

NEDGROUP MEDICAL AID SCHEME

MEMBER GUIDE 2012



The benefits in this guide are valid from **1 January 2012 to 31 December 2012** and will be reviewed at the end of that period.

Contact Details

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Emergency Medical Services	Tel: 084 124 or 0861NED911 (0861 633 911)	Tel: 084 124 or 0861NED911 (0861 633 911)
Website	www.medscheme.co.za Medscheme's convenient and secure website gives you access to your membership details, claims status, savings balance and available benefits, as well as an electronic version of member communications.	www.carecross.co.za Members on the Traditional Plus Plan have access to the ONECARE secure website for their claims status, available benefits as well as member statements.

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Disclaimer: Although every effort has been made to ensure that this member guide is an accurate explanation of the benefits offered by the Nedgroup Medical Aid Scheme, please note that this guide does not replace the Rules of the Scheme, which take precedence over any wording in this guide.

I. Welcome

IN THIS SECTION

- [Why have a medical scheme?](#)
- [How can this Member Guide help me?](#)
- [What are my responsibilities as a member?](#)



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 my responsibilities as a member?

- Understand how the Scheme and specific Plans work by reading this Member Guide.
- Keep the Scheme up to date on any changes to your membership details.
- 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.
- Inform the Scheme before you are admitted 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.

Please note: It is your responsibility as a member to check whether the correct contributions are deducted from your salary. With effect from 1 January 2012, child dependants over the age of 23 will pay the adult contribution.

Abbreviations used in this guide:

- MSR - Medical Scheme Rate
- PSA - Personal Savings Account
- PPR - Private Provider Rates

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2. How to choose your Plan for 2012

IN THIS SECTION

- [What are the main changes for 2012?](#)
- [What are the employee contributions for 2012?](#)
- [Can I have a quick overview of the Plans?](#)
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The benefit structure for the 2012 benefit year will continue to offer a choice of five Plans, catering to our various members' needs.

Before the new benefit year starts on 1 January 2012, you will need to decide whether your current Plan still meets your medical scheme needs or whether you should consider switching to a more suitable Plan.

This section offers a quick and easy comparison of the five Plans to help you to determine which Plan will work for you. When making this important decision, you will basically have to weigh up the benefits and contributions of the various Plans with your needs – so please read this member guide carefully to get all the information you need before making your decision.

If you have any questions after reading this guide, or need help in making your choice, please contact Medscheme (Hospital, Savings, Traditional or Platinum Plan enquiries) on 0860 100 080 or contact ONECARE (Traditional Plus Plan enquiries) on 0860 103 491.

What are the main changes for 2012?

- The Nedgroup Medical Aid Scheme has introduced a GP and specialist network for all Plans, called the Nedgroup GP and Specialist network, to ensure that you receive the appropriate treatment for your PMB condition. This network is managed by ONECARE Health. Please ensure that you use GP or specialists on the network, as this will ensure that funding for these claims will be paid from your PMB insured benefit from rand one. If you choose a GP or specialist outside of the network, your claims will first be paid from your Everyday Services Benefit at MSR rates, and thereafter be covered by the PMB benefit with a co-payment of 25% that you will need to cover from your own pocket.
Hospital Plan, Savings Plan, Traditional Plan and Platinum Plan members should contact Medscheme on 0860 100 080 to check whether a GP or specialist is on the network.
Traditional Plus Plan members should contact ONECARE on 0860 103 491 to check whether a GP or specialist is on the network.
- To allow members the option of having laparoscopic procedures as a less invasive, but more expensive alternative to conventional open surgery, the Scheme is implementing different co-payments that members would be responsible for; should they prefer to have a laparoscopic procedure done. These co-payments are shown on [page 13](#).
- Adult rates will now be charged from age 23 (no longer age 26) for children who are financially dependent on their parents. In the case of disabled children, the Scheme will continue to charge child dependant rates, to assist their parents financially. (Contributions are still only payable for the first child dependant.)
- ER24 has been appointed as the preferred provider of emergency services for 2012.

What are the employee contributions for 2012?

Please note:

- Contributions for active employees are based on Total Guaranteed Package (TGP).
- Contributions are only payable for the first child dependant.
- No contributions may be made towards the medical savings account except on the Savings Plan.
- Contributions are payable in arrears and your revised contributions will come into effect on 1 April 2012.

The following tables reflect the contributions for 1 January to 31 March 2012.

M = Member | **A** = Additional Adult | **C** = Child

P Platinum Plan

Monthly Income	Monthly Contributions				
	Single M	Family M+C	Family M+A	Family M+A+C	Additional A
All levels	R2 397	R3 239	R4 196	R5 038	R1 799

T+ Traditional Plus Plan

Monthly Income	Monthly Contributions				
	Single M	Family M+C	Family M+A	Family M+A+C	Additional A
Up to R3 000 pm	R1 385	R1 859	R2 423	R2 897	R1 038
R3 001 – R3 500 pm	R1 529	R2 057	R2 674	R3 202	R1 145
R3 501 – R4 500 pm	R1 755	R2 327	R3 068	R3 640	R1 313
R4 501 – R6 000 pm	R1 929	R2 566	R3 373	R4 010	R1 444
R6 001 + pm	R1 967	R2 624	R3 438	R4 095	R1 471

T Traditional Plan

Monthly Income	Monthly Contributions				
	Single M	Family M+C	Family M+A	Family M+A+C	Additional A
Up to R3 500 pm	R1 450	R1 951	R2 538	R3 039	R1 088
R3 501 – R4 500 pm	R1 668	R2 212	R2 920	R3 464	R1 252
R4 501 – R6 000 pm	R1 832	R2 412	R3 206	R3 786	R1 374
R6 001 + pm	R1 869	R2 494	R3 271	R3 896	R1 402

What are the employee contributions for 2012? (continued)

S Savings Plan

Monthly Income	Monthly Contributions				
	Single M	Family M+C	Family M+A	Family M+A+C	Additional A
Up to R3 500	R 786	R1 197	R1 541	R1 952	R755
R3 501 – R4 500 pm	R 945	R1 419	R1 857	R2 331	R912
R4 501 – R6 000 pm	R1 070	R1 574	R1 982	R2 486	R912
R6 001 + pm	R1 166	R1 765	R2 301	R2 900	R1 135

H Hospital Plan

Monthly Income	Monthly Contributions				
	Single M	Family M+C	Family M+A	Family M+A+C	Additional A
Up to R3 500 pm	R 504	R 770	R 991	R1 257	R 487
R3 501 – R4 500 pm	R 588	R 900	R1 157	R1 469	R 569
R4 501 – R6 000 pm	R 674	R1 000	R1 256	R1 582	R 582
R6 001 + pm	R 837	R1 277	R1 655	R2 095	R 818

The contribution tables have been adjusted to reflect a revised minimum band from 1 April 2012 (after the annual salary increase). The 2011/2012 bands effective until 31 March 2012 will collapse as the following bands are introduced as entry salary bands. To maintain the Scheme's solvency position, all the current income bands will be collapsed into one income band over the next three years.

From 1 April 2012, the following contributions will apply.

M = Member | A= Additional Adult | C= Child

P Platinum Plan

Monthly Income	Monthly Contributions		
	M	A	C
All levels	R2 661	R1 997	R935

What are the employee contributions for 2012? (continued)

T+ Traditional Plus Plan

Monthly Income	Monthly Contributions		
	M	A	C
Up to R3 500 pm	R1 682	R1 260	R 581
R3 501 – R4 500 pm	R1 931	R1 444	R 629
R4 501 – R6 000 pm	R2 122	R1 588	R 701
R6 001 + pm	R2 164	R1 618	R 723

T Traditional Plan

Monthly Income	Monthly Contributions		
	M	A	C
Up to R4 500 pm	R1 699	R1 275	R 569
R4 501 – R6 000 pm	R1 997	R1 498	R 632
R6 001 + pm	R2 037	R1 528	R 681

S Savings Plan

Monthly Income	Monthly Contributions		
	M	A	C
Up to R4 500 pm	R1 021	R 985	R 512
R4 501 – R6 000 pm	R1 156	R 985	R 544
R6 001 + pm	R1 259	R1 226	R 647

H Hospital Plan

Monthly Income	Monthly Contributions		
	M	A	C
Up to R4 500 pm	R 632	R 612	R 335
R4 501 – R6 000 pm	R 725	R 626	R 350
R6 001 + pm	R 900	R 879	R 473

Can I have a quick overview of the Plans?

The Plans, from most expensive (and most extensive Everyday Services Benefits cover) to least expensive (and least extensive Everyday Services Benefits cover) are as follows:

P Platinum Plan	T+ Traditional Plus Plan	T Traditional Plan	S Savings Plan	H Hospital Plan
EVERYDAY SERVICES BENEFITS				
Routine Medical Benefit (RMB) with sub-limits Benefits paid at 3 x MSR from the Routine Medical Benefit limit with additional sub-limits for dentistry, optical and maternity benefits. Once your sub-limits and Routine Medical Benefit are depleted, you will be liable for payment.	Sub-limits on each category of service Benefits paid at MSR or cost, whichever is the lesser, up to sub-limits. Once sub-limits are depleted you continue to have access to additional basic primary healthcare cover, subject to formularies via network GP. Once sub-limits are depleted, you will be liable for payment for services outside of the network and/or which are not on the formulary.	Sub-limits on each category of service Benefits paid at MSR or cost, whichever is the lesser, up to the sub-limit. Once sub-limits are depleted, you will be liable for payment.	Personal Savings Account allocation. 22% of your monthly contribution allocated towards your PSA. 12 months up-front PSA allocation at the beginning of the year. When you have used up all your savings, you will be liable for payment.	No cover for Everyday Services.
WELLNESS BENEFITS via selected ScriptNet pharmacies				
Chronic Medicine Benefits (26 PMB and 20 non-PMB chronic conditions) limited to R7 700 per family per year at ScriptNet pharmacies. Once limit is reached, paid from RMB. Once RMB depleted, PMB chronic medicine paid from PMB benefit at ScriptNet pharmacies.	PRESCRIBED MINIMUM BENEFITS (PMB)			
	CHRONIC MEDICINE BENEFITS (26 PMB AND 20 non-PMB chronic conditions) 20 non-PMB chronic conditions limited to R7 700 per family per year at Scriptnet pharmacies. PMB chronic medicine paid from PMB benefit at ScriptNet pharmacies.			PMB chronic medicine paid from PMB benefit at ScriptNet pharmacies.
CHRONIC MEDICINE BENEFITS (basic 26 PMB Chronic disease list) via ScriptNet pharmacies				
HOSPITAL AND TRAUMA BENEFITS at Medical Scheme Rate (MSR), including Managed Healthcare Programmes for HIV/Aids, cancer & organ transplants				



How should I decide which Plan is best for me?

All five Plans offer the same Major Medical Expenses cover, with different Everyday Services Benefits. See who would typically choose the various Plans:

P The Platinum Plan

When only the best will do for you and your healthy family! You will have peace of mind knowing that your everyday services will be covered at 3 x MSR. The Platinum Plan caters for young families, preferably without any chronic ailments. It offers extensive cover with a comprehensive Routine Medical Benefit limit and sub-limits on certain benefits.

T+ Traditional Plus Plan

Managing your chronic condition is crucial to you, and you need comprehensive medical benefits. Your everyday services will be covered up to pre-determined sub-limits with freedom of choice and thereafter unlimited medically-necessary access to additional GP, Prescribed Medication, Radiology and Pathology benefits at a ONECARE GP, subject to ONECARE formularies and approved tariff limits.

T Traditional Plan

The Traditional Plan offers all-inclusive medical benefits. Your everyday services will be covered up to the pre-determined sub-limits with freedom of choice.

S Savings Plan

You want to manage your benefits, yet still need peace of mind knowing that you are covered for everyday services from your annual savings allocation. On a monthly basis approximately 22% of your contributions will be allocated towards your Personal Savings Account. It gives you the power to decide how to spend your annual savings allocation. Any balance remaining in your medical savings account at the end of the year will be carried forward to the following year.

H Hospital Plan

So, you are healthy and rarely visit a doctor. However, you need to be prepared for those unforeseen hospital procedures and diseases. The Hospital Plan is the best Plan for you. You will have peace of mind knowing that you have hospital benefits with the freedom of choice to select your hospital and cover for the 26 PMB chronic conditions.

What to do before you make your final choice

- Review the benefits offered by each of the five Plans to make sure that you choose the Plan most suited to your medical needs.
- Review your past medical claims history (in other words, what your medical expenses were during the 2011 benefit year).
- Estimate your anticipated medical expenses during the coming year.
- Consider any medical procedures that are planned for the next benefit year.
- Think about the number of dependants you have and whether they may require chronic medication and treatment.
- Consider whether you have an existing chronic ailment that may require chronic medication and treatment.
- Verify the monthly contribution rates of each Plan to make sure that you can afford the Plan you select. At the same time, there is no point in moving down to a cheaper Plan if that Plan doesn't provide you with enough benefits and requires you to make regular co-payments.
- Check if your GP is part of the ONECARE network.



3. Benefits: Hospital and Trauma

(These benefits are the same across all Plans.)

IN THIS SECTION

- [What are Hospital and Trauma benefits?](#)
- [What is our overall annual limit?](#)
- [How does pre-certification before hospitalisation work?](#)
- [What services and procedures are covered during hospitalisation?](#)
- [What services in doctors' rooms are covered?](#)
- [How do the Managed Care programmes for cancer, HIV/AIDS and organ transplants work?](#)
- [What should we do in an emergency situation?](#)



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.

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.

Priority	Explanation	Paid From
Red (58804)	Immediate treatment – unstable	Hospital and Trauma Benefits
Orange (58803)	Very urgent treatment – potentially unstable	Hospital and Trauma Benefits
Yellow (58802)	Urgent treatment – stable	Routine Medical Benefit (Platinum Plan) and available savings (Savings Plan). Subject to motivation.
Green (58801)	Non-urgent/delayed treatment	Savings Plan (For member's own account on all other Plans)

What is our overall annual limit?

All members have access to **unlimited** Hospital and Trauma Benefits **at Medical Scheme Rates (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 [page 14 - 21](#) for a detailed breakdown of the sub-limits that apply to Hospital and Trauma Benefits under the various Plans.

How does pre-certification before hospitalisation work?

The purpose of pre-certification 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.

- 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-certification.
- It is recommended that you pre-certify at least ten days before being hospitalised for a procedure where an implant or an internal prosthesis will be necessary, e.g. a knee replacement.
- Pre-certification is also required for MRI, radio-isotope and CAT scans. If you need these procedures, please follow the procedure 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.

To pre-certify, please follow the process below:

Hospital Plan, Savings Plan, Traditional Plan and Platinum Plan	Traditional Plus Plan
<ul style="list-style-type: none"> • Contact Hospital Benefit Management at 0860 100 081 (or send an email to authorisations.cpt@medscheme.co.za) three working days before being admitted to hospital (ten days for implants or internal prostheses). • Please note that the Scheme has a speech recognition self-service system that allows you to enter information on the system before being redirected. • In the case of an emergency, you must arrange to notify Hospital Benefit Management on the first working day after being admitted. 	<ul style="list-style-type: none"> • Contact ONECARE on 0860 102 183 at least three working days before being admitted to hospital. • In the case of an emergency, you must arrange to notify ONECARE 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 of the hospital;
 - the proposed treatment or procedure/tariff code (ICD10 code) and CPT4 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 while you are in hospital.
- The Hospital Benefit Management consultant will confirm whether you have enough benefits available to cover the procedure and whether your hospital admission is approved.

- You will receive a pre-certification number, which the hospital will request when you are admitted. If your hospitalisation is postponed or if you are re-admitted to hospital, you will need to pre-certify 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-certified.
- 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 rates (MSR), whichever is the lesser.
- See the tables on the next pages for the full list of the services and procedures that are covered, as well as the sub-limits that apply.
- If you live in an area where specialists tend to charge higher rates, please refer to *Treatment by a specialist while in hospital* below for more details on the specialist network. Alternatively, you can take out **hospital gap cover insurance**. For Nedbank and Mutual & Federal employees the application forms for this product are available from your Human Resources Department.

Basic dentistry

- Hospitalisation will only be considered for basic dentistry procedures performed on persons who are 12 years or younger.
- 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.

Laparoscopic surgery

- To allow members the option of having laparoscopic procedures as a less invasive, but more expensive alternative to conventional open surgery, the Scheme is implementing the following co-payments that members would be responsible for, should they prefer to have a laparoscopic procedure done:

Laparoscopic surgery (continued)

Procedure	Co-payment
Laparoscopic appendectomy	R8 000
Laparoscopic hernia repair	R4 000
Laparoscopic assisted vaginal hysterectomy	R8 000
Laparoscopic radical prostatectomy	R16 000
Laparoscopic nephrectomy	R16 000
Laparoscopic pyeloplasty	R13 000
Knee arthroscopy	R5 000
Hip arthroscopy for femoroacetabular impingement (FAI) reconstruction, where it forms part of other diagnostic or therapeutic hip arthroscopy procedures	R10 000
Upper GI endoscopy / colonoscopy	R1 600
Balloon sinuplasty	R 5 000
Transvaginal mesh procedures for pelvic prolapsed repair e.g. Prolift	R 5 000

Psychiatric services

- This benefit covers hospitalisation and all associated accounts, e.g. 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-certified and approved.
- Where practical, all patients/beneficiaries with a psychiatric illness should be admitted to a psychiatric unit where they will benefit from the case management process.
- 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.

Please note: 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.

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.
- This list is constantly reviewed and updated. Where new products or technology are considered, a medical practitioner should motivate for these.
- Application for or use of any item not on the list must always be submitted to the Scheme with a motivation from the treating practitioner.

Services and procedures covered during hospitalisation

The following services and procedures are covered at 100% of cost or MSR; whichever is the lesser, unless otherwise stated:

Service Category	Benefit
Unlimited cover for major medical expenses, subject to the pre-certification and case management process and, for cases over R500 000, subject to the Medical Advisor's approval. Certain sub-limits apply.	
1. Hospital and Nursing home accommodation To avoid incurring unnecessary hospital costs: <ul style="list-style-type: none"> • On the day of discharge, you should arrange to leave the hospital before 12h00. • If scheduled to undergo an operation in the afternoon, you should ask your doctor to admit you after 12h00. 	100% of MSR rates as determined in the Rules for accommodation in: <ul style="list-style-type: none"> • 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.
<ul style="list-style-type: none"> • Facility fees (only for emergency) • Medicine on discharge (TTO) 	100% of MSR as determined in the Rules 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. Platinum Plan: Paid from Routine Medical Benefit limit, subject to motivation. Savings Plan: Paid from Medical Savings Account, subject to motivation. Limited to R370 per beneficiary per admission
2. Nursing services and hospices	100% of cost with a sub-limit of R12 740 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.

Services and procedures covered during hospitalisation (continued)

Service Category	Benefit
<ul style="list-style-type: none"> • Prescribed Medication 	Medication provided may be covered from either the Everyday Services Benefits, or Medical Savings Account, where applicable. Prescribed (acute) medicines will not be covered on the Hospital Plan, except for those conditions covered under Prescribed Minimum Benefits. Please note: You must apply for this benefit and it must be pre-authorized by the Case Manager.
3. Maternity <ul style="list-style-type: none"> • Confinement in hospital • Midwife delivery • Confinement in a registered birthing unit 	100% of cost or MSR , whichever is the lesser, subject to the overall annual limit. <ul style="list-style-type: none"> • 3 days for normal birth, and • 4 days for Caesarean birth. Further days will require motivation by the attending doctor and approval by a Case Manager. 100% of the Society for Private Nurse Practitioners' tariffs , including pre-and-post confinement costs, if a gynaecologist is not used. 100% of cost or MSR , whichever is the lesser, subject to the overall annual limit. <ul style="list-style-type: none"> • Including 4 x post-natal midwife consultations per event.
4. Ambulance services	100% of the tariff agreed with the Scheme's preferred provider, ER24, with a sub-limit of R7 280 per family per year.
5. General practitioners & medical specialists in hospital	100% of MSR for the following services: <ul style="list-style-type: none"> • surgery • procedures in hospital • anaesthetics • applicable portion of assistant's fees at operations • hospital visits
6. Radiology and Pathology General Radiology and Pathology (in hospital) 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-certification. Ultrasound scans (in and out of hospital – other than pregnancy scans)	100% of cost or MSR , whichever is the lesser, subject to the overall annual limit. 100% of cost or MSR , whichever is the lesser, limited to R12 140 per family per year. 100% of cost or MSR , whichever is the lesser, up to a maximum of R4 670 per family per year.
7. Maxillofacial & oral surgery	100% of MSR subject to submission and approval of a quotation.

Services and procedures covered during hospitalisation (continued)

Service Category	Benefit
<p>8. Dental implants (In and out of hospital)</p> <p>Subject to the relevant managed healthcare programme and to prior authorisation. Implant placements and implant components are subject to this limit. Implant supported crowns are subject to the advance dentistry limit.</p>	<p>100% of MSR, with a sub-limit of R10 930 per family per year for the cost of implants.</p> <p>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.</p> <p>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.</p>
<p>9. Physiotherapy</p> <ul style="list-style-type: none"> In hospital. After hospitalisation, if linked to the hospital admission. 	<p>100% of MSR</p> <p>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.</p>
<p>10. Rehabilitation</p>	<p>100% of MSR with a sub-limit of R54 120 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.</p>
<p>11. Mental health</p> <ul style="list-style-type: none"> Psychiatric treatment Treatment and accommodation for substance abuse 	<p>100% of 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.</p> <p>100% of negotiated tariff up to a maximum of 21 days per beneficiary per year included in the Psychiatric treatment.</p>
<p>12. Oncology</p> <ul style="list-style-type: none"> (Including approved, related medication, MRI, CAT and radio-isotope scans as well as chemotherapy, radiotherapy, oncologists' consultations, mammograms, radiology and pathology fees) 	<p>100% of MSR with a sub-limit of R247 190 per family per year, provided the patient enrolls on the Oncology Benefit Management Programme.</p> <ul style="list-style-type: none"> A 12-month care plan must be submitted to the Case Manager, and is subject to approval by the Case Manager. The care plan should include the following information: <ul style="list-style-type: none"> date of diagnosis, the area concerned, any prior surgery or treatment, new treatment requests, as well as approximate costs.

Services and procedures covered during hospitalisation (continued)

Service Category	Benefit
<p>12. Oncology (Continued)</p> <ul style="list-style-type: none"> (Including approved, related medication, MRI, CAT and radio-isotope scans as well as chemotherapy, radiotherapy, oncologists' consultations, mammograms, radiology and pathology fees) PET scans Brachytherapy (Including seeds and disposables) and equipment. Subject to the Oncology Managed Healthcare Programme. Specialised drugs for Oncology <ul style="list-style-type: none"> Biological drugs applicable to antibodies and interleukins, Tyrosine Kinase inhibitors, Proteasome Inhibitors, e.g. Bortezomib and Azacitidine. 	<ul style="list-style-type: none"> 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. <p>100% of MSR with a sub-limit of R22 450 per family per year, subject to the approval of the Case Manager.</p> <p>100% of MSR with a sub-limit of R33 920 per family per year.</p> <p>100% of medicine price with a sub-limit of R134 830 per year, subject to the Overall Oncology Benefit limit.</p>
<p>13. Non-Oncology specialised drugs</p> <ul style="list-style-type: none"> Biological drugs applicable to monoclonal antibodies and interleukins, Human Immunoglobulin for chronic use, Iron chelating agents for chronic use and Palivizumab (Syngaxis) for prevention of RSV infection. 	<p>100% of medicine price with a sub-limit of R134 830 per family per year, provided the patient enrolls on the Oncology Benefit Management Programme, subject to the Overall Oncology Benefit limit.</p>
<p>14. Macular degeneration drugs</p> <ul style="list-style-type: none"> (treatment of macular degeneration) 	<p>100% of medicine price with a sub-limit of R42 400 per family per year, subject to a motivation received from the provider and subsequent approval.</p>

Services and procedures covered during hospitalisation (continued)

Service Category	Benefit
19. Renal dialysis (including related pathology, scans and consultations).	<p>100% of MSR. Please note: A 12-month treatment plan must be submitted to the Case Manager and is subject to approval. This plan should include the following information:</p> <ul style="list-style-type: none"> • date of diagnosis, • area concerned, • any prior surgery or treatment, • ICD10 code, • tariff code, • doctor's practice number, • new treatment requested, and • the approximate cost. <p>Pre-authorization is required from the Chronic Benefit Management Department for the related medication from a preferred provider.</p>
20. HIV/AIDS Benefit	<p>On diagnosis, please register on the HIV/AIDS Management Programme. Benefits are unlimited, subject to the Scheme's guidelines for patients who are registered on the HIV/AIDS Management Programme for medication and medical management (including visits to general practitioners) and blood tests (provided that the tests are done by designated service providers). This is subject to compliance with the Scheme's protocols and guidelines regarding the management of HIV/AIDS. Mother-to-child, accidental exposure and rape-prophylactics must be pre-authorized by the HIV/AIDS Care Manager. For a rape case, the hospital will provide a three days "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-authorized by the Care Manager.</p> <ul style="list-style-type: none"> • HCT benefits (Government's National HIV Counselling and Testing Campaign) <p>It covers the following services:</p> <ul style="list-style-type: none"> • Pre-testing counselling, • Testing and post-test counselling. <p>Limited to 2 tests per beneficiary per year and subject to the preferred provider negotiated rate.</p>
21. All refractive procedures (Including excimer laser, radial keratotomy, holmium procedures, LASIK phakic lenses and intra-stromal rings).	<p>100% of MSR with a sub-limit of R5 170 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 with the set refraction limit within the Scheme's guidelines.</p> <p>Platinum Plan: Once this limit has been exceeded, claims will be paid from the Routine Medical Benefit.</p>

Services and procedures covered during hospitalisation (continued)

Service Category	Benefit
22. Artificial limbs and artificial eyes	<p>100% of cost according to clinical protocols, subject to the following sub-limits:</p> <ul style="list-style-type: none"> • R56 810 per artificial leg per beneficiary (every 2-3 years for children and every 5 years for adults). • R56 810 per artificial arm per beneficiary (every 2-3 years for children and every 5 years for adults). • R19 790 per artificial eye per beneficiary (every 2 years for a glass eye and every 5 years for an acrylic eye). <p>The benefits will be subject to pre-authorization and approval by the Case Manager, as well as the submission of three quotes before purchasing. The Case Manager will have the discretion to decide on the most appropriate quote to use.</p>
23. Home oxygen therapy Subject to the relevant managed healthcare programme and pre-authorization.	<p>100% of cost with a sub-limit of R13 360 per family per year.</p> <p>Please note: You must apply for this benefit and it must be pre-authorized by the Case Manager.</p>
24. Hyperbaric oxygen therapy	<p>100% of cost with a sub-limit of R43 690 per family per year.</p> <p>Please note: This benefit must be motivated by a specialist and pre-authorized 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.</p>
25. Stoma care products	<p>100% of cost with a sub-limit of R15 540 per family per year, subject to pre-authorization by the Case Manager.</p>
26. Breast reduction	<p>100% of MSR.</p> <p>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 criteria applied by the Scheme.</p>

Treatment by a specialist while in hospital

- If you are diagnosed and need to be admitted to hospital for a procedure, it will be to your advantage if the admitting specialist is part of the Nedgroup specialist network, as you will obtain cover of up to 2 x MSR.
 - If your treating specialist is not part of the Nedgroup specialist network, all accounts will be covered at 100% of MSR.
 - 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-certification or admission.**

Hospital Plan, Savings Plan, Traditional Plan and Platinum Plan	Traditional Plus Plan
<ul style="list-style-type: none">• To find out whether the specialist is on the Nedgroup specialist network, please contact Medscheme at 0860 100 080.	<ul style="list-style-type: none">• To find out whether the specialist is on the Nedgroup specialist network, please contact ONECARE at 0860 101 159.

What services in doctors' rooms are covered?

If you have obtained a pre-certification number, certain procedures that are undertaken in doctors' rooms will be covered under your Hospital and Trauma Benefits at 100% of cost or MSR, 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)
- Sigmoidoscopy
- Surgical biopsies (needle biopsies) (subject to motivation)
- Tonsillectomy (laser)
- Vasectomy
- 0300 Stitching of wound
- 0301 Stitching of additional wound
- 0307 Excision and repair
- 0255 Drainage of subcutaneous abscess & avulsion of nail
- 2133 Circumcision-clamp
- Any other minor procedures (subject to motivation)

How do the Managed Care programmes for cancer, HIV/AIDS and organ transplants work?

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

- Oncology Benefit Management Programme
- Aid for AIDS (or CareWorks for Traditional Plus Plan members)
- Renal dialysis and organ transplants



Oncology Benefit Management Programme (for cancer patients)

If you are diagnosed with cancer, 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.

- By joining the Programme, you will qualify for the annual Oncology family limit.
- 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.
- You will be required to submit a proposed care plan from your treating oncologist for pre- authorisation before treatment commences. If your care plan is not approved, the Oncology limit will not cover you and all cancer-related accounts will be paid from your Everyday Services Benefits.
- The Oncology Case Manager will address any concerns with the treating oncologist.

The care plan from your treating oncologist should provide the following information:

- the date of diagnosis;
- diagnosis code (ICD10);
- the area concerned;
- any prior surgery or treatment;
- new treatment requested; and
- approximate costs.

Hospital Plan, Savings Plan, Traditional Plan and Platinum Plan	Traditional Plus Plan
<ul style="list-style-type: none"> • Please submit your care plan to Medscheme via email 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 at 0860 100 572. 	<ul style="list-style-type: none"> • Please submit your care plan by fax to the Oncology Case Manager, ONECARE Clinical Referral Centre. • Fax: 021 413 0512. • If you have any queries regarding the Oncology Benefit Management Programme or your condition, please contact the Oncology Case Manager at 0860 102 183.

Your care plan will be evaluated and, where necessary, discussed with the treating oncologist in order to manage your condition in relation to the benefits available to you. If this programme changes at any time, your oncologist must obtain approval from the Oncology Case Manager by submitting a revised care plan before treatment commences.

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

HIV and AIDS management programme

The purpose of the HIV and AIDS Management Programme is to support HIV-positive members or dependants through counselling and education, to coordinate their treatment via their provider, to manage their benefits optimally and to optimise the medical costs resulting from the treatment. By joining this programme, you will qualify for unlimited benefits per beneficiary, subject to the HIV/AIDS treatment guidelines.

This includes the following services:

- telephone counselling to members and their family;
- authorisation of anti-retroviral therapy (ART);
- medical practitioner consultations; and
- blood tests you will need for the treatment of this condition.

Any member or registered dependant on the Scheme who has tested positive for HIV/AIDS should join the HIV and AIDS Management Programme. It is important to register as soon as you are diagnosed, even before your doctor says you are ready for treatment. This will enable you to gain access to invaluable support and guidance, thus preparing you mentally and emotionally for the journey ahead. You will also be well placed to be introduced to treatment at the right time, which is critical for improving the effectiveness of the medicine.

Early treatment, close monitoring and appropriate drug regimes can help members with HIV/AIDS to enjoy healthier and more productive lives. Where the condition is treated sooner rather than later (in line with a professionally developed and managed programme), the need for frequent hospitalisation and visits to the doctor is likely to reduce.



HIV and AIDS management programme (continued)

Hospital Plan, Savings Plan, Traditional Plan and Platinum Plan	Traditional Plus Plan
<ul style="list-style-type: none"> Managed by Aid for AIDS (AfA). To join the Programme, call Aid for AIDS on 0860 100 646. 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. If you select a specialist from the Nedgroup specialist network, you will obtain full cover (no co-payments) for your specialist accounts. 	<ul style="list-style-type: none"> Managed by CareWorks. To join the Programme, call CareWorks on 0860 101 110. The CareWorks Case Manager can assist with all your questions regarding the condition, its treatment, social issues or any concerns that you may have. If you are concerned that you may be HIV-positive and want to undergo an HIV test, CareWorks can help you. If you select a specialist from the Nedgroup specialist network, you will obtain full cover (no co-payments) for your specialist accounts.

Your clinical information is confidential and only accessible by the Care Manager. Therefore no-one, not even your employer or the Board of Trustees of the Scheme, will be notified about your enrolment on the Programme, or the HIV status of a beneficiary.

Renal dialysis and organ transplants

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

Hospital Plan, Savings Plan, Traditional Plan and Platinum Plan	Traditional Plus Plan
<ul style="list-style-type: none"> A 12-month care plan must be submitted to, and approved by, the Case Manager. This plan should include the following information: <ul style="list-style-type: none"> date of diagnosis; the area concerned; any prior surgery or treatment; ICD10 code; tariff code; practice number of doctor or supplier; and new treatment requested as well as approximate costs. Please submit your care plan to: Hospital Benefit Management, PO Box 1094, Woodstock, 7915 	<ul style="list-style-type: none"> A 12-month care plan must be submitted to, and approved by, the Case Manager. This plan should include the following information: <ul style="list-style-type: none"> date of diagnosis; the area concerned; any prior surgery or treatment; ICD10 code; tariff code; practice number of doctor or supplier; and new treatment requested as well as approximate costs. Please submit your care plan to: Case Manager ONECARE PO Box 44991, Claremont. 7735

What should we do in an emergency situation?

You and your registered dependants will have access to emergency medical transportation in South Africa 24 hours a day, provided that this is authorised by ER24 (the Scheme's new DSP for emergency 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
- Authorised inter-hospital transfers

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

Remember that, in the case of an emergency where you (or your dependants) are admitted to hospital, you must arrange to notify the Scheme on the first working day after being admitted (see [page 11](#) for more information).

What to do in a medical emergency

- Always call or get someone to call: 084 124 or 0861NED911 (0861 633 911)**
- Tell the ER24 operator that you are a Nedgroup Medical Aid Scheme member - they will prompt you or the caller through all the information they require to get help to you.**



4. Benefits: Prescribed Minimum Benefits (PMB)

(These benefits are the same across all Plans.)

IN THIS SECTION

- [What are PMB?](#)
- [Why do we have PMB?](#)
- [Which PMB conditions are covered by the Scheme?](#)
- [Who are the Scheme's designated service providers for PMB?](#)
- [How do I register on the PMB Medical Management Programme?](#)



What are PMB?

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 (PMB) 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.

PMB 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; and
- 26 chronic conditions (defined in the Regulations and published under the PMB Chronic Condition List on [page 34](#) of this member guide).

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	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 PMB?

There are two reasons why PMB are in place:

- To ensure that medical scheme beneficiaries have continuous cover for healthcare. 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 doctors suspect that the patient is suffering from a condition covered by PMB, the medical scheme has to approve treatment. Schemes may request that the diagnosis be confirmed with 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 an acute 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 on 0860 100 080 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 ICD 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

Hospital Plan, Savings Plan, Traditional Plan and Platinum Plan	Traditional Plus Plan
<ul style="list-style-type: none"> • You can contact the Scheme at 0860 100 080 to enquire about the reason for the rejection and process to follow. 	<ul style="list-style-type: none"> • You can contact ONECARE at 0860 103 491 to enquire about the reason for the rejection of the claim.
<p>It is important to check that your practitioner has put the correct codes on your invoice.</p>	

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 PMB?

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 specialists 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 account will be paid from the PMB benefit.

Alternatively, you may wish to continue consulting your own general practitioner or specialist, even if he/she is not part of the network. In such a case your account will be paid from available Everyday Services Benefits at MSR and thereafter be covered from the PMB benefit with a co-payment of 25% that you will need to cover from your own pocket.

Hospital Plan, Savings Plan, Traditional Plan and Platinum Plan	Traditional Plus Plan
<ul style="list-style-type: none"> • To find out whether the specialist is on the Nedgroup specialist network, please contact Medscheme at 0860 100 080. • The consultant will confirm whether the specialist is part of the Nedgroup specialist network, or provide details of the specialists on the network. 	<ul style="list-style-type: none"> • To find out whether the specialist is on the Nedgroup specialist network, please call 0860 101 159. • The consultant will confirm whether the specialist is part of the network, or provide details of specialists on the network.

Pharmacies

ScriptNet 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 20 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 ScriptNet pharmacy.

Further to this the regulations stipulate that a member's 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.

Hospital Plan, Savings Plan, Traditional Plan and Platinum Plan	Traditional Plus Plan
<ul style="list-style-type: none"> • To apply for authorisation for chronic medicines, please contact ScriptPharm Risk Management on (010) 591 0150 Monday to Friday, 08:00 – 17:00 or fax the application form to 0866 791 579 or email pre-auth@scriptpharm.co.za. 	<ul style="list-style-type: none"> • To apply for authorisation for chronic medicines, please contact ScriptPharm Risk Management on (010) 591 0150 Monday to Friday, 08:00 – 17:00 or fax the application form to 0866 791 579 or email pre-auth@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?

Hospital Plan, Savings Plan, Traditional Plan and Platinum Plan	Traditional Plus Plan
<ul style="list-style-type: none"> Please contact Chronic Medicine Management at 0860 100 081 Medical practitioners will be provided with a share-call hotline for registering and updating medical management treatment plans. 	<ul style="list-style-type: none"> Please contact the ONECARE Clinical Referral Centre at 0860 102 183.

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; and
- Whether you are already registered as a chronic medicine user.

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



5. Benefits: Chronic Conditions

(Cover depends on Plan selected.)

IN THIS SECTION

- [What is a chronic condition?](#)
- [Which basic chronic conditions are covered by all Plans?](#)
- [What additional chronic medicine benefits are covered under each Plan?](#)
- [How does payment for chronic medication work under each Plan?](#)
- [How do I apply for the Chronic Medicine Benefit?](#)
- [How do I make changes to my chronic medication?](#)
- [Who are the Scheme's designated service providers for chronic medication?](#)



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 of these conditions.

Which basic chronic conditions are covered by all Plans?

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 *26 PMB Chronic Conditions* listed in the left-hand side of the table below. To manage the risk and ensure that appropriate standards of health are applied, so-called 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 provide is not allowed to be inferior to the published algorithms.

If you have one of the 26 PMB chronic conditions, your medical scheme not only has to cover chronic medication, but also the doctor's consultations and certain tests related to your condition. The Scheme may make use of protocols, formularies (list of specified medicines) and Designated Services Providers to manage this benefit.

Registered Chronic Conditions

A further 20 chronic conditions are covered by the Scheme – see *20 Other Registered Chronic Conditions* listed in the right-hand side of the table below.

PMB Chronic Conditions	20 Other registered Chronic Conditions
1. Addison's disease	1. Anxiety (if linked to another approved psychiatric chronic condition)
2. Asthma	2. Acne (cystic nodular)
3. Bipolar mood disorder	3. Allergic rhinitis (if beneficiary has asthma or is under 12 years)
4. Bronchiectasis	4. Attention deficit syndrome (if prescribed by a specialist and under the age of 18 years)
5. Cardiac failure	5. Alzheimer's disease
6. Cardiomyopathy disease	6. Deep vein thrombosis
7. Chronic renal disease	7. Depression/mood disorders
8. Chronic obstructive pulmonary disease (emphysema)	8. GORD (if linked to another PMB condition)
9. Coronary artery disease (angina pectoris and ischaemic heart disease)	9. Gout (if linked to hypertension and/or diabetes)
10. Crohn's disease	10. Hormone replacement therapy
11. Diabetes insipidus	11. Hypofunction of the pituitary gland
12. Diabetes mellitus type 1 & 2	12. Hypotension
13. Dysrhythmias	13. Hyperfunction of the pituitary gland
14. Epilepsy	14. Hyperthyroidism
15. Glaucoma	15. Hypoparathyroidism
16. Haemophilia	16. Insomnia (sleep disorders) (if linked to another approved psychiatric condition)
17. HIV/AIDS*	17. Migraine prophylactics (prevention)
18. Hyperlipidaemia (high cholesterol)	18. Osteoarthritis
19. Hypertension (high blood pressure)	19. Osteoporosis
20. Hypothyroidism	20. Psoriasis
21. Multiple sclerosis	
22. Parkinson's disease	
23. Rheumatoid arthritis	
24. Schizophrenia	
25. Systemic lupus erythematosus	
26. Ulcerative colitis	

* Please refer to **HIV AND AIDS MANAGEMENT PROGRAMME** under the Hospital and Trauma Benefits section for more information about benefits available.

What additional chronic medicine benefits are covered under each Plan?

	P Platinum Plan	T+ Traditional Plus Plan	T Traditional Plan	S Savings Plan	H Hospital Plan
26 PMB Chronic conditions	100% of medicine price for PMB and non-PMB chronic medicine subject to R7 700 per family per year, provided it is obtained from a DSP (ScriptNet pharmacy).	100% of cost for chronic medication paid from PMB benefit, provided it is obtained from a DSP (ScriptNet pharmacy).		100% of cost for chronic medication paid from PMB benefit, provided it is obtained from a DSP (ScriptNet pharmacy).	
20 Other registered Chronic conditions	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 (ScriptNet pharmacy). Advanced Medicine Formulary applies. No further benefit for 20 other registered chronic conditions.	Advanced Medicine Formulary list applies.	Standard Medicine Formulary list applies.	Standard Medicine Formulary list applies.	No cover for 20 other registered chronic conditions.
		100% of medicine price, limited to R7 700 per family per year, provided it is obtained from a DSP (ScriptNet 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.		100% of medicine price, limited to R7 700 per family per year, provided it is obtained from a DSP (ScriptNet 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.	

What additional chronic medicine benefits are covered under each Plan? (continued)

	P	T+	T	S	H
	Platinum Plan	Traditional Plus Plan	Traditional Plan	Savings Plan	Hospital Plan
Medical Management of 26 PMB Chronic Conditions	100% of cost at DSP paid from PMB benefit, subject to the Schemes 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.				
DSP for Chronic Medication	ScriptNet Pharmacies is the DSP for chronic medication				

How does payment for chronic medication work under each Plan?

Members will receive unlimited Chronic Medicine Benefits for the 26 PMB chronic conditions. This applies to members on all Plans, provided that you use a DSP. There is, however, a sub-limit for the other registered Chronic Conditions, which is applicable to all Plans except the Hospital Plan. The Hospital Plan does not have any cover for the other registered Chronic Conditions.

For members on the Platinum Plan, both the PMB and non-PMB chronic medicine claims are paid from the chronic medicine benefit sub-limit, provided that you use a DSP. Once this sub-limit is exceeded, claims will be paid from the overall Everyday Services Routine Medical Benefit and thereafter you will have unlimited cover for PMB chronic medicine from the PMB benefit, provided the chronic medicine is obtained from a DSP.

Once you have utilised the benefits for other registered Chronic Conditions for the year, any additional costs will be recovered as follows:

- P Platinum Plan:** From your Routine Medical Benefit limit. If no more benefits are available, you will have to pay in full at the point of sale.
- T+ Traditional Plan:** From your Prescribed Medicines limit. If no more benefits are available, you will have to pay in full at the point of sale.
- T Traditional Plus Plan:** From your Prescribed Medicines limit. If no more benefits are available, you will have to pay in full at the point of sale.
- S Savings Plan:** From your Medical Savings Account, if there are funds available. Otherwise you will need to pay in full at the point of sale.
- H Hospital Plan:** No benefit for other registered Chronic Conditions. You will need to pay in full at the point of sale.

How do I apply for the Chronic Medicine Benefit?

Should you 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 registered Chronic Conditions list to ensure that your condition is covered on your selected Plan. Refer to [page 34](#) for a full list of conditions covered.
- Complete a chronic medicine application form. Application forms can be obtained on the intranet or from the ScriptPharm website at www.scriptnet.co.za, or call ScriptPharm on 010 591 0150 to request a 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 as per the details above.
- 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 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 to your pharmacist. Pharmacies will not dispense your chronic medication without a valid prescription.

Please note: It will take a maximum of five working days for your application to be processed.

Your application will be processed as follows (continued):

Hospital Plan, Savings Plan, Traditional Plan and Platinum Plan	Traditional Plus Plan
<p>Please contact ScriptPharm Risk Management on:</p> <p>Postal address: ScriptPharm Risk Management P O Box 653590 Benmore 2010</p> <p>Telephone: 010 591 0150 Fax: 086 679 1579 E-mail: nedgroup@scriptpharm.co.za</p> <p>Business hours: Monday to Friday 08:00 – 17:00</p>	<p>Please contact ScriptPharm Risk Management on:</p> <p>Postal address: ScriptPharm Risk Management P O Box 653590 Benmore 2010</p> <p>Telephone: 010 591 0150 Fax: 086 679 1579 E-mail: onecare@scriptpharm.co.za</p> <p>Business hours: Monday to Friday 08:00 – 17:00</p>

Other chronic diseases

Authorisation for other chronic conditions, e.g. 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 the Chronic Medicine Management department at Medscheme (or ONECARE for members on the Traditional Plus Plan).

Hospital Plan, Savings Plan, Traditional Plan and Platinum Plan	Traditional Plus Plan
Should you be diagnosed with one of the 270 other chronic conditions listed as PMB conditions, please contact the Chronic Medicine Management department at 0860 100 081.	Should you be diagnosed with one of the 270 other chronic conditions listed as PMB conditions, please contact the ONECARE Clinical Referral Centre at 0860 102 183.

How do I make changes to my chronic medication?

If you need new or additional medication for a registered chronic condition, your medical practitioner or pharmacist may contact ScriptPharm to process your requested change. 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 010 591 0150. 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; and
- Patient’s contact details; for example, telephone number, fax number, postal address and/or e-mail address.

When applying for an additional month’s supply of chronic medication, please supply the following in advance:

- A completed “Extended supply” application form (obtainable from the intranet or ScriptPharm’s website at www.scriptnet.co.za) with 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 registered chronic conditions from the Scheme’s designated service providers (DSP).

The Scheme’s DSP for chronic medication are as follows:

- **ScriptNet Pharmacies:** The ScriptNet Pharmacies network has been identified as the Scheme’s DSP for chronic medication. To find out where the nearest ScriptNet Pharmacy is, you may contact:

Tel: 010 591 0150
E-mail: nedgroup@scriptpharm.co.za
Website: www.scriptnet.co.za (click on Locate a ScriptNet Pharmacy)

- **Clicks Direct Medicines (courier pharmacy):** If you currently obtain your chronic medication from Clicks Direct Medicines or if you are a new chronic medicine user and prefer to use a courier pharmacy, or do not live within a reasonable distance of a ScriptNet Pharmacy, you may use Clicks Direct Medicines as your DSP.

Postal address:
PO Box 751902
Gardenview
2047

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

General fax line:
0861 44 44 14 / 0861 44 44 12

6. Benefits: Wellness Benefits

(These benefits are the same across all Plans.)

IN THIS SECTION

- [How can the Wellness Benefits help me?](#)
- [Where can I access these benefits?](#)



How can the Wellness Benefits help me?

This preventative benefit is available on all the Plans. It gives you access to the ScriptNet pharmacy Screening Programme and allows you and your dependants to visit a participating ScriptNet wellness pharmacy so that a qualified nurse can give you advice on how to improve your health.

You will be covered for the following tests (one set of tests per beneficiary per year):

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

Where can I access these benefits?

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

Tel: 010 591 0150

E-mail: nedgroup@scriptpharm.co.za



7. Benefits: Everyday Services

(Cover depends on Plan selected.)

IN THIS SECTION

- [What types of everyday services are covered?](#)
- [How do the following Plans work?](#)
 - [Platinum Plan](#)
 - [Traditional Plus Plan](#)
 - [Traditional Plan](#)
 - [Savings Plan](#)
 - [Hospital Plan](#)



What types of everyday services are covered?

Everyday Services Benefits typically cover medical treatment that you receive out of hospital or as an out-patient at a hospital. Unlike the services and procedures covered under Hospital and Trauma Benefits, these are usually lower 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 below for more information.

Flu injections, anti-malaria tablets and contraceptives (excluding condoms) are covered under Everyday Services Benefits. Other vaccines and immunisation for babies are only covered on the Savings and Platinum Plan; otherwise these will be for your own account. 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 (or according to the ONECARE acute medicine formulary, for Traditional Plus Plan members).

How do the following Plans work?

- P** [Platinum Plan](#)
- T+** [Traditional Plus Plan](#)
- T** [Traditional Plan](#)
- S** [Savings Plan](#)
- H** [Hospital Plan](#)

P Platinum Plan

The Platinum Plan provides maximum flexibility and peace of mind, with Everyday Services Benefits paid at up to 3 x MSR.

- The benefits structure is such that once the dentistry, optical or maternity sub-limits have been depleted, claims will continue to be paid from the Routine Medical Benefit limit.
- No medical savings account allocation can be made on this Plan.
- The cover of 3 x MSR applies only to Everyday Services Benefits, while all in-hospital benefits are covered at 100% of MSR. The Routine Medical Benefit limit covers all your routine medical needs at Private Provider Rates (PPR), up to 3 x of MSR. These include general practitioner and specialist visits, procedures out of hospital not covered under Hospital and Trauma Benefits, acute medicines, antenatal vitamins, supplementary health services, physiotherapy, medical appliances, hearing aids, physiotherapy radiology and pathology.
- Should there be a shortfall between the benefit covered (at PPR) by the Scheme and the actual cost of the service, you will need to pay this difference at the point of sale. Refer to the detailed tables below for more information on what is covered on the Platinum Plan.

Routine Medical Benefit limit

This limit covers all your routine medical needs, paid at PPR (capped at 3 x MSR) up to the following available limits:

Single M	A	C
R11 880	R8 810	R2 935

M= Member | **A**= Additional Adult | **C**= Child dependant

The Routine Medical Benefit covers the following:

- **Visits** to general practitioners, homeopaths and specialists.
- **Procedures out-of-hospital** not covered under the Hospital and Trauma benefits.
- **Prescribed (acute) medicine** including Pharmacy Advised therapy (excluding the administration fee). The funding of compound analgesics e.g. Mypradol®, 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 Chronic Medicine Management department on 0860 100 608. The agents on this line will consider verbal motivations from medical professionals and members will be provided with the details of the information that is required to motivate for additional medication.
- **Antenatal vitamins** prescribed during pregnancy (excluding calcium supplements and Omega preparations).
- **Supplementary health services** - acupuncturists, anthroposophical treatment, applied kinesiology, audiometry/audiology, autologous donation of blood, ayurvedic treatment, biokinetics, chiropody, chiropractic services, naturopaths, occupational therapy, orthoptic treatment, osteopaths, phytotherapy, podiatry, reflexology, remedial therapy, speech therapists and social workers.

The Routine Medical Benefit covers the following (continued):

- **Physiotherapy** following hospitalisation is covered under the Hospital and Trauma Benefits, provided it is 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.
- **X-rays** – out of hospital.
- **Pathology** – out of hospital.
- **Eye tests**
- Once the **Optical benefits** limit has been exceeded, you may submit claims under this benefit.
- **Childhood vaccinations** - in a private clinic or at a doctor.
- **Medical appliances**
- **Hearing aids** – Benefit available per beneficiary every 24 months.
- **Psychology** – out of hospital.
- Once the **Maternity benefit** limit has been exceeded, you may submit claims under this benefit.
- **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.

Sub-limits for certain services

The following benefits are paid at 3 x MSR up to the specified sub-limits. Once these sub-limits have been exceeded, claims will be paid from the Routine Medical Benefit limit:

Service	M	A	C
<ul style="list-style-type: none"> • Basic and Advanced dentistry 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. Inlays, bridgework, crowns excluding gold content, mounted study models, metal base partial dentures, orthodontics, periodontists, prosthodontists and dental technicians. 	<p>R4 010 per beneficiary per year Once this limit is exceeded, claims will be paid from the Routine Medical Benefit.</p>		
<ul style="list-style-type: none"> • Optical Lenses, contact lenses, fitting of lenses and frames. 	<p>R3 450 per beneficiary per year Once this limit is exceeded, claims will be paid from the Routine Medical Benefit.</p>		
<ul style="list-style-type: none"> • Maternity Antenatal visits, ultrasound scans and antenatal classes. 	<p>R5 620 per family per year Once this limit is exceeded, claims will be paid from the Routine Medical Benefit.</p>		

T+ Traditional Plus Plan

The Traditional Plus Plan is managed by ONECARE and any queries that you have about the Plan should be directed to ONECARE.

This Plan offers comprehensive benefits up to pre-determined sub-limits, with services paid at cost or MSR, whichever is the lesser. Once these sub-limits have been reached, the Plan **continues to offer access to primary healthcare cover**, on condition that you register/consult with a ONECARE GP for these additional services (a network of more than 2 700 GP's).

This Plan ensures that you do not run out of medically necessary access to GP consultations, prescribed medicines, radiology and pathology benefits obtained at a ONECARE GP, subject to the ONECARE formulary and approved tariff list.

You will find a list of contracted GPs on the ONECARE website, www.carecross.co.za / www.onecarehealth.co.za. As with any GP consultation, you need to make an appointment before you see your chosen ONECARE doctor.

Everyday Services Benefits

Claims will initially be paid from the various sub-limits. Once these sub-limits have been reached, you will have access to the following additional benefits via the ONECARE general practitioner:

- **Access to additional General Practitioner benefits once sub-limit has been reached**
Once you have exhausted the General Practitioner and Specialist sub-limit, certain procedures performed in your chosen ONECARE GP's surgery, as well as radiology and pathology tests as requested by this ONECARE GP subject to the ONECARE protocols and approved tariff lists, are covered.
- **Access to additional Prescribed Medicines once the medicine sub-limit has been reached**
Once the medicine sub-limit has been exhausted, you will also enjoy additional cover for acute medication as prescribed or dispensed by your chosen ONECARE GP according to a comprehensive ONECARE medicine formulary list. Your doctor will refer to this list when dispensing or prescribing medicines. Antenatal vitamins prescribed during pregnancy (excluding calcium supplements and Omega preparations) are also covered.

If your GP is a licensed dispensing doctor, the practice will provide you with acute medication as per the ONECARE acute medicine formulary. If your ONECARE GP is not a licensed dispensing doctor, you will be given a prescription that should be taken to your nearest ONECARE contracted pharmacy. The pharmacist will claim directly from ONECARE and you will not have to pay for these medicines. Where the medicine prescribed is not on the formulary, you can ask the pharmacist for an equivalent on the formulary, otherwise you will be required to pay for the medicines out of your own pocket at point of sale and no benefit will be allowed. If you consult a GP who is not part of the network and the GP gives you a prescription, you will be required to pay for this medication out of your own pocket.

To find out whether your prescribed medicines are on the ONECARE acute medicine formulary, refer to the ONECARE website (www.carecross.co.za / www.onecarehealth.co.za) for a copy of the latest acute medicine formulary, or contact 0860 103 491.

You will find a list of contracted pharmacies on the ScriptNet website at www.scriptnet.co.za (click on *Locate a ScriptNet Pharmacy*).

Access to additional Specialist benefits

Once the sub-limit for General Practitioner and Specialist services has been reached, you can only access the additional specialist benefits as well as procedures in specialists' rooms if you are referred by a ONECARE GP and you use a specialist authorised by ONECARE. You will need to contact the ONECARE Clinical Referral Centre to obtain the necessary authorisation number before visiting the specialist.

If you are not referred by your ONECARE GP and you do not obtain the necessary authorisation, no benefits will be payable and you will be liable for the payment of these services. **Please contact ONECARE to obtain the necessary authorisation number before going to the specialist.**

Pathology and Radiology Services

All pathology and radiology services will initially be paid from the pathology and radiology sub-limits. Once these limits have been reached, you will have access to additional pathology and radiology services out of hospital, provided that the services were requested by the ONECARE GP and that these services are in accordance with the ONECARE approved tariff list.

Frequently asked questions

What if my chosen ONECARE GP leaves the network?

Should your chosen ONECARE GP decide to leave the network, you will be contacted as soon as ONECARE becomes aware of the GP's decision to leave, so that you may choose another ONECARE provider in your area.

When will I be liable for the payment of primary care services?

You will be liable in the following instances:

- If the annual sub-limit for General Practitioners has been reached and you do not consult your chosen ONECARE GP.
- If the annual sub-limit for General Practitioners has been reached and your chosen ONECARE GP performs surgical procedures not covered by the ONECARE benefit and tariff structure.
- If your annual sub-limit for prescribed medicine has been reached and your chosen ONECARE GP prescribes medication that is not on the Prescribed Medicine Formulary list.
- If the annual radiology and pathology sub-limits have been reached and the services received from a radiologist or pathologist are not covered by the benefit and tariff structure of the Scheme (i.e. tests are requested by a specialist or non-ONECARE GP).

How do I ensure the timeous payment of claims?

To ensure that claims are paid timeously, claims should be submitted directly to ONECARE.

What happens if my annual sub-limit for General Practitioners has been reached and I am out of town/on holiday when I get sick and have to go to a doctor? Will you pay the account?

As long as you see a General Practitioner on the ONECARE network, the account will be paid. If you see a non-ONECARE network provider the account will not be paid and you will be liable for the settlement of this account.

Can I go to any dentist or must I go to a ONECARE dentist?

Members can go to their dentist of choice.

What supplementary health services are available?

Supplementary health services include 23 practice areas including acupuncturists, anthroposophical treatment, applied kinesiology, audiometry/audiology, autologous donation of blood, ayurvedic treatment, biokinetics, chiropody, chiropractic services, clinical technology, dieticians, herbalists, naturopaths, occupational therapy, orthoptic treatment, osteopaths, phytotherapy, podiatry, reflexology, remedial therapy, speech therapists, social workers. These will be paid at 100% of cost or MSR, whichever is the lesser, up to the available limit.

Traditional Plus Plan

Services	M	A	C
<p>1. GP, Homeopath and Specialist consultations Visits, consultations, outpatient visits and procedures out-of-hospital not covered under Hospital and Trauma Benefits, as stated on page 14 - 21, paid at 100% of cost or MSR, whichever is the lesser, up to the available limit.</p> <ul style="list-style-type: none"> • Access to additional GP visits once limit is exceeded. • Access to additional procedures performed in a ONECARE GP's rooms once limit is exceeded (Surgery that would have necessitated hospital admission.) • Access to additional Specialist consultations (subject to referral) once limit is exceeded. • Access to additional Procedures performed in a specialist's room, if referred by your ONECARE GP. Pre-authorisation needs to be obtained for specialists consultation, paid at 100% of cost or MSR, whichever is the lesser. 	R1 490	R1 485	R885
	100% of cover for basic primary care at your chosen ONECARE GP.		
	Code 0887 Limb cast, including cost of plaster of paris and other material and procedures out-of-hospital not covered under Hospital and Trauma benefits, as stated on page 14 - 21 . You will be reimbursed according to the approved diagnosis and procedure codes.		
	1 visit per year	3 visits per family per year	
	R1 055	R2 110 per family per year	

Traditional Plus Plan (continued)

Services	M	A	C
<p>2. Basic dentistry Paid at 100% of cost or MSR, whichever is the lesser. 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.</p>	R2 245 per beneficiary per year. Once this limit is exceeded, claims will be paid from the Advanced dentistry limit.		
<p>3. Advanced dentistry Paid at 100% of cost or MSR whichever is the lesser. Inlays, bridgework, crowns excluding gold content, mounted study models, metal base partial dentures, orthodontics, periodontists, prosthodontists and dental technicians.</p>	R2 230	R1 490	R740
<p>4. Medicine</p> <ul style="list-style-type: none"> Prescribed medicines Once the limit is exceeded, 100% cover for medicine prescribed or dispensed by your contracted ONECARE provider according to the prescribed medicine formulary. No benefit paid for medicines not included in the prescribed medicine formulary. Includes antenatal vitamins prescribed during pregnancy (excluding calcium supplements and Omega preparations). 	R2 230	R1 490	R740
<ul style="list-style-type: none"> Pharmacy advised therapy (PAT) Paid from the Prescribed Medicine limit Access to additional Prescribed Medicines once limit exceeded 	R1000 per family (subject to the prescribed medicines limit) as prescribed or dispensed by your chosen ONECARE GP according to a comprehensive ONECARE medicine formulary list. Antenatal vitamins prescribed during pregnancy (excluding calcium supplements and Omega preparations) are also covered.		
<p>5. Pathology Paid at 100% of cost or MSR, whichever is the lesser, up to the available limit.</p> <ul style="list-style-type: none"> Access to additional Pathology benefits once limit exceeded where requested by the ONECARE GP in accordance with the ONECARE approved tariff list 	R1 335	R450	R155
	100% of cover for pathology tests requested by ONECARE GP and on the ONECARE approved tariff list.		

Traditional Plus Plan (continued)

Services	M	A	C
<p>6. Radiology Paid at 100% of cost or MSR, whichever is the lesser, up to the available limit.</p> <ul style="list-style-type: none"> Access to additional Radiology benefits once limit exceeded where requested by the ONECARE GP in accordance with the ONECARE approved tariff list. 	R1 785 per family per year. 100% of cover for radiology tests requested by ONECARE GP and on the ONECARE approved tariff list.		
<p>7. Supplementary health services* (e.g. chiropody, chiropractic services, speech therapists, biokinetics), paid at 100% of cost or MSR, whichever is the lesser, up to the available limit *Refer to the previous pages for a full list of services.</p>	R1 490	R1 485	R885
<p>8. Physiotherapy Paid at 100% of cost or MSR, whichever is the lesser, up to the available limit. Physiotherapy following hospitalisation is covered under the Hospital and Trauma Benefits, provided it is 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.</p>	R2 380 per family per year.		
<p>9. Psychology Paid at 100% of cost or MSR, whichever is the lesser, up to the available limit.</p>	R4 460 per family per year.		
<p>10. Medical appliances Not forming an integral part of an operation, e.g. baumanometer, all orthopaedic braces, wheelchairs and crutches. These are paid at 100% of cost or MSR, whichever is the lesser, up to the available limit. 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.</p>	R7 430 per family per year. The frequency of the benefit will be subject to the Scheme's clinical protocols.		

Traditional Plus Plan (continued)

Services	M	A	C
<p>11. Hearing aids</p> <p>Can be purchased or hired and will be paid for, following motivation by the treating doctor and approval by the Scheme before acquisition.</p> <ul style="list-style-type: none"> These are paid at 100% of cost or MSR, whichever is the lesser, up to the available limit. 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. 	<p>R24 800 per family for dependants 6 years and younger.</p> <p>R11 880 per family for dependants 7 years and older.</p> <p>Benefit available per beneficiary every 24 months.</p>		
<p>12. Optical benefits</p> <ul style="list-style-type: none"> Eye test unlimited (payable from the Optical benefit limit and, once exceeded, payable from the Overall Annual Limit) Lenses, contact lenses and fittings paid at 100% of cost or MSR, whichever is the lesser, up to the available limit. Frames subject to the available limits up to a maximum of R670 per beneficiary every 24 months, included in the optical limit. 	R1 785	R1 195	R595
<p>13. Maternity benefits</p> <p>Paid at 100% of cost or MSR, whichever is the lesser, up to the available limit.</p>	<ul style="list-style-type: none"> Antenatal visits: R2 185 per family per year. Ultrasound scans: 2 x two-dimensional scans per family per year. Antenatal classes: R910 per family per year. 		

T Traditional Plan

The Traditional Plan offers comprehensive benefits up to pre-determined sub-limits, with services paid at cost or MSR, whichever is the lesser. No medical savings account allocation can be made on this Plan.

The following services are covered, with specific sub-limits for each:

- General practitioners and specialists (visits, consultations, outpatients, procedures out of hospital not covered under Hospital and Trauma Benefits)
- Basic dental services
- Intermediate and advanced dentistry (inlays, crowns, bridgework, mounted study models, metal base partial dentures, treatment by periodontists, treatment by prosthodontists and dental technicians fees), paid at 100% of MSR
- Prescribed medicines paid at 100% of maximum medical aid price and antenatal vitamins prescribed during pregnancy (excluding calcium supplements and Omega preparations)

- Pathology
- Radiology (including x-rays and mammograms)
- Supplementary health services (23 practice areas including acupuncturists, anthroposophical treatment, applied kinesiology, audiometry/audiology, autologous donation of blood, ayurvedic treatment, biokinetics, chiroprody, chiropractic services, clinical technology, dieticians, herbalists, naturopaths, occupational therapy, orthoptic treatment, osteopaths, phytotherapy, podiatry, reflexology, remedial therapy, speech therapists, social workers)
- Physiotherapy
- Psychology
- Medical appliances
- Hearing aids
- Optical benefits (unlimited eye tests, but frames and lenses are subject to limits)
- Maternity benefit (sub-limits for antenatal visits, ultrasound scans and antenatal classes).
- Specific sub-limits are set out in the table below. 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.

Traditional Plan

The following annual limits apply:

Services	M	A	C
<p>1. General practitioners, homeopaths and specialists:</p> <p>Visits, consultations, outpatient visits and procedures out-of-hospital not covered under Hospital and Trauma Benefits, as stated on page 14 - 21, paid at 100% of cost or MSR, whichever is the lesser, up to the available limit.</p>	R1 490	R1 485	R885
<p>2. Basic dentistry</p> <p>Paid at 100% of cost or MSR, whichever is the lesser.</p> <p>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.</p>	<p>R2 245 per beneficiary per year.</p> <p>Once this limit is exceeded, claims will be paid from the Advanced dentistry limit.</p>		

Traditional Plan (continued)

Services	M	A	C
3. Advanced dentistry Paid at 100% of cost or MSR , whichever is the lesser, up to the available limit. Inlays, bridgework, crowns excluding gold content, mounted study models, metal base partial dentures, orthodontics, periodontists, prosthodontists and dental technicians.	R2 230	R1 490	R740
4. Medicine <ul style="list-style-type: none"> • Prescribed (acute) medicines paid at 100% of Medicine Price or Medicine Price List, whichever is the lesser. • Pharmacy advised therapy (PAT) – medicines supplied by a registered pharmacist without a prescription from a medical practitioner or dentist. • Antenatal vitamins prescribed during pregnancy – excluding calcium supplements and Omega preparations. 	R2 230 R1 000 per family (subject to the prescribed medicines limit)	R1 490	R740
5. Pathology Paid at 100% of cost or MSR, whichever is the lesser, up to the available limit.	R1 335	R450	R155
6. Radiology X-rays and mammograms paid at 100% of cost or MSR, whichever is the lesser, up to the available limit.	R1 785 per family per year		
7. Supplementary health services Paid at 100% of cost or MSR , whichever is the lesser, up to the available limit. Physiotherapy following hospitalisation is covered under the Hospital and Trauma Benefits, provided it is 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.	R2 380 per family per year		
8. Physiotherapy Paid at 100% of cost or MSR , whichever is the lesser, up to the available limit. Physiotherapy following hospitalisation is covered under the Hospital and Trauma Benefits.	R2 380 per family per year, provided it is 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.		
9. Psychology Paid at 100% of cost or MSR , whichever is the lesser, up to the available limit.	R4 460 per family per year.		

Traditional Plan (continued)

Services	M	A	C
10. Medical appliances Not forming an integral part of an operation, e.g. baumanometer, all orthopaedic braces, wheelchairs, crutches. These are paid at 100% of cost or MSR , whichever is the lesser, up to the available limit. 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.	R7 430 per family per year. The frequency of the benefit will be subject to the Scheme's clinical protocols.		
11. Hearing aids Can be purchased or hired and will be paid for, following motivation by the treating doctor and approval by the Scheme before acquisition. <ul style="list-style-type: none"> • These are paid at 100% of cost or MSR, whichever is the lesser, up to the available limit. • 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. 	R24 800 per family for dependants 6 years and younger. R11 880 per family for dependants 7 years and older. Benefit available per beneficiary every 24 months.		
12. Optical benefits <ul style="list-style-type: none"> • Eye test unlimited (payable from the Optical benefit limit and, once exceeded, payable from Overall Annual Limit) • Lenses, contact lenses and fittings paid at 100% of cost or MSR, whichever is the lesser, up to the available limit. • Frames subject to the available limits up to a maximum of R670 per beneficiary every 24 months, included in the optical limit. 	R1 785	R1 195	R595
13. Maternity benefits Paid at 100% of cost or MSR , whichever is the lesser, up to the available limit.	<ul style="list-style-type: none"> • Antenatal visits: R2 185 per family per year. • Ultrasound scans: 2 x two-dimensional scans per family per year. • Antenatal classes: R910 per family per year. 		

S Savings Plan

The Savings Plan consist of a medical savings account that provides an upfront (for the entire year) rand value amount, from which your Everyday Services Benefits claims such as doctors, specialists, optometrists and prescription medication are paid. You also qualify for additional maternity benefits, as well as Hospital and Trauma Benefits and Prescribed Minimum Benefits.

Approximately 22% of your monthly contribution is allocated upfront (for the entire year) to a medical savings account. This is then used to cover your Everyday Services Benefits at cost.

How much savings will be allocated for the year?

The annual amount available to pay for Everyday Services Benefits is 12 x your monthly allocation. The 2012 annual amount to pay for Everyday Services Benefits will be calculated and allocated as follows:

- 22% of your monthly contributions x 3 (1 January 2012 to 31 March 2012) plus
- 22% of your monthly contributions x 9 (1 April 2012 to 31 December 2012)
- Contributions are only payable for the first child dependant.
- The total amounts to your 12 months' allocation as indicated in the table below.

Monthly Income	Member	Per Adult	Child (maximum of one child)
0 - R3 500	R2 544	R2 451	R1 287
R3 501 – R4 500	R2 649	R2 556	R1 329
R4 501 – R6 000	R2 991	R2 556	R1 413
R6 001+	R3 264	R3 180	R1 674

Your Everyday Services treatments will be reimbursed at cost from your medical savings account until there are no more funds available. If you have insufficient funds available in your medical savings account, you will need to pay any difference at the point of sale or service.

Any balance remaining in your medical savings account at the end of the benefit year will be carried forward to the following year. **Please note that no interest will be payable on accumulated savings balances transfers.**

If you leave the Scheme during the benefit year, your benefits will be pro-rated. You will therefore be liable for any benefit paid by the Scheme that is more than the pro-rated amount to which you are entitled to. Please note that it is your responsibility to settle this amount before leaving the employ of the company. For example, if you terminate your employment and membership of the Scheme in June, you will only have contributed 6 months towards the savings benefit. You may, however, have used more than 6 months' allocation and a debt would therefore be owing to the Scheme. The annual allocation for a single member in the highest income band on the Savings Plan for savings is R3 264. If you have utilised your full savings allocation by the end of June, you will owe the Scheme 6 months of savings contributions.

Savings Plan Additional Maternity Benefits

Item	Benefits
Maternity Benefits Over and above your savings, paid at 100% of cost or MSR, whichever is the lesser, up to the available limit.	<ul style="list-style-type: none"> • Antenatal visits: R2 185 per family per year. • Ultrasound scans: 2 x two-dimensional scans per family per year. • Antenatal classes: R910 per family per year.

H Hospital Plan

The Hospital Plan offers Hospital and Trauma Benefits, but does not offer Everyday Services Benefits. You do, however, qualify for the Wellness Benefit (covering a prescribed list of annual check-ups and preventative health screening tests subject to the use of the selected ScriptNet pharmacy), which will be covered by the Scheme.

You are also covered for those services that fall under Prescribed Minimum Benefits where treatment is received from your DSP, but there is no cover for the other registered chronic conditions.

No medical savings account allocation is available on this Plan.



8. More about your medical scheme

IN THIS SECTION

- [Who administers my medical scheme?](#)
- [When does the benefit year start?](#)
- [What is the difference between medical scheme rates and private provider rates?](#)
- [What services are *not* covered by the Scheme?](#)



Who administers my medical scheme?

The Scheme is administered by Medscheme Holdings (PTY) LTD and the Traditional Plus Plan is administered by ONECARE. Where there is a different administrative process to follow and where contact details differ for the Plans, these are clearly indicated in the relevant sections of the member guide.

When does the benefit year start?

The Scheme's benefit year runs from 1 January to 31 December of each year. This means that if you join the Scheme from 1 January, you are entitled to the full allocation of benefits and limits. However, if you join the Scheme during a benefit year, you are only entitled to a time-appropriate proportion of the benefits and limits. If any of the benefits or contributions change during the year, the Board of Trustees will notify you accordingly.

Please note: You have the opportunity to review and change your choice of Plan a few months before the beginning of each benefit year. Once you have selected a Plan for the benefit year, you cannot change your Plan during that benefit year.

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 medical savings account, if they have funds available.

Please note that 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 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 wilful or self-inflicted injury or 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 [page 66](#) 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
- Sleep therapy
- 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; and
 - exercise equipment.
- Unregistered medicines (i.e. those not approved by the Medicines Control Council)
- Orthodontic treatment for persons over the age of 21, excluding services required after trauma

9. All about 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 do I need to do if my dependants/membership details change?](#)
- [What will happen when my Scheme membership comes to an end?](#)



Who can be a member of the Scheme?

All permanent employees of Nedbank Group Limited and Mutual & Federal 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.

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 member of another medical scheme:

- **Employees** - Permanent staff.
- **Married employees** - If you are married, you may either join the Nedgroup Medical Aid Scheme or your spouse's medical scheme.
- **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, this group of dependants is entitled to apply to become continuation members of the Scheme. 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:

- **Spouse** - Your spouse to whom you are legally married and who is not a member of another medical scheme. *Documentation required:* A certified copy of the marriage certificate.
- **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).
- **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.
- **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 (available from your respective HR Consultant).

- **Children, adopted children, stepchildren and 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 their registration 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 and financial proof).
- **Indigent parent(s)** - A parent for whom you, as the member, are liable for family care and support. *Documentation required:* Affidavit to prove that your indigent parent qualifies and that you are legally obliged to support this person financially.
- **Indigent sibling(s)/grandchildren of member** - A brother, sister or grandchild for whom you, as the member, are liable for family care and support. You will need to re-apply before the beginning of each benefit year. *Documentation required:* Affidavit to prove that you are legally obliged to support your indigent sibling financially with proof of the current financial support provided to the sibling. Affidavit to prove that the grandchild is currently permanently residing with you and that you are legally obliged to support your grandchild financially. (Affidavit available from your respective HR Consultant).

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 (e.g. 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.
- You can obtain application forms for membership from your respective Benefit or HR Consultant.
- 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?

No waiting period will apply for new employees who join the Scheme within 30 days of first becoming an employee.

No waiting period will apply for an employee who undergoes a life-changing event and applies to join the Scheme within 30 days of the life-changing event taking place. A life-changing event is defined as divorce, marriage, retrenchment, spouse's or partner's change of employment or death.

Waiting periods will apply when members join the Scheme or dependants are registered in the following instances:

- Members who were on their spouse's medical scheme and who voluntarily resigned to join the Nedgroup Medical Aid Scheme, other than when they first qualified to become a member.
- Dependants who were not registered at the time that they first qualified to be registered as dependants on the Scheme.

Depending on previous medical scheme membership or registration as a dependant, the waiting period to be applied may be a three-month general waiting period or a twelve-month condition-specific waiting period, or both.

Waiting periods will apply as follows:

- If you have never been a member or dependant of a medical scheme or were not covered for a period of more than 90 days immediately before applying to the Scheme, the Scheme may impose the general waiting period and the condition-specific waiting period (if the beneficiary suffers from a pre-existing condition). The waiting periods will also apply to Prescribed Minimum Benefits.
- If you have been a member or dependant of a medical scheme for less than 24 months and you apply for membership or registration as a dependant within three months of termination from the previous medical scheme (other than due to a change of employment), a condition-specific waiting period will apply. If the beneficiary suffers from a pre-existing condition, the Scheme may also impose any unexpired balances imposed by the previous scheme. The beneficiary will be entitled to Prescribed Minimum Benefits.
- If you have been a beneficiary of a medical scheme for more than 24 months and apply for membership or registration as a dependant within three months of termination from the previous medical scheme (other than due to a change of employment), the general waiting period will apply. You will be entitled to Prescribed Minimum Benefits.

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

If you are an employee, you must notify your respective HR/Benefit Consultant and if you are a retiree, you must notify Medscheme or the Pension Fund administrator, of the following:

- 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).

What you need to do:

- Obtain a Change in Membership Details form from your HR/Benefit Consultant (or from Medscheme, if you are a retiree).
- Include the necessary documentation such as birth certificate, registration certificate issued by the hospital or death certificate.

- Return the completed form and documentation to your HR Consultant (or to Medscheme, if you are a retiree).

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.

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 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 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.

As Everyday Services Benefits under the Savings Plan are pro-rated, it is possible that (should you have selected the Savings Plan) you may have a shortfall if you terminate your membership during the benefit year. In this case, you will be responsible for settling the balance with the Scheme.

What will happen to my medical savings account balance?

If you leave the Scheme or transfer to a Plan that does not permit medical savings, then your medical savings account balance will be refunded to you. If you leave the Scheme and join another medical scheme that permits medical savings, then your medical savings balance must be transferred to the new Scheme.

The refund or transfer of 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 medical savings account balance. The Scheme will recover any outstanding amounts from you directly if your medical savings balance is insufficient or if the balance has already been paid out.

Membership of 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.

10. How to claim

IN THIS SECTION

- [How do I submit a claim?](#)
- [How can service providers submit claims electronically?](#)
- [How can I see my claims online?](#)
- [Whom should I contact if I have any queries about claims?](#)



How do I submit a claim?

You do not need to complete a claim form – simply sign all accounts and invoices and submit them 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 (e.g. doctor or pharmacy)
- ICD10 code
- A pre-certification 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. Sign the account and 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

Hospital Plan, Savings Plan, Traditional Plan and Platinum Plan	Traditional Plus Plan
<p>Via internal mail: Nedgroup Medical Aid Scheme 36 Merriman Avenue 2nd Floor Vereeniging</p> <p>Via the post office: Nedgroup Medical Aid Scheme PO Box 74 Vereeniging 1930</p> <p>Via fax: 0860 111 784 Via scan: nedgroupmedaid@medscheme.co.za</p>	<p>Via internal mail: ONECARE Health 10 Mill street Newlands</p> <p>Via the post office: ONECARE Health P O Box 4499 I Claremont 7735</p> <p>Via fax: 021 673 1811 Via scan: nedgroup@onecarehealth.co.za</p>

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.

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 member statements.

How can service providers submit claims electronically (continued)?

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 medical savings account statements for your records.



How can I see my claims online?

Hospital Plan, Savings Plan, Traditional Plan and Platinum Plan	Traditional Plus Plan
Members may register on Medscheme's website and access the following self-help facilities of Medscheme on www.medscheme.co.za :	Members may register on ONECARE's website and access the following self-help facilities of ONECARE on www.carecross.co.za :
<p>Registration information</p> <p>The process to register will only take a few minutes and in future you will have direct access to your medical scheme information.</p> <ol style="list-style-type: none"> 1. Go to www.medscheme.co.za 2. Click on the Sign Up tab on the top left-hand corner of the Homepage. 3. Click on the appropriate registration option: Members. 4. Enter your membership number and the Principal member's ID number. 5. Click on Validate Code once your details have been entered. 6. Select a beneficiary to register. 7. Choose a username. Your username has to be longer than 8 characters. 8. Type in your email address. 9. Choose a Password. Your password must be 8 characters and is case sensitive. No "&" signs allowed. 10. Click on Create Account. 11. You will shortly thereafter receive an e-mail from webquery@medscheme.co.za. Click on the Activate link in the e-mail. It will direct you to the login section of the member zone of the site. 12. You will now be able to login and use the website functionality with your username and password. 	<p>Registration information</p> <p>The process to register will only take a few minutes and in future you will have direct access to your medical scheme information.</p> <ol style="list-style-type: none"> 1. Go to www.carecross.co.za 2. Click on the Register tab on top right-hand corner of the Homepage. 3. Click on the I agree for the Terms and Conditions. 4. Click on the appropriate registration option: Members. 5. Complete the form to register as an online user and click on Register Member. 6. Carecross will generate a username and password for you that will be emailed or SMS'ed to you. 7. 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?

Hospital Plan, Savings Plan, Traditional Plan and Platinum Plan	Traditional Plus Plan
<p>Queries</p> <p>If you have any queries regarding claims, you should contact Medscheme at 0860 100 080.</p>	<p>Queries</p> <p>If you have any queries regarding claims, you should contact ONECARE Health at 0860 103 491.</p>

11. Frequently asked questions

IN THIS SECTION

- What medical scheme cover will I have while outside South Africa on holiday or on business?
- What rules apply if I have been involved in a motor vehicle accident?
- How can I claim in terms of the Compensation for Occupational Injuries and Diseases Act?
- What can I do if I have a complaint against my medical scheme?
- How can I keep my medical costs low?
- What should I do if I suspect fraudulent activity against the Scheme?
- When do I get my tax certificate from the Scheme and how can I request a copy of the tax certificate?
- Where can I obtain a membership certificate?
- How can I replace or get additional medical scheme cards?
- As a retiree, why am I entitled to maternity benefits when the Scheme could rather increase my other benefits?



What medical scheme cover will I have while outside South Africa on holiday or on business?

If you are injured or become ill while outside South Africa on holiday or business, you will be responsible for settling the account. You may claim the cost back from the Scheme when you return. However, if your account is in a foreign language, this must be fully translated and detailed.

The benefit will be paid according to the equivalent South African medical benefit and will be refunded in rands. If you are intending to travel abroad, it is wise to take out additional medical cover. Your travel agent will be able to assist you with this.

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, i.e. the Road Accident Fund. 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 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 professionals, private hospital or nurse, can submit a complaint to the Registrar's Office.

- A complaint form is available on their website (www.medicalschemes.com).
- Complaints can be submitted through fax, e-mail or in person at the Registrar's office.
- 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 Registrar's Ruling and appeal to Council (continued)

- 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 of R2000 is payable for Section 50 Appeals.

How can I keep my medical costs low?

- Negotiate with your doctor to charge the recommended tariff or to give you a discount, if he or she has opted out of charging medical scheme rates.
- Talk to your doctor about prescribed medicines. An alternative generic medicine may be as effective, and cost you much less. If you are too shy to approach the doctor, the dispensing pharmacist can do this for you.
- Try to avoid all unnecessary treatments. This is wasteful and costly to you and the Scheme.
- 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, please arrange for the hospital admission after 12pm. That way the Scheme will only pay for the afternoon (i.e. a half-day).

What do 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 0860 222 117. 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 e-mail the tax certificate to you in April each year. Email nedgroupmedaid@medscheme.co.za to request a copy. Alternatively, log on to the secure website at www.medscheme.co.za and download your tax certificate.

Where can I obtain a membership certificate?

E-mail nedgroupmedaid@medscheme.co.za or log on to the secure website at www.medscheme.co.za and download your membership certificate.

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

Contact your Benefit or HR consultant or E-mail nedgroupmedaid@medscheme.co.za.

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

Maternity benefits are part of the Prescribed Minimum Benefits (PMB) that must by law (Medical Schemes Act, 1998) be made available to all members by the Scheme, irrespective of age. That is why you will find maternity benefits offered on all our Plans. It is therefore not permissible to remove this benefit from retirees' benefits and 'credit' them with other, more age-related benefits.

12. 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 time-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 under the age of 23 years.
Everyday Services Benefits	These benefits cover medical treatment that you receive out of hospital or as an outpatient at a hospital.
Designated service provider (DSP)	Appointed by the Scheme to provide certain specified medical services to members, e.g. 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 in hospital.
ICD 10 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.
Medical protocols	A set of pre-approved treatments authorised for PMB and other conditions to be followed by service providers.
Medical scheme rates (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.
Medical savings account	A savings account to accumulate funds for future approved medical needs (Savings Plan only).
Pre-certification	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-certify.
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.
Waiting period	<p>The period during which you will not be covered for any medical expenses incurred, even though you will be making contributions to the Scheme.</p> <p>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.</p> <p>General waiting period: A three-month period during which a beneficiary is not entitled to claim any benefits.</p>

Contact Details

	Hospital Plan, Savings Plan, Traditional Plan and Platinum Plan	Traditional Plus Plan
Administrator	Medscheme	ONECARE Health
Postal address	Nedgroup Medical Aid Scheme PO Box 74 Vereeniging 1930	ONECARE Health PO Box 44991 Claremont 7735
Internal mail	Nedgroup Medical Aid Scheme 37 Conrad Road, Florida North, Roodepoort, 1709	Nedgroup Medical Aid Scheme ONECARE Health 10 Mill Street, Newlands
E-mail	nedgroupmedaid@medscheme.co.za	nedgroup@onecarehealth.co.za
Claims and Benefits Enquiries	Tel: 0860 100 080 / 011 671 6833 Fax: 0860 111 784 / 011 758 7041 Faxed accounts: 0860 111 784 Scanned accounts: nedgroupmedaid@medscheme.co.za	Tel: 0860 103 491 Fax: 021 673 1811 Faxed accounts: 021 673 1811 Scanned accounts: nedgroup@onecarehealth.co.za
Hospital Benefit Management	Tel: 0860 100 081 Fax: 0860 21 22 23 or 021 466 1913 E-mail: authorisations.cpt@medscheme.co.za	Tel: 0860 102 183 Fax: 021 413 0512 Email: crc@onecarehealth.co.za
HIV and AIDS Management	Programme with Aid for AIDS Tel: 0860 100 646 Fax: 0800 600 773 Email: afa@afadm.co.za	Programme with CareWorks Tel: 0860 101 110 Fax: 0860 105 147
Oncology Management Programme (for cancer patients)	Tel: 0860 100 572 Fax: 021 466 2303 E-mail: cancerinfo@medscheme.co.za	Tel: 0860 102 183 Fax: 021 413 0512 E-mail: crc@onecarehealth.co.za
Chronic Medicine Medical Management (270 PMB conditions)	Tel: 0860 100 081 Fax: 0800 223 670/680 E-mail: cmm@medscheme.co.za	Tel: 0860 102 183 Fax: 021 413 0512 E-mail: crc@onecarehealth.co.za
Chronic Medicine Authorisation (25 PMB conditions and 20 non-PMB chronic conditions only)	ScriptPharm Risk Management Tel: 010 591 0150 Fax: 086 679 1579 E-mail: nedgroup@scriptpharm.co.za Web: www.scriptnet.co.za	Script Pharm Risk Management Tel: 010 591 0150 Fax: 086 679 1579 E-mail: onecare@scriptpharm.co.za Web: www.scriptnet.co.za
Nedgroup Specialist Network	Tel: 0860 100 080	Tel: 0860 101 159
Emergency Medical Services	Tel: 084 124 or 0861NED911 (0861 633 911)	Tel: 084 124 or 0861NED911 (0861 633 911)
Website	www.medscheme.co.za Medscheme's convenient and secure website gives you access to your membership details, claims status, savings balance and available benefits, as well as an electronic version of member communications.	www.carecross.co.za Members on the Traditional Plus Plan have access to the ONECARE secure website for their claims status, available benefits as well as member statements.

