare providers for malpractice, doctors may also err on the side of safety by encouraging a mother-to-be to choose a C-section.

WHAT ARE THE BENEFITS OF NATURAL BIRTH?

There are many benefits to choosing natural birth over C-section (if the mother's and baby's health permits this).

GOOD FOR BABY

Babies born via natural delivery have physiological advantages, say the experts. For example, babies' digestive systems are colonised by their mother's flora as they pass through the birth canal; they receive stimulation from being squeezed and having their lungs compressed, and emerge more enlivened, with fewer admissions for wet lungs, fewer respiratory problems, and a lower incidence of asthma. The way you birth could also affect your baby's development. A 2012 study by Yale University in America revealed that babies born naturally may have higher IQs than those born by C-section. The research says that when women give birth naturally there are higher levels of a special protein in babies' brains that helps boost intelligence levels as they develop.

GOOD FOR MOM

For the mother, recovery time is quicker and bonding is easier, and she can experience birth as empowering.

GOOD FOR THE BUDGET

A natural delivery's costs are around half of that of a C-section. This means that you have smaller out-of-pocket expenses with a natural childbirth. Your medical scheme also has lower delivery claims, which ultimately has a positive effect on your contributions and benefits.

AFTER BIRTH

REGISTERING YOUR BABY AS A DEPENDANT	You have to notify the Scheme of the birth of your baby, and arrange for him/her to be registered as a dependant on the Scheme. Your new-born baby can be registered telephonically by calling 0860 100 080. We will require the full name, surname and date of birth of your baby. Be sure to register the baby as a dependant within 30 days of birth, so that the Scheme can register your baby from date of birth and therefore cover any medical claims incurred for the baby during that time.
AFTER-BIRTH CARE SERVICES	After-birth care services, for example home visits by a registered nurse and phototherapy treatment for your baby at home (if necessary) are subject to managed healthcare protocols and prior authorisation.
CHILD VACCINATIONS	The **Platinum Plan** covers child immunisations at a private clinic or doctor at the **Medicine Price List**, up to a limit of **R5 380** per family per year. (This is for medication only – the facility fee or nursing consultation fee will not be covered from this amount.)

Contact the Customer Service Centre for more information:

Telephone: 0860 100 080 / 011 671 6833

Fax: 0860 111 784 / 011 758 7041

Internal mail: Nedgroup Medical Aid Scheme, 37 Conrad Road, Florida North, Roodepoort 1709

Email: nedgroup.enquiries@medscheme.co.za

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TRAVEL BENEFITS

IN THIS SECTION

What should I keep in mind if I plan to travel 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. 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 and detailed before you submit it to the Scheme.
- 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 was 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.

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 arrange for advance supplies. Do so at least seven working days before you leave.**

What if we have a medical emergency outside the borders of South Africa?

Members outside the borders of South Africa (members in Namibia, Lesotho and Swaziland) may call ER24 by dialling +27 10 205 3052 for the following services:

- Life-threatening emergency (primary)
- For primary service, but not life-threatening
- Any inter-hospital transfers

IMPORTANT!
Medical care abroad can be very expensive (depending on the country you will be travelling to) and, given our exchange rate, it may be wise to take out additional medical cover. Your travel agent will be able to assist you with this.

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CLAIMING

IN THIS SECTION

How do I submit a claim?

You do not need to complete a claim form – simply submit all invoices directly to the Scheme. Remember to keep a copy for your records.

1. Before submitting your claim, check that the following information appears on the account:
   - The name of the Scheme
   - Your membership number
   - Surname and initials of member
   - The patient's first name(s) as it appears on your membership card, together with the date of birth
   - The name and practice number of the service provider (for example, doctor or pharmacy)
   - ICD10 code
   - A pre-authorisation number on hospital accounts or related accounts
   - Date of service or treatment
   - Amount claimed and tariff code
   - Name, quantity and price for each supply of medicine (where relevant)
   - Duration of operation (where relevant)

   If any of the above information does not appear on the account, it may lead to a delay in the processing of your account. Please request another account from your service provider.
2. Check that the account details are correct and that you have been charged the correct amount.
3. If you have already paid the account, clearly write "Account Paid" on the account and attach the receipt.
4. Keep a copy for your records.
5. Submit your claim (see below for details).
6. Your claim will be settled within 30 days of receipt and, in the case of a pre-paid account, the refund will be generated to you.

WHERE TO SUBMIT YOUR CLAIM

Via internal mail:
Nedgroup Medical Aid Scheme
2nd Floor, 36 Merriman Avenue, Vereeniging

Via the post office:
Nedgroup Medical Aid Scheme
PO Box 74, Vereeniging, 1930

Via fax: 0860 111 784

Via scan: nedgroup.newclaims@medscheme.co.za

IF YOU ARE FAXING OR SCANNING CLAIMS

To ensure that claims are promptly processed, please consider the following:

- Check legibility. (If the scan is illegible, the administrators will be unable to process the claim. If the contact details are not legible, the member can also not be notified of the concerns.)
- Place your name and contact number on the claim.
- Use the scan facility, the fax facility or normal postage services (but please do not submit the same claim using various methods, as duplicate claims may also lead to delays).
- For audits, the administrator is required to retain legible copies of all member claims.
- Check the size of the email and zip the attachment (if necessary) to ensure that the size of the email is smaller than 2MB. Emails larger than 2MB will not be received by the server.

How can service providers submit claims electronically?

Most service providers submit claims electronically. These claims are then paid directly by the Scheme to the service provider, subject to available limits.

If your service provider uses this facility, ask them for a copy of the claim for your records and check that the services and amounts charged are in fact correct. You do not need to submit a copy, unless you notice on your member statement that the claim has not been processed after a reasonable time. Remember, it remains the member's responsibility to ensure that claims have been submitted within a period of four months after treatment has been obtained and paid, and you are encouraged to review your monthly claims advice/remittance statements.

If the Scheme amends any of the benefits offered, **PLEASE NOTE** that claims submitted after these amendments will be paid according to the rules that existed at the date of the service and not the rules that exist at the date when the claims are submitted or received.

HINTS:

- Check whether your doctor has submitted the claim on your behalf.
- You must submit your claim as soon as possible after receiving the service. **If your claim is received later than four months after the date of service, the claim will be considered stale and will not be paid by the Scheme.** For example, if you visit the dentist on 20 April, the administrator must receive the claim before 20 August of the same year.
- Remember to keep all your claims advices, payment advices and personal medical savings account statements for your records.

How can I see my claims online?

Members may register on and log in to the Member Zone and access the self-help facilities via nmas.medscheme.com, or download and use the new smartphone-friendly Scheme app to see claims, remaining benefits and more.

REGISTRATION INFORMATION

The process to register will only take a few minutes and in future you will have direct access to your medical scheme information.

1. Go to **nmas.medscheme.com**.
2. Click on **LOGIN** on the top right-hand corner of the Homepage menu.
3. Click on **Log in as a member**.
4. Click on **Register**.
5. Click on the appropriate registration option: **I would like to register as a Member.**
6. Enter your **membership** number.
7. Click on **Validate Code** once your details have been entered.
8. Select a beneficiary to register.
9. Choose a **username**. Your username has to be longer than 8 characters.
10. Type in your **email address**.
11. Choose a **password**: Your password must be 8 characters and is case sensitive. No "&" signs allowed.
12. Click on **Create Account**.
13. You will shortly thereafter receive an email from webquery@medscheme.co.za. Click on the **Activate** link in the email. It will direct you to the login section of the member zone of the site.

You will now be able to login and use the website functionality with your username and password.

Whom should I contact if I have any queries about claims?

Queries

If you have any queries regarding claims, you should contact Medscheme on 0860 100 080.

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MEMBERSHIP

IN THIS SECTION

- Who can be a member of the Scheme?
- Who is regarded as a dependant of the member?
- How are waiting periods applied?
- What is a Late Joiner Penalty (LJP)?
- What do I need to do if my dependants/membership details change?
- What will happen when my Scheme membership comes to an end?
- What will happen to my personal medical savings account balance?
- Can I belong to more than one medical scheme?

Who can be a member of the Scheme?

All permanent employees of Nedbank Group Limited and Old Mutual Insure must belong to the Nedgroup Medical Aid Scheme as a condition of employment, unless they are dependants on their spouse's or partner's medical scheme. (If you terminate your employment with Nedgroup or Old Mutual Insure, you may no longer belong to the Nedgroup Medical Aid Scheme.)

As an employee, you qualify to become a member of the Scheme if you fall into one of the following categories and are not a beneficiary of another medical scheme:

- **Employees** – Permanent staff.
- **Married employees or partner** – If you are married or in a committed relationship, you may either join the Nedgroup Medical Aid Scheme or your spouse's or partner's medical scheme as a dependant.
- **Retirees/pensioners** – A member of the Scheme who retires and continues to belong to the Scheme is called a continuation member. Retirees who were not members of the Nedgroup Medical Aid Scheme prior to retirement do not qualify for membership after retirement. Retirees who leave the Nedgroup Medical Aid Scheme after retirement do not qualify to join the Scheme again at a later stage.
- **Widow/widower and dependants of a deceased member** – Unless they join another medical scheme, these dependants are entitled to apply to become continuation members of the Scheme. However, a new spouse of a continuation member cannot join the Scheme. Also, dependants of a deceased member who elect not to join the Nedgroup Medical Aid Scheme following the member's death do not qualify to join the Scheme at a later stage.

Who is regarded as a dependant of the member?

The following people qualify as dependants:

GENERAL DEPENDANTS

- **Spouse** – Your spouse to whom you are legally married and who is not a member of another medical scheme. Documentation required: A copy of the marriage certificate or ID.
- **Spouse(s) in polygamous and traditional marriages** – Your spouse(s) to whom you are married in terms of any law or custom and who is not a member of another medical scheme. Documentation required: A marriage certificate, suitable other certificate or an affidavit (available from your respective HR Consultant), and a copy of the ID.
- **Same-sex or other partner** – A person with whom you have a committed and serious relationship, similar to a marriage, based on objective criteria of mutual dependency and a shared and common household, irrespective of the gender of either party. Documentation required: An affidavit and a copy of the ID.
- **Children, adopted children, stepchildren, as well as children placed in the care and custody of a member, spouse or partner by virtue of a court order** – You or your spouse's/ partner's child who is dependent on you, until the child turns 23. After the child turns 23, you will need to provide proof of the child's financial dependency on you. When your child marries, he /she will no longer qualify to continue as your dependant and you are obligated to advise the Scheme of this change of marital status. The child's membership of the Scheme will terminate with effect from the end of the month in which he/she is married. There are two categories of dependency:
  - A child who is financially dependent on you (you must submit financial proof of this dependence).
  - A child who is incapable of earning an income owing to mental or physical disabilities, or any similar cause (you must submit medical proof). This dependant will be charged child dependant rates.

SPECIAL DEPENDANTS

- **Ex-spouse** – Your ex-spouse for whose medical expenses you are responsible in terms of a divorce settlement. Documentation required: A copy of the relevant portion of the divorce agreement.
- Any other member of the member's immediate family (parent, brother or sister, grandchild) in respect of whom you are liable for family care and support, and who is dependent on you and not a member or registered dependent of a member of another medical scheme. Siblings and grandchildren will be considered if you as member are the legal guardian, or if both parents are unemployed/earn less than the annual tax threshold. (Documentation required in the latter case: Proof of income for the parents.) Grandchildren also need to live with the main member to qualify as dependants.
- Nieces and nephews will only be considered if you have legal guardianship and the parents of the niece/ nephew are deceased.
- In-laws and grandparents do NOT qualify as dependants.

PLEASE NOTE

When you, as a member, apply to add a dependant to the Scheme, you will need to provide proof of your relationship to the dependant, and of the dependant's financial dependence on you.

You should register a new dependant (for example, spouse, new-born baby, adopted child or parent) within 30 days after they become eligible to join the Scheme as a dependant, otherwise a waiting period may apply. If you are a Nedbank employee, you can register your new-born child telephonically with the Scheme's Call Centre, provided that the surname is correct. If you are an Old Mutual Insure employee, please notify your HR department. Please send Medscheme a copy of the birth certificate as soon as it becomes available.

You can obtain application forms for membership from Medscheme.

It is your responsibility to ensure that the correct contributions are deducted from your salary or, if you are a retiree, that the correct amount is deducted via debit order or any other payment method. The Scheme has implemented a credit policy to ensure that arrear debt is managed appropriately.

How are waiting periods applied?

Waiting periods will be applied as follows:

Your (or a beneficiary's) circumstances	Will a three-month general waiting period apply?	12-month condition-specific waiting period	Prescribed Minimum Benefits (PMBs)
If your membership of the Nedgroup Medical Aid Scheme is compulsory.	No, there will not be waiting period, provided you apply within 30 days of your employment.	Will not apply.	Will be covered immediately.
If, for a period of more than 90 days before your application to the Nedgroup Medical Aid Scheme, you were not a member of a medical scheme.	Yes, a three-month waiting period will apply, including for Prescribed Minimum Benefits (PMBs).	Will apply if you have a pre-existing medical condition.	Will not be covered for the first 12 months if you have a pre-existing medical condition.
If you have been a member of a medical scheme for less than 24 months and you apply to the Nedgroup Medical Aid Scheme within three months terminating your membership of the previous medical scheme.	It depends. In the case of pre-existing medical conditions, any unexpired waiting period balance on your previous medical scheme will be applied.	Will apply if you have a pre-existing medical condition.	Will be covered immediately.
If you (or a beneficiary) have been a beneficiary of a medical scheme for more than 24 months and you apply to the Nedgroup Medical Aid Scheme within three months of terminating your membership of the previous medical scheme.	Yes, a three-month waiting period will apply. You will be entitled to Prescribed Minimum Benefits (PMBs).	Will not apply.	Will be covered immediately.
If you have a child while you are a member of the Scheme and you register him/her within 30 days from the date of birth.	No, there will not be a waiting period for the child and he/she will be covered from date of birth.	Will not apply.	Will be covered immediately.
If you have a child while you are a member of the Scheme and you register him/her after 30 days but before 24 months from the date of birth.	No, there will not be a waiting period for the child, and he/she will be covered from the 1st of the month following registration.	Will not apply.	Will be covered immediately.
If you have a child while you are a member of the Scheme and you register him/her after 24 months from the date of birth.	Yes, a three-month waiting period will apply, including for Prescribed Minimum Benefits (PMBs).	Will apply if he/she has a pre-existing medical condition.	Will not be covered for the first 12 months if he/she has a pre-existing medical condition.
If you experience one of the following life-changing events: • Divorce; • Marriage; • Retrenchment; or • Partner's change of employment, or death.	No, there will not be a waiting period, provided that you apply to join, and submit proof of the life-changing event, within 30 days of the event taking place.	Will not apply.	Will be covered immediately.

What is a Late Joiner Penalty (LJP)?

An LJP will be applied to any special dependant over the age of 35 who has insufficient creditable coverage on a medical scheme.

Dependants' LJPs are, for example, calculated as follows: A dependant is 65 years and has had 5 years' previous medical scheme cover. Then we take 65 (age) – 35 = 30 (without medical scheme cover) – 5 (previous cover) = 25 years without medical scheme cover, therefore the LJP will be 75%.

Years without medical cover	Late joiner penalty (LJP) payable
1 – 4 years	5% of contribution
5 – 14 years	25% of contribution
15 – 24 years	50% of contribution
25 years and more	75% of contribution

On receipt of the member's application form, the administrator will impose LJPs and waiting periods as per the approved Scheme Rules.

It is important to provide all supporting documents, such as membership certificates of previous medical schemes (indicating the membership end date) to the Scheme as soon as possible, to ensure that LJPs, if applicable, are not calculated incorrectly. An affidavit will also be accepted in respect of proof of previous medical scheme cover. Any LJP is only adjusted from the 1st of the next month after proof of previous membership is received and there will be no refunds or backdating.

Please take note that LJPs are implemented for life and do not expire.

What do I need to do if my dependants/ membership details change?

You must notify Medscheme of the following (Old Mutual Insure employees must notify their HR Consultant):

- a change in your marital status
- the birth of an infant or adoption of a child
- the death of any of your dependants
- your child becoming independent/self-supporting, or if the child marries
- your child registering as a dependant or a member of another scheme
- change in banking details (refunds will only be done to the member's bank account). (Supporting documents must also be sent.)

WHAT YOU NEED TO DO:

- Obtain a Change in Membership Details form from Medscheme.
- Include the necessary documentation such as birth certificate, registration certificate issued by the hospital, or death certificate.
- Return the completed form and documentation to Medscheme.

Once these changes have been processed, your monthly contributions and benefits will be adjusted accordingly.

Although your membership details may change during the benefit year, you may not change Plans until the beginning of the following benefit year.

What will happen when my Scheme membership comes to an end?

You are entitled to benefits until the last day of the month in which you terminate your membership.

- Contributions are payable for the full month when a member terminates their employment on or after the 11th day of such month and benefits will continue until the end of such month. The termination date will be for the end of that month.

If your membership of the Scheme ends, for example if you resign, are retrenched, die or transfer to your spouse's medical scheme, the following will happen:

- Any amounts that have been paid by the Scheme, but which exceed the benefits to which you are entitled, will be recovered from you (or your estate).
- The money in your personal medical savings account (if applicable) will be used by the Scheme to settle your share of any outstanding claims.
- If there is no money in your personal medical savings account, only the benefit amount will be paid to the service provider. You (or your estate) will be responsible for settling the balance with the service provider.

If you were on the **Savings** or **Comprehensive** Plans and you have used your upfront PMSA and then resigned before the end of the benefit year, the overspent amount will have to be paid back to the Scheme within 30 days of your membership termination date.

What will happen to my personal medical savings account balance?

If you leave the Scheme , your personal medical savings account balance will be refunded to you. If you leave the Scheme and join another medical scheme that permits personal medical savings, then your personal medical savings balance must be transferred to the new medical scheme.

The refund or transfer of personal medical savings account balances will take place six months after you leave or transfer. This period allows any outstanding claims to be settled against your personal medical savings account balance. The Scheme will recover any outstanding amounts from you directly if your personal medical savings balance is insufficient or if the balance has already been paid out.

Can I belong to more than one medical scheme?

Section 28 of the Medical Schemes Act No 131 of 1998 prohibits any person from being a member or dependant of more than one medical scheme. It is unlawful for any person to claim or accept benefits from more than one medical scheme. The medical scheme industry monitors for duplicate membership and should the Nedgroup Medical Aid Scheme become aware of any duplicate membership for a dependant, your dependant's membership will be automatically terminated to the date prior to the start of their membership on the other medical scheme. Any authorisation or claim paid after the date of their membership on the new medical scheme will be reversed by Nedgroup Medical Aid Scheme and must be submitted to the new medical scheme for processing.

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FREQUENTLY ASKED QUESTIONS

IN THIS SECTION

What is the difference between medical scheme rates and private provider rates?

- Medical scheme rates (MSR) are the rates determined by the Board of Trustees. MSR are generally lower than private provider rates.
- Private provider rates (PPR) are private rates charged by the service providers.

As PPR are substantially higher than MSR, patients generally have to make a co-payment (this is where the difference comes in), unless you are on the **Platinum Plan** (which provides cover at 3 x MSR for Everyday Services Benefit claims) or the **Savings Plan** (which pays 100% of cost for Everyday Services Benefit claims).

If you visit a practitioner who charges more than the rates covered by your chosen Plan, you will have to settle the difference directly with your practitioner. This does not apply to members of the **Savings Plan**, as any shortfall will be paid from their personal medical savings account, if they have funds available.

PLEASE NOTE
The Scheme pays only up to the benefit limit, as stated for each Plan, for both Hospital and Trauma Benefits and Everyday Services Benefits. The Scheme will therefore not pay the difference, even if you have not used up your annual sub-limit for a particular benefit.

What rules apply if I have been involved in a motor car accident?

In certain circumstances, you may not be covered by the Scheme for injuries resulting from a motor vehicle accident, as these medical expenses can be claimed from a third party.

If you are involved in a motor vehicle accident, you should consult an attorney to find out whether you have a claim against the Road Accident Fund.

If you have a valid claim, your attorney must submit an indemnity letter to the Scheme, in which case the Scheme will pay for your medical costs up to the available benefits. This will be done on the undertaking that the Scheme will be reimbursed once the claim is paid by the third party, in other words, the Road Accident Fund. (Batsumi is contracted by the Scheme to identify Road Accident Fund Claims and to liaise with your attorney and the Road Accident Fund to recover monies paid on your behalf for past medical expenses related to the accident.) You should always inform the Scheme when you claim from another source.

If the attorney determines that there is no claim against the Road Accident Fund, the Scheme will pay for the medical costs that were incurred as per the Scheme Rules.

How can I claim in terms of the Compensation for Occupational Injuries and Diseases Act?

In certain circumstances, you may not be covered by the Scheme for injuries resulting from an accident sustained in the workplace, as these medical expenses can be claimed from a third party. Claims in terms of the Compensation for Occupational Injuries and Diseases Act are not covered by the Scheme.

Forms for the Compensation for Occupational Injuries and Diseases Act should be completed by the treating hospital or medical practitioner and the relevant employer, and then submitted to the Commissioner of Occupational Injuries and Diseases.

The Scheme will not pay any benefits until the Commissioner rules that the injury does not fall under the Compensation for Occupational Injuries and Diseases Act.

What is the escalation process if I am unhappy with the service that I receive?

We understand that members expect reliable and efficient service from the Scheme at all times. To help you resolve any medical scheme issues with regard to the service you receive, please follow the process below.

Before you log a complaint with the Council for Medical Schemes, you must exhaust all internal channels for resolving your complaint with the Scheme.

1. Contact the Call Centre telephonically or via email and provide the details of your complaint.
2. If you are not satisfied with the outcome, you are requested to make use of the following process to contact the specific managers via email unless specified otherwise.
   - **Operations Manager (Call Centre):**
     Liesel Alexander
     @ lieselsu@medscheme.co.za
     011 758 8034
   - **Membership /Credit Management:**
     Sonia Alexandre
     @ soniaa@medscheme.co.za
     011 671 2198

- **Fund Manager's Office:**
  Trevor Bailey
  @ trevorb@medscheme.co.za
  021 466 1632

3. If you are still not satisfied, please escalate to the office of the Principal Officer:
   - **Nicole Jones**
     @ nicolejon@nedbank.co.za
     021 412 3587
   - **Julia le Roux**
     @ julial@nedbank.co.za
     021 412 3814

What can I do if I have a complaint against my medical scheme?

The Registrar of Medical Schemes is the regulator of the medical scheme industry. Any member or any person who is aggrieved with the conduct of a medical scheme, health professional, private hospital or nurse, can submit a complaint to the Registrar's Office. However, the Registrar requires that members FIRST try to resolve any complaints with their medical scheme, before they contact the Registrar.

Once you have tried and failed to resolve a complaint with the Scheme, you may contact the Registrar to make a complaint. Complaints can be submitted through fax, email or in person at the Registrar's office.

The Registrar's contact details are as follows:

Council for Medical Schemes

Address: Block A Eco Glades 2 Office Park, 420 Witch-Hazel Street, Ecopark, Centurion, 0157

Website address: medicalschemes.com – (on the landing page there is a quick links toolbar; click on the *How to lodge a complaint* link for further information.)

Telephone: 012 431 0500

Fax: 012 431 0608

Customer Care Share: 0861 123 267

Email address: complaints@medicalschemes.com

- The Registrar's Office will send a written acknowledgement of a complaint within 3 working days of its receipt, providing the name, reference number and contact details of the person who will be dealing with the complaint.
- In terms of Section 47 of the Medical Schemes Act, a written complaint received in relation to any matter provided for in this Act will be referred to the medical scheme. The medical scheme is obliged to provide a written response to the Registrar's Office within 30 days.
- The Registrar's Office shall within 4 days of receiving the complaint from the administrator, analyse the complaint and refer a complaint to the medical scheme for comments.
- Upon receipt of the response from the medical scheme, the Registrar's Office will analyse the response in order to make a decision or ruling. Decisions/rulings will be made within 120 days of the date of referral of a complaint and communicated to the parties.

THE REGISTRAR'S RULING AND APPEAL TO COUNCIL

- Section 49 of the Act makes provision for any party who is aggrieved with the decision of the Registrar to appeal such a decision. This appeal is at no cost to either of the parties.
- An appeal must be lodged within 30 days of the date of the decision. The operation of the decision shall be suspended pending review of the matter by the Council's Appeals Committee.
- The secretariat of the Appeals Committee will inform all parties involved of the date and time of the hearing. This notice should be provided no less than 14 days before the date of the hearing.
- The parties may appear before the Committee and tender evidence or submit written arguments or explanations in person or through a representative.
- The Appeals Committee may after the hearing confirm or vary the decision concerned or rescind it and give another decision as they deem just.

THE SECTION 50 APPEALS PROCESS

- Any party that is aggrieved with the decision of the Appeals Committee may appeal to the Appeal Board.
- The aggrieved party has 60 days within which to appeal the decision and must submit written arguments or explanation of the grounds of his or her appeal.
- The Appeal Board shall determine the date, time and venue for the hearing and all parties will be notified in writing.
- Appeal Board shall be heard in public unless the chairperson decides otherwise.
- The Appeal Board shall have the powers which the High Court has to summon witnesses, to cause an oath or affirmation to be administered by them, to examine them, and to call for the production of books, documents and objects.
- The decisions of the Appeal Board are in writing and a copy thereof shall be furnished to parties. A prescribed fee is payable for Section 50 Appeals.

What should I do if I suspect fraudulent activity against the Scheme?

Unnecessary and fraudulent expenses are funded by you, the member, through increased contributions. You can contribute towards the fight against fraud by carefully and regularly checking your claims transactions and making sure that you have not been involved in a fraud scam without your knowledge.

Examples of fraud scams discovered by the Scheme have been:

- A service provider putting in a claim for services that were never rendered.
- A service provider performing a procedure or giving treatment that is excluded by the Scheme rules, and then charging for it under a different code.
- A pharmacy providing generic medicine, but charging for the more expensive brand name.

If you suspect that a service provider, colleague or any other person or organisation may be engaged in fraudulent activities against the Scheme, please contact the Fraud Hotline on 0800 112 811. This hotline is managed by an independent company, Tip-Offs Anonymous, and you can choose to remain anonymous. You can also email fraud@medscheme.co.za to report your suspicions.

When do I get my tax certificate from the Scheme and how can I request a copy of the tax certificate?

The medical scheme will email the tax certificate to you in May of each year.

You may email nedgroup.enquiries@medscheme.co.za to request a copy. Alternatively, log on to the secure website at medscheme.co.za and download your tax certificate or make use of the member self-help service.

Where can I obtain a membership certificate?

You may email nedgroup.enquiries@medscheme.co.za

How can I replace or get additional medical scheme membership cards?

In line with the latest trends in the healthcare industry, Nedgroup Medical Aid Scheme has rolled out an electronic membership card with a One Time Pin (OTP) solution. This e-card offers you even greater peace of mind, as it will help ensure that your electronic membership card is accessed only by you. This process will run in parallel with the printed cards until we are satisfied that the process is flawless. If you require a printed membership card, contact Medscheme or email nedgroup.enquiries@medscheme.co.za.

As a retiree, why am I entitled to maternity benefits when the Scheme could rather increase my other benefits?

In accordance with the Medical Scheme Act, all members registered on the same Plan must be provided the same benefit package. No differentiation of benefits is allowed based on age, gender or income. It is therefore not permissible to remove this benefit from retirees' benefits and 'credit' them with other, more age-related benefits.

What services are not covered by the Scheme?

There are certain services and procedures not covered by the Scheme, and these are known as exclusions. These exclusions apply in respect of all benefits other than the Prescribed Minimum Benefits. Unless otherwise authorised by the Scheme, no benefits will be granted in respect of any expenses or charges resulting from any of these services. A full list of excluded services and procedures is available from the Scheme upon request, but the following is given as an overview:

- All costs incurred for the treatment of conditions or injuries for which any other party may be liable
- Any injury that can be claimed from another source (such as a personal accident policy, the Road Accident Fund, Compensation for Occupational Injuries and Diseases Act, etc.) (Please refer to *What rules apply if I have been involved in a motor car accident?* earlier in this chapter for more information.)
- Injuries resulting from professional sport
- Investigations, operations or treatments for cosmetic purposes, artificial insemination, impotence or erectile dysfunction
- Examinations for insurance, employment, visas, pilot and driver's licences
- Holidays for recuperative purposes
- Experimental treatments
- The purchase of:
  - patent medicines, vitamins and proprietary preparations
  - applicators, toiletries and beauty preparations
  - bandages, cotton wool and similar aids
  - patented foods, including baby foods
  - tonics, slimming preparations and drugs as advertised to the public
  - household and biochemical remedies
  - sunglasses and domestic remedies
  - exercise equipment
- Unregistered medicines (in other words, those not approved by the Medicines Control Council)
- Orthodontic treatment for persons 21 years or older, excluding services required after trauma (applicable to all Plans)
- Sleep therapy

14. JARGON GUIDE

Annual limit	The maximum amount of cover that you have for medical expenses during a benefit year.
Benefit year	The period for which benefits and allocations apply, in this case 1 January to 31 December. Should you join the Scheme during a benefit year, you are only entitled to a month-appropriate portion of the benefits and limits specified for that year.
Child dependant	A member's dependent child, including a stepchild or legally adopted child, who is 22 years old or younger.
Everyday Services Benefits	These benefits cover medical treatment that you receive out of hospital or as an outpatient at a hospital.
DBC – Document Based Care	The company providing the Back and Neck Rehabilitation Programme
Designated service provider (DSP)	Appointed by the Scheme to provide certain specified medical services to members for example, a group of service providers or a state facility.
Hospital & Trauma Benefits	These generally cover the major medical expenses that you would incur when undergoing surgery or while admitted in hospital.
ICD10 code	International Classification of Diseases (ICD 10) coding is a system that classifies diseases and the complications connected to these diseases according to a specific category.
Late Joiner Penalty (LJP)	A penalty imposed on members (or dependants) who join a medical scheme after the age of 35, or who have never been medical scheme members, or who have not belonged to a medical scheme for a specified period of time. The penalty aims to compensate for potentially increased claims by people who join a medical scheme when they are already older or infirm, and range from 5% to 75% of contributions.
Medical protocols	A set of pre-approved treatments authorised for PMB and other conditions to be followed by service providers.
Medical Scheme Rate (MSR)	The rate determined by the Board of Trustees.
Medicine formularies	A list of approved medicines that may be used by a dispensing doctor or pharmacist for treatment.
Medicine price (SEP)	Single exit price plus dispensing fee.
Personal Medical Savings Account	A savings account to accumulate funds for future approved medical needs (**Savings** and **Comprehensive** Plans only).
Pre-authorisation	The process whereby a member advises the Scheme of his/her or a dependant's admission to hospital. Penalties are payable if you do not pre-authorise.
Prescribed Minimum Benefits (PMB)	The unlimited benefit to which all members are entitled for treatment related to the conditions specified in the Medical Schemes Act, provided this treatment is obtained at a DSP and subject to the Scheme's treatment protocols and formularies.
Private Provider Rates (PPR)	The rates charged by private providers.
Shortfall	Any amount paid by the Scheme on your behalf that exceeds the amount to which you are entitled.
Sub-limit	The maximum amount of cover you have available for specified medical expenses during a benefit year.
Treatment Plan	A summary of benefits that will be covered in terms of your PMB related condition.
Waiting period	The period during which you will not be covered for any medical expenses incurred, even though you will be making contributions to the Scheme. **Condition-specific waiting period:** A period during which a beneficiary is not entitled to claim benefits in respect of a condition for which medical advice, diagnosis, care or treatment was recommended or received within the 12-month period ending on the date on which an application for membership was made. **General waiting period:** A three-month period during which a beneficiary is not entitled to claim any benefits.

Although every effort has been made to ensure that this document gives an accurate summary of the benefits offered by the Nedgroup Medical Aid Scheme, it does not replace the Rules of the Scheme, which take precedence over any wording in this document. You can view the Rules of the Scheme on the logged-in Member Zone of the Scheme's website, nmas.medscheme.com.

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