2023
MEMBER GUIDE

Taking care of our own at every stage of their ***health journey***

moto HEALTH CARE

taking care of our own

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MOTO HEALTH CARE (MHC) *Key Features*

Join a medical scheme created exclusively for the people in the motor industry.

Healthcare reimagined. Get savvy about your options! Healthcare should be simple, fast and uncomplicated. Let us help you find your perfect cover from our range of options, all tailored to suit your lifestyle.

Cover created especially for you. 7 options to choose from, catering for various needs through the most advanced digital health technology.

Free access to patient management programmes/services e.g. diabetes, oncology and maternity. Additional non-PMB conditions covered to assist you in managing your chronic conditions.

Extensive day-to-day benefits that include general practitioner (GP) and specialists visits, dentistry, optical and radiology. Unlimited private and state hospital cover plus take home medications.

High quality and world class service from our networks of doctors, hospitals and pharmacies.

Reduce your risk and stay healthy. You and your family can benefit from a host of free preventative care tests via the wellness programmes across all options.

Virtual advice via Hello Doctor. Talk to a doctor on your phone for free - any time, any where, in any official language.

Best value for money in terms of benefit versus cost. A value-based healthcare system that lowers healthcare costs, resulting in lower contributions.

COMPREHENSIVE COVER AND ENHANCED VALUE AT *Affordable Rates*

'Taking care of our own' means you get quality and affordable medical cover inclusive of many value adding innovative products such as free virtual advice and tips via Hello Doctor, the MHC mobile app, free preventative care benefits, a maternity programme tailored for all expectant parents, as well as free patient care programmes with dedicated wellness coaches and innovative products such as Nubabi. You get even more with comprehensive hospital and day-to-day cover for complete peace of mind.

PLEASE NOTE Product rules, limits, terms and conditions apply. Where there is a discrepancy between the content provided in this member guide, the website and the Scheme rules, the Scheme rules will prevail.

The Scheme rules are available on request. Benefits are subject to approval from the Council for Medical Schemes (CMS).

WELLNESS *Programme*

MHC offers wellness and preventative care benefits on all our plans to help our members lead healthier and happier lives. Preventative screening is important in making sure you detect medical conditions early and we can ensure the best care for you. Having these specific tests (up to the specified number) does not affect your day-to-day benefits and you should not have any out-of-pocket expenses. The healthcare professional will provide counselling upon receipt of your test results. Information will be shared on the steps you can take to prevent or reduce your health risks. You can also receive health tips on topics of your choice by downloading the Hello Doctor app and may be contacted by one of our wellness or lifestyle coaches if you are classified as a high-risk member.

DOWNLOAD THE HELLO DOCTOR APP

GET IT ON Google Play

Download on the App Store

EXPLORE IT ON AppGallery

hello doctor

Powered by momentum

WELLNESS PROGRAMME *Benefits*

What is covered under the Wellness benefit

ESSENTIAL AND CUSTOM OPTIONS

Preventative Care

What does the programme cover?	Age covered	Frequency	Tariff code	Comment
Baby immunisation	0 - six years	In line with the Department of Health protocols		Subject to use of network provider
Flu vaccines		One flu vaccine per beneficiary per year		Subject to use of and referral by network provider
Pneumococcal vaccines	High risk and beneficiaries older than 60 years		836699 755826 715858	Subject to use of and referral by network provider

ESSENTIAL OPTION: Early Detection Tests

What does the programme cover?	Age covered	Frequency	Tariff code	Comment
Blood pressure testing				Subject to use of network provider
Blood glucose testing (pathologist)	Principal members and adult beneficiaries	Once a year	4057	Subject to use of network provider
Cholesterol test (pathologist)	Principal members and adult beneficiaries	Once a year	4026 4027 4028 4147	Subject to use of network provider
Clinical breast screening	High risk members			Subject to pre-authorisation and use of network provider
Pap smear (GP)	Women 15 years and older	Once a year	4566	Subject to use of network provider
Prostate specific antigen (PSA) testing	Men 40 to 49 years Men 50 to 59 years Men 60 to 69 years Men 70 years and older	Once every five years Once every three years Once every two years Once a year	4519	Subject to use of network provider
TB screening (pathologist)	All beneficiaries		3916	Subject to use of network provider

CUSTOM OPTION: Early Detection Tests				
Blood pressure testing				Subject to use of network provider
Blood glucose testing (pathologist)	Principal members and adult beneficiaries	Once a year	4057	Subject to use of network provider
Cholesterol test (pathologist)	Principal members and adult beneficiaries	Once a year	4026 4027 4028 4147	Subject to use of network provider
Mammogram	Women 38 years and older	Once every two years	34100 34101	Subject to use of network provider and pre-authorisation
Pap smear (GP and gynaecologist)	Women 15 years and older	Once a year	4566	Subject to use of network provider
Prostate specific antigen (PSA) testing	Men 40 to 49 years Men 50 to 59 years Men 60 to 69 years Men 70 years and older	Once every five years Once every three years Once every two years Once a year	4519	Subject to use of network provider
TB screening (pathologist)	All beneficiaries		3916	Subject to use of network provider

MATERNITY PROGRAMME (subject to registration on the Maternity Management Programme Baby Bumps between 12 and 20 weeks of pregnancy)	
ESSENTIAL OPTION	
Ante-natal care (GP)	Available from a primary care provider for the first 20 weeks
Paediatric visit	One paediatric visit per family subject to the use of a network provider and specialist limit
Pregnancy vitamins	Subject to medication formulary and registration onto the programme
Scans	Two 2D scans per pregnancy | 3D and 4D scans will be paid at 2D scan rates

MATERNITY PROGRAMME
(subject to registration on the Maternity Management Programme Baby Bumps between 12 and 20 weeks of pregnancy)

CUSTOM OPTION: Subject to the Specialist Limit and use of a Network Provider

Ante-natal care (gynaecologist)	4 visits subject to registration onto the programme
Paediatric visit	Subject to GP referral and Specialist Limit
Pregnancy vitamins	Subject to medication formulary and registration onto the programme
Scans	Two 2D scans per pregnancy 3D and 4D scans will be paid at 2D scan rates
Urine tests	4 tests subject to registration onto the programme

Patient Care Programmes

Includes disease management for conditions such as diabetes, hypertension, HIV/AIDS. Please call **0861 000 300** for more information.

PLEASE NOTE Belly Babies provide expert antenatal knowledge and support to expecting parents throughout their pregnancy. This innovative product is endorsed by MHC, members can access these benefits independently and also have them paid via the HealthSaver product where the member has chosen this product.

CLASSIC + CLASSIC NETWORK AND OPTIMUM OPTIONS
Please call **0861 000 300** for more information

Preventative Care

What does the programme cover?	Age covered	Frequency	Tariff code	Comment
Baby immunisation	0 - six years	In line with the Department of Health protocols		Subject to pre-authorisation
Flu vaccine	High risk and beneficiaries older than 65 years	Once per beneficiary per year		Subject to pre-authorisation
Pneumococcal vaccine	High risk and beneficiaries older than 60 years	Once per beneficiary per year	836699 755826 714999 715858 705032	Subject to pre-authorisation

CLASSIC + CLASSIC NETWORK AND OPTIMUM OPTIONS

Please call **0861 000 300** for more information

Early Detection Tests

What does the programme cover?	Age covered	Frequency	Tariff code	Comment
Dexa bone density scan	Beneficiaries 50 years and older	Once every 3 years	3604 50120	Subject to pre-authorisation
Health risk assessment at a pharmacy network provider – includes a finger prick cholesterol and glucose test, blood pressure check and measurement of waist, height and weight (BMI)	Principal members and adult beneficiaries	Once a year	Nappi 711326001	
Glaucoma screening	All beneficiaries 40 to 49 years and older All beneficiaries 50 years and older	Once every two years (guideline for non-network users) Once a year		Included in the PPN annual composite consultation if a PPN network provider is utilised
Mammogram	Women 38 years and older	Once every two years	34100 34101	Subject to pre-authorisation
One basic dental consult (Only applicable to the Classic and Classic Network members)	All beneficiaries	Once a year	8101 8109 8110	Subject to pre-authorisation
Pap smear	Women 15 years and older	Once a year	4566	Subject to pre-authorisation
Prostate specific antigen (PSA) testing	Men 40 to 49 years Men 50 to 59 years Men 60 to 69 years Men 70 and older	Once every five years Once every three years Once every two years Once a year	4519 4524	Subject to pre-authorisation
TB Screening (pathologist)	All beneficiaries		3916	Subject to pre-authorisation
Tetanus diphtheria injection	All beneficiaries	As needed		Subject to pre-authorisation

HOSPICARE + HOSPICARE NETWORK, CLASSIC + CLASSIC NETWORK, OPTIMUM OPTIONS

MATERNITY PROGRAMME

(subject to registration on the Maternity Management Programme Baby Bumps between 12 and 20 weeks of pregnancy)

Ante-natal visits (Midwives, GP or Gynaecologists)	12 visits per pregnancy (excludes exercises)
Paediatric visits	2 per pregnancy
Pathology tests	1 test per pregnancy: Full blood count, blood group, rhesus (Rh antigen), IgG (specific antibody titer), VDRL (veneral disease research laboratory), glucose strip test Urine test - Microscopic culture and sensitivity test
Pregnancy Vitamins	Subject to formulary
Scans	Two 2D scans per pregnancy: At 20-24 weeks (growth scan) At 24 weeks (pregnancy scan) 3D and 4D scans will be paid at 2D scan rates
Urine Test (dipstick)	12 per pregnancy

Patient Care Programmes

Includes disease management for conditions such as diabetes, hypertension, HIV/AIDS, oncology, chronic renal failure, organ transplants and alcohol and drug rehabilitation. Please call **0861 000 300** for more information.

PLEASE NOTE

Belly Babies provide expert antenatal knowledge and support to expecting parents throughout their pregnancy. This innovative product is endorsed by MHC, members can access these benefits independently and also have them paid via the HealthSaver product where the member has chosen this product.

WELCOME TO *Hello Doctor!*

hello doctor
Powered by momentum

Hello Doctor lets you talk to your doctor on your phone, any time, any where.

Just request a call or send your question via text.

Download the app

GET IT ON Google Play

Download on the App Store

EXPLORE IT ON AppGallery

Log in via our website

www.hellodoctor.co.za

*Dial *120*1019#* from your phone and follow the prompts to request a call.

WORKS ON ALL PHONES

No time to stop by a clinic or doctor? Trusted help is just a tap away

Get access to quality healthcare without ever leaving your home, your job or wherever you are. Talk to a doctor on your phone, any time, any where, in any official language – for free.

Hello Doctor - a free, voluntary, mobile-based service that gives you access to doctors within minutes. You can get expert health advice through your phone, tablet or computer at no cost to you. Simply download the Hello Doctor app and log in with a one time pin and enjoy instant access to the full suite of convenient, easy to use health services. You can also access Hello Doctor through your MHC app – just tap on the icon, confirm your number and a doctor will call you back.

Hello Doctor doesn't charge any service fees. All you need is data or a Wi-Fi connection to use the app and since our doctors call you, you won't need to use your airtime. Hello Doctor also integrates with the Nubabi product as an additional call-back functionality for advice and support. Refer to page 17 for more information on Nubabi.

HELLO DOCTOR OFFERS YOU:

DOCTOR ACCESS

Speak to a doctor over the phone, or chat via text message. All consultations are completely private and confidential.

HEALTH EDUCATION

Get free daily advice with Hello Doctor's health tips and health coaching. Subscribe to any category that interests you and walk the journey to better health.

MONTHLY EMAILS

Emails give you the latest health trends and advice.

USSD - UNSTRUCTURED SUPPLEMENTARY SERVICE DATA

You can dial *120*1019# from your mobile phone and follow the menu prompts to request a call back from a doctor or send a text message to the number that they provide. Just enter your ID/Passport number and you'll receive a one-time password (OTP) via SMS. OTP not arriving? Call us on 087 230 0002 to confirm your details or WhatsApp us on 073 778 4632.

No waiting in queues, no delays, no worries.
Download the app and get relevant and reliable health advice at the touch of a button.

THE MHC *Healthcare App*

Access your healthcare any where, any time

As the digital transformation of healthcare gains momentum, you can benefit from continuously enhanced state-of-the-art technology and services when you join Moto Health Care.

Digital health technology supporting you 24/7

Click on your preferred operating system icon below to download the App or log onto the website www.mhcmf.co.za for more information.

MHC mobile app key features

- Track your claims and medical expenditure
- Download key documents – tax certificates and claims statements
- Access your digital membership card
- Submit your enquiry online via the App
- View your monthly contributions and track your payment history
- Search for healthcare professionals in our network
- Designed for GP's, hospitals and pharmacies
- Search for a specific benefit category and sub category
- Access dashboards that provide you with an overview of your information in real time
- Manage your pregnancy and your baby's health
- Understand and manage your health risk
- View the history of medication dispensed by providers

Download the App today!

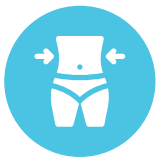
GET IT ON Google Play | Download on the App Store | EXPLORE IT ON AppGallery

WE BELIEVE IN GIVING *You More*

You can get the following paid from your annual savings limit:


Oral contraception and devices


Treatment for sexual dysfunction


Slimming preparations


Vitamins


Treatment that assists with smoking cessation

ER made easy

ER made EASY for Classic, Classic Network and Optimum members, is an initiative that offers all beneficiaries, regardless of their age, free emergency medical cover when you need it the most. Each beneficiary will have direct access to a hospital's Emergency Room (ER) for medical treatment in emergency situations.

Even if the member doesn't have normal benefits available, the cost of the ER visit will be covered up to a maximum of R1 000. MHC offers one emergency visit per beneficiary per annum, members need to pay upfront for services and, if the incident meets the emergency criteria/protocol, a maximum of R1 000 will be reimbursed.

These emergency circumstances may include:


Sport injuries


Car accidents


Playground accidents


Assault

COMPLEMENT YOUR COVER WITH *HealthSaver*

You can use additional complementary products to seamlessly enhance your medical scheme. Save for additional medical expenses with HealthSaver. HealthSaver lets you save for additional day-to-day medical expenses, such as co payments, exclusions and more.

Note: All Moto Health Care members qualify for this product, which is regulated outside the Scheme benefits and rules. The cost for this product is excluded from the MHC monthly contribution. Members interested in the product must sign up directly. Refer to page 84 for contact details.

DISCLAIMER

As a Moto Health Care member, you can choose to make use of additional products available from Momentum, part of Momentum Metropolitan Life Limited, to seamlessly enhance your medical cover. Momentum is not a medical scheme, and is a separate entity to your medical scheme. These voluntary complementary products range from a world-class lifestyle rewards programme, to the HealthSaver account. These complementary products are not medical scheme benefits. You can be a member of Moto Health Care without taking any of the complementary products.

WELCOME TO *Baby Bumps*

A comprehensive programme designed with the needs of expectant parents, and their support network, in mind. We aim to give you support, education and advice through all stages of your pregnancy, the confinement and post-natal (after birth) period. Welcoming a little one to the family is one of the happiest times of your life. As a MHC member you can rest assured that mom and baby's every healthcare needs are more than taken care of.

Share your happy news with us as soon as your pregnancy has been confirmed. Register between 12 and 20 weeks of your pregnancy to gain access to these additional benefits. This cover does not affect your day-to-day benefits. Benefits will be activated when your pregnancy profile is created.

During your pregnancy

Antenatal consultations

You are covered for up to 12 visits at your gynaecologist, GP or midwife based on the plan you choose.

Ultrasound scans

You are covered for up to two 2D ultrasound scans. 3D and 4D scans are paid up to the rate we pay for 2D scans.

Vitamins

Only pregnancy related vitamins are covered.

Paediatric visits

Your baby is covered up to two visits. Cover depends on the plan you choose.

How do I access the benefits?

- Members on the Essential and Custom options must visit their network general practitioner for antenatal care.
- Members on the Custom option will be referred to a specialist on the network and Essential option members will be given a letter to visit their nearest state facility.
- All maternity care outside the network must be pre-authorised.
- Members on the Hospicare, Hospicare Network, Classic, Classic Network and Optimum options can visit a specialist of their choice.
- All members need to contact the call centre to obtain pre-authorisation for hospital admission for the birth. Pre-authorisation is subject to designated service provider arrangements if applicable to your plan of choice.

MHC offers members an opportunity to use Network Hospitals on some plans, in exchange for lower premiums. To prevent unnecessary co-payments and out of pocket expenses - Click onto www.mhcmf.co.za and use the help bubble to chat with an agent or call **0861 000 300** to make sure that your treating practitioner is based at a network hospital.

The maternity programme is headed by highly skilled and experienced, registered nursing sisters with additional qualifications in midwifery who will provide you with support, education and advice throughout your pregnancy.

Registering on the programme

Contact the call centre between weeks 12 and 20 of your pregnancy to telephonically enrol on the programme. Refer to the Wellness Benefit for the details on the various tests covered by the Scheme.

WELCOME TO *Belly Babies*

A new, revolutionary maternity benefit! Belly Babies provide expert antenatal knowledge and support to expecting parents throughout their pregnancy.

Belly Babies is endorsed by MHC. Members can access these benefits independently and have them paid via the HealthSaver product.

Once members sign up they have access to:

- Online antenatal classes
- Postnatal classes
- Video consultations

For more information, please email Belly Babies at support@bellybabies.co.za. Our Preventative Care benefit covers child immunisations according to the Department of Health Immunisation Schedule.

The department of health has added the following vaccines to the schedule:

- 6 months – Measles vaccine
- 12 months – Measles vaccine

Download the immunisation schedule from the MHC website, which lists all vaccines for children under the age of 12.

AN IMMUNISED CHILD IS A HEALTHY AND PROTECTED CHILD!

Nubabi Adding more health for less with digitised maternity journey

In keeping with the needs of our members, MHC has endorsed a new end to end maternity app called Nubabi that focuses on expectant parents' post-natal journey. Nubabi is a more digitised approach to our maternity and parenting communication channels. This digital App was introduced as a value add to support parents through the first few years post a child's birth. The innovative app is an all-in-one development and parenting app and is offered for free to expectant parents which supports them through the parenting journey and focuses on the baby's different development stages. It helps parents understand the development milestones – from the first smile, to walking and talking and also provides activities to help stimulate development through each of these stages. Treasure these memories as every special moment can be captured and securely stored online too. Call **0861 000 300** for more information.

PRESCRIBED MINIMUM BENEFIT *Conditions*

To access prescribed minimum benefits, there are rules that apply

In terms of the Medical Schemes Act 131 of 1998 and its Regulations, all medical schemes have to cover the costs related to the diagnosis, treatment and care of:

- An emergency medical condition
- A list of 271 diagnoses
- A list of 26 chronic conditions

Your medical condition must qualify for cover and be part of the defined list of Prescribed Minimum Benefit (PMB) conditions. The treatment needed must match the treatments in the defined benefits. You must use designated service providers (DSPs) in our network if applicable to your plan.

This does not apply in emergencies. However, even in these cases, where appropriate and according to the rules of the Scheme, you may be transferred to a hospital or other service providers in our network once your condition has stabilised. If your treatment doesn't meet the above criteria, the Scheme can apply co-payments or pay for PMBs at Scheme rates.

You will be responsible for the difference between what the Scheme pays and the actual cost of your treatment. PMB claims for **Custom and Essential options** members will be paid at the Scheme rates, as these options are exempt from the PMBs.

What is an emergency?

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

An emergency does not necessarily require a hospital admission. We may ask you for additional information to confirm the emergency.

Please remember to call the designated service provider - Europ Assistance on **0861 009 353** and **011 991 8000** for emergency services and transportation via ambulance and **0861 000 300** for pre-authorisation.

You get extensive cover for chronic conditions

MHC members living with a chronic illness get the best care when they register on the Chronic Care Programme. The programme grants you free access to treatment for a list of medical conditions under the Prescribed Minimum Benefits (PMBs). The PMBs cover 26 chronic conditions on the Chronic Disease List (CDL). Some of our plans cover conditions that are richer than the PMBs, and cover depends on the plan you choose.

Chronic Illness Benefit

This benefit covers you for a defined list of chronic conditions. You need to apply to have your medicine covered for your chronic condition. Refer to page 23 for additional info (process flow).

Medicine cover for the Chronic Disease List

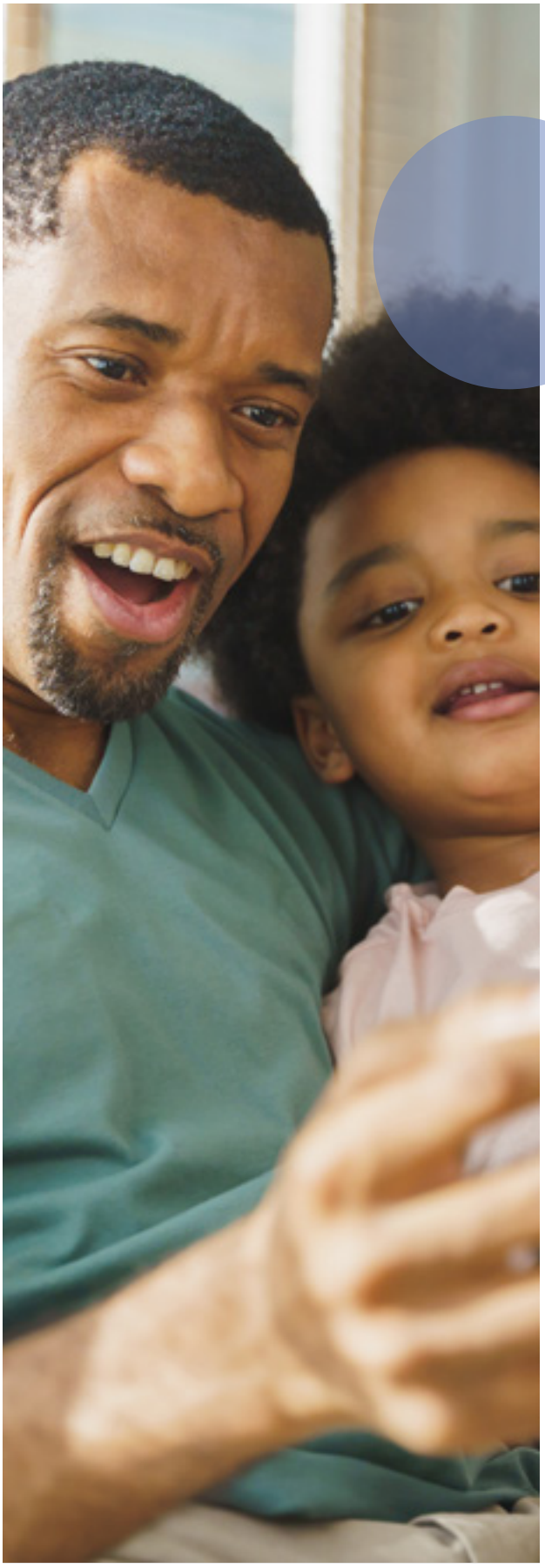
You get full cover for approved chronic medicine on our list. For medicine not on our list, you may incur a co-payment.

Medicine cover for the Additional Disease List

If you are on the Optimum plan we cover an additional 28 conditions while the Classic and Classic Network plans cover 10 conditions for medicine on the Additional Disease List (non-PMB conditions). Refer to page 20.

How do we pay for medicine?

We pay for medicine up to the maximum of the Moto Health Care (MHC) rate including the fee for dispensing it.



CHRONIC CONDITIONS *Covered*

Additional non-pmb chronic conditions

CLASSIC OPTION & CLASSIC NETWORK OPTION	OPTIMUM OPTION	CUSTOM OPTION
Acne Allergic Rhinitis Ankylosing Spondylitis Depression Eczema Gastro-Oesophageal Reflux Disease (GORD) Gout Prophylaxis Osteoporosis Osteoarthritis Psoriasis	Acne Allergic Rhinitis Ankylosing Spondylitis Attention Deficit Hyperactivity Disorder Cystic Fibrosis Depression Eczema Gastro-Oesophageal Reflux Disease (GORD) Gout Prophylaxis Meniere's Disease Migraine Prophylaxis Motor Neuron Disease Narcolepsy Neurogenic Bladder Onychomycosis Osteoporosis Osteoarthritis Overactive Bladder Syndrome Paget's Disease Peptic Ulcer Disease Peripheral Arterial Disease Primary Hypogonadism (Hormonal Levels Required) Psoriasis Psoriatic Arthritis Renal Calculi Thromboembolic Disease Tourette Syndrome Trigeminal Neuralgia	Depression Menopause

REMEMBER

Chronic medicines approved from the additional non-PMB chronic condition benefit on the Classic,Classic Network and Optimum options will be paid subject to an annual limit. Please call **0861 000 300** for more information.

To ensure that you continue to obtain your chronic medication and as per the pharmacy requirements, a new script and ICD-10 (diagnosis code) needs to be submitted every six months.

WHERE TO OBTAIN YOUR *Medication*

The plans listed below have Designated Service Providers (DSPs) for chronic medication

ESSENTIAL AND CUSTOM OPTIONS	HOSPICARE OPTION	HOSPICARE NETWORK OPTION	CLASSIC OPTION	CLASSIC NETWORK OPTION
You must use a network pharmacy or allocated GP	Scheme pharmacy network	Medipost	Scheme pharmacy network	Medipost

Avoid a 30% co-payment by using these DSPs.

How are co-payments applied?

OPTION	CHRONIC MEDICATION NETWORK	MEDICATION OUT-OF-NETWORK CO-PAYMENT	OUT-OF-FORMULARY CO-PAYMENT	ACUTE MEDICATION NETWORK	OUT-OF-NETWORK HOSPITALISATION
ESSENTIAL	Subject to network formulary/ pharmacy	N/A	Subject to protocols	Subject to network formulary/ pharmacy	No benefit unless it is an emergency admission
CUSTOM	Subject to network formulary/ pharmacy	N/A	Subject to protocols	Subject to network formulary/ pharmacy	30%
HOSPICARE NETWORK	Medipost Pharmacy	30%	20%	N/A	30%
HOSPICARE	Scheme pharmacy network	30%	20%	N/A	N/A
CLASSIC NETWORK	Medipost Pharmacy	30%	20%	Scheme pharmacy network	30%
CLASSIC	Scheme pharmacy network	30%	20%	Scheme pharmacy network	N/A
OPTIMUM	Any	N/A	20%	Any	N/A

Pharmacies, doctors and hospital networks: Use the stipulated networks to ensure no co-payments will apply. Pharmacies (generic versus original, brand-name medicine): Where possible, ask your doctor or pharmacist to prescribe and dispense generic medicine instead of original, brand-name medicine.

HOW DO I REGISTER FOR *Chronic Medication?*

ESSENTIAL/CUSTOM OPTIONS

1 Ask your network doctor to **complete the chronic application form**

2 Your network doctor will **submit the form, together with a copy of the script**, to the chronic department on your behalf
Email: carecrossmotoc@momentum.co.za

3 **Notification of the outcome will be sent** to both you and your doctor

4 **Take your original prescription to the approved network pharmacy** to obtain your medication

HOSPICARE + HOSPICARE NETWORK, CLASSIC + CLASSIC NETWORK, OPTIMUM OPTIONS

1

Send the prescription, inclusive of the diagnosis codes (ICD-10 codes) to the chronic department via:
Email: chronic@mhcmf.co.za
Fax: 031 580 0625

2

Your pharmacist/healthcare provider may call the chronic team on **0861 000 300** to register you telephonically for your chronic conditions/medication

3

Notification of the outcome will be sent to both you and your doctor

4

HOSPICARE & CLASSIC
Take your original prescription to a network pharmacy to obtain your chronic medication

5

HOSPICARE & CLASSIC NETWORK
Send your script to Medipost Courier Pharmacy via:
Tel: 012 426 4000
Email: mhealth@medipost.co.za
Fax: 086 65 2201

6

OPTIMUM
Collect your medication from the pharmacy. Remember, if you use a network pharmacy, co-payments may be avoided

REMEMBER Chronic medicines approved from the additional non-PMB chronic condition benefit on the Classic, Classic Network and Optimum options will be paid subject to an annual limit.

GETTING THE MOST OUT OF YOUR CHRONIC MEDICATION *Benefits*

DO	OR YOU MAY
If applicable to your option, get your medication from one of our DSP pharmacies who charge special rates (available on online or from our client service team)	Deplete your chronic medication benefit before the end of the year
Enquire about your specific condition's chronic basket (available on www.mhcmf.co.za or telephonically from our Chronic Management Team)	Be required to contribute towards your medication cost
Opt for generic versions of your medication as far as possible to stretch every Rand	Deplete your chronic medication benefit before the year ends
Double check that your doctor or pharmacy has registered your chronic condition with the Scheme	Face out-of-pocket expenses
Ensure that your treating doctor includes the ICD-10 code on your prescription	Have your medication declined as they do not correlate with your diagnosis
Ensure that you ask about and understand the Reference Pricing and Generic Reference Pricing that may be applied to the medicine product on your prescription	Have unforeseen out-of-pocket expenses

INTEGRATED *Care*

To ensure you get high quality coordinated healthcare and the best outcomes, we have care programmes that will assist you in maximising your benefits and help you manage your condition optimally.

These programmes assist our at-risk members to manage their health and benefits better so that they are always able to get the care they need when they need it the most. Members will be assigned to personal wellness coaches that will assist them every step of the way. Wellness coaches will develop a tailor-made care path based on your unique healthcare needs which also include unlocking extra benefits.

NOTE

If your oncology treatment plan changes or additional benefits are required, please ensure that your oncologist notifies the oncology management team.

Who will benefit from this programme?

- Chronic patients (depending on the severity of your condition) for example members who have been diagnosed with diabetes, hypertension, HIV and cancer.
- Patients with an increased risk of having an adverse health event that may, for example, result in hospitalisation.
- Patients who have had severe in-hospital or other acute health events patients with rare diseases who require constant monitoring.

Who qualifies for the Care Management Programmes?

It's important to keep in mind that Integrated Care is a health management programme and not a medical scheme benefit. We have a sophisticated process, based on our advanced managed care principles and protocols, that quickly identifies members who could benefit from the helping hand the programme offers. Once identified, we start helping you to use your specific option's benefits better. In some cases, we'll even unlock extra benefits that assist you to stay as healthy as possible, for as long as possible.

How to register on the programme

If you have registered on the Chronic Illness Benefit, you can join the patient care programme especially designed to assist you manage your chronic condition. Partnering with your healthcare practitioner, the care programme unlocks additional services according to your unique needs and condition, for example diabetic enrolees have additional benefits for dieticians. Upon registration onto the programme, you will also be allocated to your personal wellness or lifestyle coach depending on your risk profile, these coaches are there to assist and advise you during every step of your healthcare journey.

Our HIV/Your Life care programme covers you for the care you need

Special care is taken to ensure your privacy and confidentiality is maintained, including the way in which your medication is delivered.

- Contact **0860 109 793** or download the registration form from www.mhcmf.co.za
- Return completed form via fax on 012 675 3848 or email to ha@mhcmf.co.za
- A care coach from the HIV/Your Life programme will contact you.

Palliative Care

Holistic home-based end of life care and services are provided via our Palliative care programme, assisting members and their families to cope better. This benefit is subject to Scheme rules and clinical protocols.

Oncology Care

If you are diagnosed with cancer, register for the oncology programme as soon as possible. Once we have approved your cancer treatment, you are covered for additional benefits offered by the programme. Benefits include chemotherapy, radiotherapy, visits to the Oncologists and cancer related blood tests.

How do you register on the programme?

1. Your oncologist must email your histology report and treatment plan to oncology@mhcmf.co.za.
2. Your treatment plan will be reviewed and a member of the clinical team will contact your doctor.
3. The oncology management team will call you to discuss the authorised treatment plan.

EMERGENCY *Services*

The Scheme has a contract with Europ Assistance to provide emergency medical services to members of the Scheme.

When you call **0861 009 353** or **011 991 8000**, the emergency operations centre will assign an ambulance to the incident.

Emergency medical services include:

- Access to a 24-hour emergency medical assistance contact centre.
- Assisted by medically trained and registered agents with the HPCSA.
- Immediate dispatch of emergency medical services in order to provide lifesaving assistance.
- Constant monitoring of the incident untill ambulance provider has transferred the member to the hospital.
- Emergency pre-arrival instructions provided by agents e.g. CPR.

Emergency transportation by air or road ambulance depending on the plan you choose

The procedure you should follow is:

- Dial **0861 009 353/ 011 991 8000**.
- Give your name and the telephone number that you are calling from.
- Provide a brief description of what has happened and how serious the situation is.
- Provide the address or location of the incident to help paramedics get there.
- Do not put down the phone until the person on the other side has disconnected the call.

Important points

Please ensure that all your registered dependants are aware of this service.

Inform your child's school that he/she is your dependant on the Scheme and make sure your child and the school is aware of the emergency medical service number.

HOW TO APPLY FOR *Membership*

Any person who is employed in the retail motor industry may join the Scheme.

Here's how to apply in FIVE easy steps:

ACTIVE EMPLOYEE MEMBERSHIP		CONTINUATION MEMBERSHIP
Visit your HR Department to obtain a copy of the membership application form	1	Dial **0861 000 300** to confirm if you meet the requirements for continuation membership on the Scheme
The application form can also be accessed via the contact centre: **0861 000 300** or www.mhcmf.co.za	2	If YES complete the continuation form which can be obtained from the contact centre: **0861 000 300** or www.mhcmf.co.za
Ensure that all the required documentation is submitted together with the fully completed application form (refer to page 12 of the membership application form for the details) Remember to complete the inception date	3	Ensure that all the required documentation is submitted together with the fully completed application form Remember to complete the inception date
Request your HR to sign your application form	4	A bank confirmation letter is available on your banking APP or at some ATM machines

5 **Active employee membership and continuation membership:**
Submit your completed application form to membership@mhcmf.co.za. The reference number provided can be used to follow up on the progress of your application.

MEMBERSHIP

Continuation of membership

Members who were employed in the motor industry and who leave for one of the following reasons can continue as members of the Scheme:

- when you are retrenched
- when you retire
- if you are unable to work due to ill health
- when you pass away, your surviving spouse and children may continue as beneficiaries
- if you become disabled
- if you resign from a company that offers medical cover on MHC and are employed by another company in the industry which does not offer medical cover on MHC
- If you leave your employer to start your own business in the industry

Make sure MHC has your latest contact details on record to ensure that you receive the latest news from the Scheme.

Register your new baby in time!

- Complete the registration form at www.mhcmf.co.za and enclose a certified copy of the birth certificate.
- Forward it to the Scheme within 30 days of the birth of your child.
- Should the baby's surname differ from yours, please provide the Scheme with an affidavit confirming that the child is your biological child.
- Contributions for the baby will be due from the first day of the month after the month in which the baby was born.
- Babies who are not registered within 30 days of birth will not qualify for benefits and may be underwritten if registered after 90 days.

NOTE

Should you need to add dependants, please refer to the Scheme's website at www.mhcmf.co.za for the relevant requirements.

Update your membership details should the following changes occur:

- address, telephone number or other contact details
- banking details
- marital status
- monthly income
- adding or removing dependants
- passing away of the principal member or any registered dependant
- change in employer
- resignation from employer
- leaving the motor industry

Contribution statements

Each month the Scheme sends a contribution statement to members who pay their contributions directly to the Scheme.

A contribution statement is also sent to all employers each month. The contribution statement sets out the monthly contribution payments and any money that employees of the company may owe to the Scheme. This statement assists your employer to ensure that your contributions are always up to date.

MANAGING ARREAR *Contributions*

You might be behind in your payments to the Scheme if any of the following happens:

- Your employer has not deducted your monthly contribution from your salary. This might happen if you move between dealerships at the same employer and the new human resources consultant does not include you in the payment schedule.
- A backdated salary increase moved you into a higher contribution category.
- You added a dependant and this change was not submitted in time for the next contribution payment.
- Your contract ended with one employer in the motor industry and you started employment with another employer and he/she did not notify the Scheme in time for the next contribution payment.
- When a dependant reaches the age of 21 – their contribution changes from child to an adult. Timeous notification to the Scheme will avoid a large contribution from being deducted.
- A late joiner penalty has been applied

If you need help with paying your contributions, please contact the Scheme or ask your human resources department to help you with the repayment terms.

REMEMBER

You will retain the same Scheme membership number for life, even if you change employment in the motor industry. Notify the Scheme when you change employment in the industry in order for us to keep track of your movements and contribution payments. In this way you will avoid having your benefits suspended when you need medical cover the most.

CATEGORY	THREE-MONTH GENERAL WAITING PERIOD	12-MONTH CONDITION-SPECIFIC WAITING PERIOD	APPLICATION FOR PMBS
New applicants or persons who have not been members of a medical scheme for more than 90 days before joining	Yes	Yes	Yes
Applicants who were members of a medical scheme for less than two years	No	Yes	No
Change of benefit option	No	No	No
Child dependant born during period of membership	No	No	Not applicable
Involuntary transfers due to change in employment or employer changing to another medical scheme	No	No	Not applicable

The waiting periods are for 3 and 12-month periods, including the PMB category, is very important, as individuals who resign from their medical scheme and who wish to re-join a medical scheme after a few months after developing an illness/condition, will also be subject to the Scheme's underwriting. This process is called anti- selection and is legislated to prevent financial exposure and to protect medical schemes.

CHANGING BENEFIT OPTIONS *Each Year*

Choose the right Plan for your family

What is important when choosing a medical scheme for you and your family or even for your employees? Being cost-conscious your health is your most precious asset. It is therefore critical to ensure that your medical cover is adequate and effectively meets your needs to prevent out of pocket expenses. Identify your needs and abilities, and choose the plan that best suits your unique situation. To help you get started on your journey to choosing a medical aid plan, it is important to be realistic and identify the amount you are willing to spend.

Ask yourself:

- What is the status of your health? If you have ongoing health problems, you might need full medical cover rather than only a hospital plan. If you are generally healthy, but have eye or dental problems, choose a plan that makes adequate provision for this.
- How often do you visit a doctor? If you visit your GP often, a comprehensive plan that has full cover might suit you better, however, if you seldom use your medical benefits, and are willing to pay for day-to-day out of hospital benefits yourself, a hospital plan might be more affordable for you.
- Do you have any chronic ailments? You may have a co-payment if you use medicine that is not on the medicine list.
- Do you need specialist visits covered?
- Are you planning to start or expand on your family in the near future?
- Be aware of any other conditions such as waiting periods on pre-existing health conditions
- What is your budget? Your finances will determine what option you can afford to belong to. Remember to compare the different costs of each plan and look closely at the benefits and how they are structured.

You can only change your benefit option once a year

The member guide containing the benefit information and an option selection form will be sent to you in the last quarter of each year, so that you can make an informed decision in time for the following year. If you change your option, benefits on the new option will be available on 1 January of the following year. You do not need to complete an option selection form if you choose to remain on the same option, but the option selection form is a handy way of making sure that the Scheme has your most recent contact details. Please complete the form if your details have changed. It is important that you send your request to change your option by the deadline provided, which is in December each year. Option changes will not be approved after the deadline.

IMPORTANT

Understand your benefits and choose the right plan that suits your financial and healthcare needs. You are required to notify the Scheme of changes before 31 December 2022 by emailing your completed option change form to Optionchange@mhcmf.co.za.

Easy steps to select your option for 2023

1

How do I choose a plan?

Read and understand the benefits and choose the option that will best suit your financial and healthcare needs or call the contact centre for assistance on **0861 000 300**.

2

How do I inform Moto Health Care of my choice?

Complete an option selection form available from: The call centre – **0861 000 300** OR download a form on www.mhcmf.co.za

3

How do I submit the option change form?

Email: Optionchange@mhcmf.co.za
Post: PO Box 2338, Durban 4000

4

How do I follow up?

Find out whether we have received your choice by dialling **0861 000 300**.

CLAIMS *Procedure*

Who can claim?

You and your healthcare providers (general practitioner, specialist, pharmacy or hospital) can submit claims directly to the Scheme.

What information must be included on your claims?

- Your membership number
- The Scheme name
- Your benefit option (for example Optimum, Custom, etc.)
- Your surname and initials
- The patient's name and beneficiary code as it appears on your membership card.
- The name and practice number of the service provider
- The date of service
- The nature and cost of treatment
- The pre-authorisation number, if applicable
- The tariff code
- The ICD-10 code

If you paid for the service, attach proof of payment and highlight it clearly. Proof of payment can be a receipt from the healthcare provider, an electronic fund transfer (EFT) slip or a bank deposit slip. Important! To ensure that we process your refund to the correct bank account, call **0861 000 300** to verify or change your banking details.

Reasons why claims are rejected

- Incorrect member or dependant information
- Dependants are not registered or their details do not appear on the claim
- No pre-authorisation number was obtained for treatment that required pre-authorisation
- Benefits not available
- Claims will not be paid if the benefit category you are claiming from has been depleted

Where do I send my claim?

Please direct your enquiry to: info@mhcmf.co.za or claims@mhcmf.co.za can be used for submission of new accounts.
Post: PO Box 2338, Durban 4000
Ensure that all the required information is reflected on the claim (as indicated above).

Claims received after the claiming period has expired

Claims must reach the Scheme within 4 months (i.e. 120 days) of the treatment date.

The Scheme will not pay claims that are older than 4 months. You will be responsible for paying the claim if you have submitted it to us after 4 months.

Claims received after you have resigned from the Scheme

When you resign from your employer, your Scheme membership of the Scheme ends and you will not be allowed to access healthcare services. If you or your healthcare providers claim for healthcare services rendered after the date that you resigned from the Scheme, the claim will not be paid.

Scheme exclusions

You must ensure that the procedure, treatment or product you plan to claim for, qualify for benefits before obtaining it, as the Scheme will not pay for any services that are excluded in terms of the Scheme Rules. You will be responsible for paying those costs directly to the healthcare providers. Scheme exclusions are listed on page 73. Alternatively, visit www.mhcmf.co.za for a complete list of exclusions.

FRAUD, WASTE *& Abuse*

Taking no action is not an option

Some of the fraudulent and wasteful activities by medical scheme members involve the following:

- Collusion between members and healthcare providers in order to get illegal financial gain from a medical aid scheme.
- Cash back claims when members are admitted to hospital for procedures that could have been avoided in order to claim through hospital insurance products.
- Non-disclosure of prior ailments is the most common fraud reason cited. This occurs when a member fails to inform the medical scheme about previous health conditions.
- Card farming occurs when members share their medical scheme benefits with non-members. This type of fraud is reported to be prevalent with female members, who cover only one child on the medical scheme, but all the children then share the benefits of that one child who is covered. Fraud, waste and abuse have cost medical schemes billions of Rands each year, and are contributory to price increases.

The Scheme's fraud line is managed by an independent team that ensures that members reporting fraud remain anonymous. The location of the secure call centre is not made public to ensure the protection of caller records. All callers remain anonymous, unless they choose to reveal their identities. If you know of any fraud that is taking place or being planned, put an immediate stop to it by calling the anonymous, 24-hour, toll free fraud line on 0800 200 564 or email tip-offs to mhcmf@tip-offs.com

If you are found to have committed fraud, the scheme may:

- Cancel your membership.
- Insist that you pay back any amounts the Scheme had previously paid relating to the fraudulent matter.
- Open a criminal case against you.
- Report you to your employer.

PRE-AUTHORISATION *Process*

The pre-authorisation process ensures that the treatment or procedure is both necessary and appropriate. Except in emergencies, pre-authorisation must be obtained 48 hours before any hospital admission.

Pre-authorisation is required for the following, among others:

- All admissions to hospital
- Outpatient treatment in a hospital, i.e. when you do not stay overnight at the hospital
- Admission to a day hospital
- MRI or CT scans or radio-isotope studies
- Access to patient care programmes
- Emergency ambulance transportation
- Specialised and surgical dentistry in hospital
- Visits to a specialist if you are on the Custom and Essential options
- Additional consultations on the Classic and Classic Network options once your savings are depleted

Ask your healthcare practitioner for a full description of:

- The reason for admission to hospital or for the scan
- The associated medical diagnosis
- The planned procedure
- All the tariff and ICD-10 codes that the doctor intends to use
- Additional information required
- Your membership number
- Name and date of birth of the patient
- Date of admission
- Name and practice number of the treating practitioner
- Name and practice number of the hospital

REMEMBER

In case of an emergency you may obtain authorisation within 48 working hours. Any of your relatives/family/friends may phone to obtain a pre-authorisation number if it is not possible for you to phone.

You may request a quotation for planned procedures prior to the admission by sending the quotation to auths@mhcmf.co.za

DID YOU *Know?*

That you may ask for a list of medications for your condition which Moto Health Care will fund on your Option? (This list is called a Formulary and will assist your doctor in prescribing a medication which would not cost you money.) Dial **0861 000 300** to find out more. Members on the Essential and Custom options who require chronic medication, will be assisted by the prescribing network provider.

All registered members will receive a letter reflecting the following information:

- list of medicine authorised or rejected as chronic
- authorisation period
- a care plan outlining the authorised treatment and benefits.

To ensure that you continue to obtain your chronic medication, a new prescription needs to be submitted every 6 months.

CHRONIC MEDICATION

A chronic condition is a condition that requires ongoing long-term or continuous medical treatment. Your benefits include cover up to 26 PMB Chronic conditions and HIV/AIDS. The Chronic Medicine Management Programme is designed to manage and authorise payment of appropriate, high-quality and cost-effective medicine from the Chronic Medicine Benefit. The legislated treatment for chronic illnesses include: Diagnosis, Medical Management and Treatment or go to the Scheme's website and click on the formulary button under your option to view the formulary.

SCOPES FOR PRE-AUTHORISATION

When you are having a planned scope it is important to call **0861 000 300** at least 48 hours before for approval. The pre-authorisation team, will confirm your benefits and also inform you how the Scheme will pay your accounts and whether, depending on the procedure you're having done and facility (rooms or hospital), a co-payment or deductible applies.

GLAUCOMA

You are covered for a composite consultation at a PPN provider, which includes refraction, tonometry and visual field screening. Tonometry is a diagnostic test that measures the pressure inside your eye, which is called intraocular pressure (IOP). This measurement can help your provider determine whether or not you may be at risk of glaucoma. Glaucoma is a serious eye disease in which there›s an increased fluid pressure within your eye.

MATERNITY PROGRAMME BABY BUMPS

Pregnant women who are members of Multiply qualify for many benefits. Please call **0861 000 300** for more information.

2023
OPTION BENEFITS

THE ESSENTIAL OPTION
At A Glance

This entry level option is ideal for first time medical cover buyers – young and healthy individuals. It offers them peace of mind every stage of their health journey by using quality provider networks that offer simple day-to-day benefits and hospital cover.

Here's a high-level summary of benefits offered on the Essential option:

Out-Of-Hospital Benefits

Unlimited GP consults Optical benefits and dentistry Pathology and radiology

Access to network specialists. Free and unlimited access to telephonic advice via Hello Doctor – any where, 24/7

11 procedures - refer to page 44

Maternity Benefits

Free comprehensive maternity benefits via the Baby Bumps programme subject to registration onto the programme

Ante-natal care via the network provider

Flu vaccination per pregnancy
Monthly pregnancy vitamins
Paediatric visits at a network provider

In-Hospital Benefits

Unlimited access to state facilities
Unlimited emergency and trauma care in a private hospital

AMBULANCE SERVICES

You have 24-hour access to emergency medical assistance - subject to use of the MHC designated service provider and authorisation

Medicine Benefit

Unlimited acute medicines subject to use of a network GP or pharmacy

Over the counter medicine subject to use of a network pharmacy/formulary

Chronic medication must be obtained from the Scheme's network pharmacy

Don't forget to register onto the Chronic Programme

Wellness Benefits

Reduce your risk and stay healthy

The Wellness benefit allows for early detection and pro-active management of your health.

You are covered by the Scheme when referred by a network provider for:

Blood glucose tests
Blood pressure testing
Cholesterol tests
Clinical Breast Screening (ultrasound) - high risk members
Flu vaccines
Pap smear
Pneumococcal vaccination – high risk members
Prostate specific antigen (PSA) testing
TB screening

Chronic Benefits

You are covered for 15 conditions in 2023:

Addison's Disease
Asthma
Bronchiectasis
Cardiac Failure
Cardiomyopathy
Chronic Obstructive Pulmonary Disease (COPD)
Coronary Artery Disease
Diabetes Insipidus
Diabetes Mellitus 1
Diabetes Mellitus 2
Epilepsy
Glaucoma
Hypertension
Hyperlipidaemia
Hypothyroidism

Other
HIV/AIDS

Don't forget to register onto the Chronic Programme

ESSENTIAL *Option*

MONTHLY CONTRIBUTION			
SALARY BAND	**MEMBER**	**ADULT**	**CHILD**
R0 – R3 275	R423	R253	R170
R3 276 – R7 030	R450	R270	R170
R7 031 – R10 305	R643	R390	R253
R10 306 +	R742	R450	R302

OUT-OF-HOSPITAL BENEFITS

Not sure what we mean? Refer to glossary on page 79

PRIMARY CARE NETWORK ONLY	
General practitioners (GPs)	Unlimited at the primary care network service provider
Specialist Limit	M = R1 660 M+ = R3 320 Subject to network GP referral, pre-authorisation and managed care/ Scheme protocols
Antenatal care	Antenatal care available from a primary care network provider for the first 20 weeks
Prescribed medicines	
Acute	Unlimited at the primary care network provider – subject to network formulary
Over the counter (OTC)	Single member = 3 prescriptions Family = 5 prescriptions
Chronic	Fifteen conditions covered subject to formulary which can be viewed on the website (see page 42) Subject to use of a primary care network provider and protocols
Pathology	Pathology out of hospital - subject to network GP referral and formulary tests
Radiology	Out of hospital - subject to network GP referral and formulary tests

This option is exempt from PMBs. Terms and conditions apply including specific exclusions which can be viewed on the Scheme website - www.mhcmf.co.za

PRIMARY CARE NETWORK ONLY	
Optometry Optical benefit available per beneficiary every 24 months	1 optical test per beneficiary per year 1 pair of clear, standard mono- or bifocal lenses in a standard frame OR Contact lenses to the value of R580 R222 towards a frame outside the standard range Subject to use of primary care network provider and protocols
Basic dentistry Subject to use of primary network provider and protocols	Per beneficiary per annum: one dental examination scaling 4 extractions will be processed automatically and any additional must be pre-authorised 4 fillings will be processed automatically and any additional must be pre-authorised polishing
External prostheses	Per family = R6 650

Out-of-hospital procedures covered by the Essential Benefit Option subject to use of a network provider

TARIFF	TARIFF DESCRIPTION
0300	Stitching of soft-tissue injuries: Stitching of wound (with or without local anaesthesia). Including normal after-care.
0301	Stitching of soft-tissue injuries: Additional wounds stitched at same session (each).
0307	Excision and repair by direct suture. Excision nail fold or other minor procedures of similar magnitude.
0308	Each additional small procedure done at the same time.
0255	Drainage of subcutaneous abscess onychia, paronychia, pulp space or avulsion of nail.
0259	Removal of foreign body in muscle or tendon sheath: simple (not to be used for post-operative removal of Kirschner wires or Steinmann pins).
2133	Circumcision: Clamp procedure.
0887	Limb cast (excluding after-care).
1232	Electrocardiogram: Without effort.
1233	Electrocardiogram: With and without effort.
1136	Nebulisation (in rooms).

This option is exempt from PMBs. Terms and conditions apply including specific exclusions which can be viewed on the Scheme website - www.mhcmf.co.za

Medical and surgical appliances (in- and out-of-hospital)	The following appliances are subject to the annual limit of R2 905 per family subject to motivation and pre-authorization
Glucometers Nebulisers Other Appliances – once every 4 years	R865 per beneficiary every 2 years R865 per family every 3 years Subject to clinical protocols and submission of a motivation/quote Please note that hearing aids are not covered on the Essential option
ADDITIONAL BENEFITS	
Out-of-Hospital Procedures subject to use of a network provider	11 Procedures covered out of hospital. Refer to list on previous page for the detailed information.
Free Hello Doctor advice	Telephonic advice via Hello Doctor. Talk or text a doctor on your phone, any time, any where, in any official language – for free. Refer to page 10 for detailed information.
Out-of-area or emergency visits	Per family = three visits to a maximum of R1 055
Paedriatric visits	1 visit per family subject to the Specialist benefit limit
Wellness Benefit	Refer to pages 5 and 6 for the detailed benefits on free early detection, preventative and ante-natal care.

IN-HOSPITAL BENEFITS

IMPORTANT

Treatment performed in-hospital or falls within the Major Medical Benefits needs to be pre-authorised prior to commencement of treatment. Conditions such as cancer will require you to register onto the Patient Care Programme to access benefits. MHC will pay benefits in accordance with the Scheme Rules and clinical protocols per condition. The sub-limits specified below apply per year. If you join the Scheme after January your limits will be pro-rated.

Public hospital	Unlimited treatment in accordance with Scheme protocols
Private hospital	Resuscitation and stabilisation only Subject to pre-authorisation within 48 hours of admission and managed care protocols
GPs and specialists	Unlimited treatment in a state facility in accordance with Scheme protocols
To-take-out medicine	Up to 7 days
Internal Prostheses	Per family = R9 930 where approved during hospital admission
Oncology	Where approved during hospital admission Subject to state and managed care protocols
Pathology	Where approved during hospital admission Subject to state and managed care protocols
Radiology	Where approved during hospital admission Subject to state and managed care protocols

This option is exempt from PMBs. Terms and conditions apply including specific exclusions which can be viewed on the Scheme website - www.mhcmf.co.za

Confinement	Treatment in accordance with Scheme and state protocols Patient will be referred to a state facility for specialist care and the confinement.
Ambulance	Emergency road transport only Subject to use of DSP, clinical protocols and pre-authorisation

This option is exempt from PMBs. Terms and conditions apply including specific exclusions which can be viewed on the Scheme website - www.mhcmf.co.za

THE CUSTOM OPTION
At A Glance

Targeted at young and healthy members. The Custom plan provides you and your dependants an opportunity to make health part of your journey with quality provider networks and a continuously enhanced benefit package. Here's a high-level summary of benefits offered on the Custom option:

Here's a high-level summary of benefits offered on the Custom option:

Out-Of-Hospital Benefits

Unlimited GP consults
Access to network specialists Optical benefits, dentistry
Pathology and radiology
Free and unlimited access to telephonic advice via Hello Doctor – any where, 24/7

Maternity Benefits

Free comprehensive maternity benefits via the Baby Bumps programme subject to registration onto the programme

Ante-natal care via the network provider
Maternity scans
Flu vaccination per pregnancy
Monthly pregnancy vitamins
Paediatric visits at a network provider

In-Hospital Benefits

Unlimited access to state facilities

Private hospital cover subject to an annual limit

AMBULANCE SERVICES

You have 24-hour access to emergency medical assistance - subject to use of the designated service provider and authorisation

Medicine Benefit

Unlimited acute medicines subject to use of a network GP or pharmacy

Over the counter medicine subject to use of a network pharmacy/formulary

Chronic medication must be obtained from the Scheme's network pharmacy

Don't forget to register onto the Chronic Programme

Chronic Benefits

You are covered for:

Addison's Disease
Asthma
Bronchiectasis
Cardiac failure
Cardiomyopathy
Chronic Obstructive Pulmonary Disease (COPD)
Chronic Renal Disease
Coronary Artery Disease
Crohn's Disease
Depression
Diabetes Insipidus
Diabetes Mellitus Type 1
Diabetes Mellitus Type 2
Dysrhythmia
Epilepsy
Glaucoma
Hyperlipidaemia
Hypertension
Hypothyroidism
Multiple Sclerosis
Parkinson's Disease
Rheumatoid Arthritis
Schizophrenia
Systemic Lupus Erythematosus (SLE)
Ulcerative Colitis

Non-CDL conditions
Depression
Menopause

Other
HIV/AIDS
Oncology

Don't forget to register onto the Chronic Programme

WELLNESS BENEFITS

Reduce your risk and stay healthy
The Wellness benefit allows for early detection and pro-active management of your health
You are covered by the Scheme when referred by a network provider for:

Baby immunisation – DoH schedule
Blood glucose tests
Cholesterol tests
Mammogram
Pap smear
Pneumococcal vaccination – high risk members
Prostate specific antigen (PSA) Testing
Flu vaccines

CUSTOM *Option*

MONTHLY CONTRIBUTION			
SALARY BAND	**MEMBER**	**ADULT**	**CHILD**
R0 – R3 490	R1160	R929	R297
R3 491 – R6 290	R1 220	R972	R308
R6 291 – R9 195	R1 336	R1 072	R335
R9 196 – R11 360	R1 528	R1 226	R390
R11 361 +	R2 127	R1 704	R533

OUT-OF-HOSPITAL BENEFITS

Not sure what we mean? Refer to glossary on page 79

PRIMARY CARE NETWORK ONLY	
General practitioners (GPs)	Unlimited at the primary care network service provider
Specialists	M = R4 300 M+ = R8 615 Subject to network GP referral, pre-authorisation and managed care/ Scheme protocols
Medicines Acute	Unlimited at the primary care network provider – subject to network formulary
Over the counter (OTC)	Single member = 5 prescriptions Family = 7 prescriptions
Chronic	24 CDL conditions (see page 48) and 2 non-CDL Formulary available on website Subject to use of primary network provider and protocols
Optometry Optical benefit available per beneficiary every 24 months	1 optical test per beneficiary per year 1 pair of clear, standard mono- or bifocal lenses in a standard frame OR Contact lenses to the value of R580 R222 towards a frame outside the standard range Subject to use of primary care network service provider and protocols

This option is exempt from PMBs. Terms and conditions apply including specific exclusions which can be viewed on the Scheme website - www.mhcmf.co.za

Pathology and Radiology Out-of-hospital	Pathology and radiology - subject to network GP referral and formulary tests
PRIMARY CARE NETWORK ONLY	
Dentistry Basic - per beneficiary per annum Subject to use of primary network provider and protocols	One dental examination Scaling 4 extractions will be processed automatically and any additional must be pre-authorised 4 fillings will be processed automatically and any additional must be pre-authorised Polishing Per adult beneficiary – 1 set of plastic dentures every 24 months
MRI, CT, PET and radio isotope scans	Sub-limit per beneficiary = R3 305, subject to specialist limit
External prosthesis	R11 045 per family per annum. Subject to clinical protocols and the overall annual limit
Medical and surgical appliances (in and out of hospital)	The following appliances are subject to the annual limit of R7 725 per family Subject to motivation and pre-authorisation Please call **0861 000 300** for assistance
Glucometers Nebulisers Other appliances – once every 4 years	R865 per beneficiary every 2 years R865 per family every 3 years Subject to clinical protocols Please note hearing aids are not covered on the Custom option
ADDITIONAL BENEFITS	
Free Hello Doctor advice	Telephonic consults via Hello Doctor. Talk or text a doctor on your phone, any time, any where, any official language – for free Refer to page 10 for detailed information
Out-of-area or emergency visits	Per family = 3 visits to a maximum of R1 055
Wellness Benefit	Refer to pages 6 and page 7 for the detailed benefits on free early detection, preventative care, ante-natal care and patient care programmes.

This option is exempt from PMBs. Terms and conditions apply including specific exclusions which can be viewed on the Scheme website - www.mhcmf.co.za

IN-HOSPITAL BENEFITS

IMPORTANT

Treatment performed in-hospital or falls within the Major Medical Benefits needs to be pre-authorised prior to commencement of treatment. Conditions such as cancer will require you to register onto the Patient Care Programme to access benefits. MHC will pay benefits in accordance with the Scheme Rules and clinical protocols per condition. The sub-limits specified below apply per year. If you join the Scheme after January your limits will be pro-rated.

Overall Annual Limit (OAL)	Single member = R344 580 Family = R605 230 All services are subject to pre-authorisation and managed care protocols
Public hospital	Unlimited treatment in accordance with Scheme and state protocols
Private hospital Network hospital: Life Healthcare	Subject to the overall annual limit and use of the Scheme network hospitals A 30% co-payment will be applied for voluntary use of a non-network provider
CO-PAYMENT FOR SPECIALISED PROCEDURES/TREATMENT	
Procedure/treatment Gastroscopy, colonoscopy, sigmoidoscopy, functional nasal and sinus procedures, nail surgery, treatment of headaches, removal of skin lesions	If performed in hospital A co-payment of R1 200 will apply per admission which needs to be paid directly by the member to the treating practitioner If performed out of hospital Procedure will be paid at scheme rate subject to pre-authorisation and clinical protocols
GPs and specialists	Unlimited treatment in accordance with Scheme protocols and use of network providers Admission to private hospital subject to overall annual limit Claims paid up to the agreed rate with the provider
To-take-out medicine	Up to 7 days
Internal prostheses	Per family per annum = R17 670 where approved during hospital admission subject to the overall annual limit
Alternate care instead of hospitalisation	Per family = 30 days to a maximum of R23 190
Mental health (in and out of hospital)	Subject to the overall annual limit and up to a sub-limit of R24 570 Subject to clinical protocols
Alcohol and drug rehabilitation	100% of the negotiated rate, at a South African National Council on Alcoholism and Drug Dependence (SANCA) approved facility, subject to the mental health sub-limit
Oncology	Per family = R77 310, subject to overall annual limit

This option is exempt from PMBs. Terms and conditions apply including specific exclusions which can be viewed on the Scheme website - www.mhcmf.co.za

Pathology	Per beneficiary = R8 090, subject to overall annual limit
Radiology	Per beneficiary = R8 090, subject to overall annual limit
CO-PAYMENT FOR SPECIALISED PROCEDURES/TREATMENT	
Medical and surgical appliances (in and out of hospital)	Per family = R7 725 subject to overall annual limit
Maternity	Confinement: Public hospital – Treatment in accordance with Scheme protocols Private hospital – Subject to overall annual limit and use of the hospital network providers
Ambulance	Emergency road transport only Subject to use of DSP, clinical protocols and pre-authorisation

This option is exempt from PMBs. Terms and conditions apply including specific exclusions which can be viewed on the Scheme website - www.mhcmf.co.za

HOSPICARE AND HOSPICARE NETWORK OPTION *At A Glance*

Targeted at members requiring hospital cover primarily. The extensive in and out of hospital benefits are for PMB conditions/treatment only with some value-added benefits. Members on the Hospicare Network option can enjoy significant savings on their monthly contributions and still enjoy comprehensive benefits.

Here's a high-level summary of benefits offered on the Hospicare and Hospicare Network options:

Out-Of-Hospital Benefits

Access to day-to-day benefits via an approved treatment plan, which includes mammograms as per clinical criteria

Free and unlimited access to telephonic advice via Hello Doctor – any where, 24/7

Maternity Benefits

Free comprehensive maternity benefits via the Baby Bumps programme subject to registration onto the programme

Benefits include ante-natal care, scans, vitamins and paediatric visits

Patient Care Programmes

Free access to patient care programmes that manage chronic diseases such as diabetes, oncology, chronic renal disease and a lot more

Medicine Benefit

Treatment for chronic conditions - subject to an approved treatment plan

Chronic medication must be obtained from the Scheme's network pharmacy

Don't forget to register onto the Chronic Programme

Chronic Benefits

You are covered for:
Addison's Disease
Asthma
Bipolar mood disorder
Bronchiectasis
Cardiac failure
Cardiomyopathy
Chronic Obstructive Pulmonary Disease (COPD)
Chronic Renal Disease
Coronary Artery Disease
Crohn's Disease
Diabetes Insipidus
Diabetes Mellitus Type 1
Diabetes Mellitus Type 2
Dysrhythmia
Epilepsy
Glaucoma
Haemophilia
Hyperlipidaemia
Hypertension
Hypothyroidism
Menopause
Multiple Sclerosis
Parkinson's Disease
Rheumatoid Arthritis
Schizophrenia
Systemic Lupus Erythematosus (SLE)
Ulcerative Colitis

Other
HIV/AIDS
Oncology

Don't forget to register onto the Chronic Programme

IN-HOSPITAL BENEFITS

Unlimited access to state facilities
Unlimited private hospital cover for PMB treatment
Additional benefits for selected non-PMB procedures performed in-hospital

AMBULANCE SERVICES

You have 24-hour access to emergency medical assistance subject to use of the MHC designated service provider and authorisation

HOSPICARE *Option*

MONTHLY CONTRIBUTION			
OPTION	**MEMBER**	**ADULT**	**CHILD**
Hospicare Network	R2 207	R1 870	R551
Hospicare	R2 556	R2 162	R635

OUT-OF-HOSPITAL BENEFITS

Not sure what we mean? Refer to glossary on page 79

	HOSPICARE NETWORK	HOSPICARE
Day-to-day	As part of an approved treatment plan	As part of an approved treatment plan
General practitioners (GPs) and specialists	271 DTPs; PMB treatment only Specialists subject to preferred provider rates	271 DTPs; PMB treatment only Specialists subject to preferred provider rates
Medicines		
Acute	271 DTPs; PMB treatment only	271 DTPs; PMB treatment only
Chronic	26 conditions (see page 55)	26 conditions (see page 54)
Network provider	Medipost Pharmacy	Scheme's pharmacy network
Co-payment for non-formulary medicine	20%	20%
Co-payment for non-network provider	30%	30%
Non-CDL chronic medicine limit	271 DTPs; PMB treatment only	271 DTPs; PMB treatment only
Optometry	271 DTPs; PMB treatment only	271 DTPs; PMB treatment only
Dentistry Basic and specialised	271 DTPs; PMB treatment only	271 DTPs; PMB treatment only
Auxiliary services	271 DTPs; PMB treatment only	271 DTPs; PMB treatment only

ADDITIONAL BENEFITS	HOSPICARE NETWORK	HOSPICARE
Free Hello Doctor advice	Telephonic advice via Hello Doctor. Talk or text a doctor on your phone, any time, any where, official language – for free Refer to page 10 for detailed information	Telephonic advice via Hello Doctor.Talk or text a doctor on your phone, any time, any where, official language – for free Refer to page 10 for detailed information
Maternity	12 antenatal visits Two 2D scans per pregnancy 3D and 4D scans are paid up to the rate of 2D scans Two paediatric visits Pregnancy related vitamins	12 antenatal visits Two 2D scans per pregnancy 3D and 4D scans are paid up to the rate of 2D scans. Two paediatric visits Pregnancy related vitamins
Medical and surgical appliances	271 DTPs; PMB treatment only	271 DTPs; PMB treatment only
Hearing aids	271 DTPs; PMB treatment only	271 DTPs; PMB treatment only
Mental health	271 DTPs; PMB treatment only	271 DTPs; PMB treatment only
Child immunisations	Up to the age of 6 years, as per Department of Health protocols	Up to the age of 6 years, as per Department of Health protocols
Patient care programmes (Diabetes, HIV, oncology)	Subject to registration and managed care protocols	Subject to registration and managed care protocols

IN-HOSPITAL BENEFITS

IMPORTANT

Treatment performed in-hospital or falls within the Major Medical Benefits needs to be pre-authorised prior to commencement of treatment. Conditions such as cancer will require you to register onto the Patient Care Programme to access benefits. MHC will pay benefits in accordance with the Scheme Rules and clinical protocols per condition. The sub-limits specified below apply per year. If you join the Scheme after January your limits will be pro-rated.

All services are subject to pre-authorisation and managed care protocols	Network hospital: Life Healthcare PMBs only	Any hospital – PMBs only
Public and private hospital	Unlimited – PMBs only 30% co-payment for use of non-network provider	Unlimited – PMBs only
GPs and specialists	271 DTPs; PMB treatment only	271 DTPs; PMB treatment only
To-take-out medicine	Up to 7 days	Up to 7 days
Organ transplant *	Unlimited – PMBs only	Unlimited – PMBs only
Prostheses	Unlimited – PMBs only	Unlimited – PMBs only
Reconstructive surgery	Unlimited – PMBs only	Unlimited – PMBs only

MRI, CT, PET and radio isotope scans	Unlimited – PMBs only	Unlimited – PMBs only
Alternate care instead of hospitalisation	Unlimited – PMBs only Subject to clinical protocols and pre-authorisation	Unlimited – PMBs only Subject to clinical protocols and pre-authorisation
Mental health	100% of Scheme rate subject to managed care protocols	100% of Scheme rate subject to managed care protocols
Alcohol and drug rehabilitation	100% of negotiated rate, at a South African National Council on Alcoholism and Drug Dependence (SANCA) approved facility Subject to managed care protocols	100% of negotiated rate, at a South African National Council on Alcoholism and Drug Dependence (SANCA) approved facility Subject to managed care protocols
Dialysis	Unlimited – PMBs only	Unlimited – PMBs only
Oncology Treatment covered at DSP rates if a network provider is used	Unlimited – PMBs only	Unlimited – PMBs only
Pathology and radiology	Unlimited – PMBs only	Unlimited – PMBs only
Ambulance transport	Road and air transportation PMB only Subject to use of preferred provider, clinical protocols and pre-authorisation	Road and air transportation PMB only Subject to use of preferred provider, clinical protocols and pre-authorisation
ADDITIONAL BENEFITS		
Only the 7 non-PMB procedures listed are covered in hospital at a network provider and is paid at the Scheme rate	Tonsillectomy Adenoidectomy Basic dentistry – up to the age of 8 Grommets Carpal tunnel Varicose veins Bunionectomy	Tonsillectomy Adenoidectomy Basic dentistry – up to the age of 8 Grommets Carpal tunnel Varicose veins Bunionectomy

***Organ transplant benefit includes:**

- Heart, liver and kidney transplants, including harvesting and transportation costs.
- Corneal transplant, including harvesting and transportation costs.

All requests will be subject to clinical protocols and use of a national donor only.

THE CLASSIC AND CLASSIC NETWORK OPTION
At A Glance

This new generation plan provides members with the flexibility and independence to manage their own day- to-day expenses via generous savings and a rich hospital cover. Members on the Classic Network option can enjoy significant savings on their monthly contributions and still enjoy comprehensive benefits.

Here's a high-level summary of benefits offered on the Classic and Classic Network options:

Out-Of-Hospital Benefits

Unlimited GP and Specialists consults
Access to optical and dentistry benefits

Free emergency medical care via ER made EASY

Free and unlimited access to telephonic advice via Hello Doctor – any where, 24/7

Maternity Benefits

Free comprehensive maternity benefits via the Baby
Bumps programme subject to registration onto the programme

Benefits include ante-natal care, scans, vitamins and paediatric visits

In-Hospital Benefits

Unlimited access to state facilities

Unlimited private hospital cover

AMBULANCE SERVICES
You have 24-hour access to emergency medical assistance - subject to use of the MHC designated service provider and authorisation

Medicine Benefit

Access to acute and preventative medicines
Over the counter medicine subject to use of a network pharmacy/formulary

Chronic medicine for 26 conditions - medicines must be obtained from the Scheme's network pharmacy. Plus, cover for non-CDL conditions and medicines

Don't forget to register onto the Chronic Programme

Chronic Benefits

You are covered for:

Addison's Disease
Asthma
Bipolar mood disorder
Bronchiectasis
Cardiac failure
Cardiomyopathy
Chronic Obstructive Pulmonary Disease (COPD)
Chronic Renal Disease
Coronary Artery Disease
Crohn's Disease
Diabetes Insipidus
Diabetes Mellitus Type 1
Diabetes Mellitus Type 2
Dysrhythmia
Epilepsy
Glaucoma
Haemophilia
Hyperlipidaemia
Hypertension
Hypothyroidism
Menopause
Multiple Sclerosis
Parkinson's Disease
Rheumatoid Arthritis
Schizophrenia
Systemic Lupus Erythematosus (SLE)
Ulcerative Colitis

Other
HIV/AIDS
Oncology

Don't forget to register onto the Chronic Programme

Wellness Benefits

Reduce your risk and stay healthy
The Wellness benefit allows for early detection and pro-active management of your health

You are covered by the Scheme for:

Dexa bone density scan
Cholesterol test
Mammogram
Pap smear
Prostate specific antigen (PSA) testing
Tetanus diphtheria injection
Glucose test
TB Screening
Glaucoma screening
Pneumococcal and flu vaccines - high risk members

CLASSIC *Option*

ANNUAL SAVINGS LIMIT (ASL)
This is the portion of your monthly contribution that is allocated to a savings account that is held in the principal member's name. The money in this account is used to pay for out-of-hospital medical expenses

OPTION	MEMBER	ADULT	CHILD
Classic Network	R7 416	R6 288	R1 848
Classic	R8 700	R7 380	R2 172
MONTHLY CONTRIBUTION			
OPTION	MEMBER	ADULT	CHILD
Classic Network	R3 670	R3 113	R918
Classic	R4 304	R3 653	R1 078

Out-Of-Hospital Benefits

Not sure what we mean? Refer to glossary on page 79

Day-to-day benefits on the Classic and Classic Network options are subject to your ASL, which covers non-PMB, out-of-hospital claims such as GPs, dentists, specialists, medication, optometrists, etc. Once you have exhausted your ASL, you will need to pay for any addition- al day-to-day claims yourself. A portion of your monthly contribution is allocated to your ASL. The annual savings amount is calculated over a period of 12 months or if you join the Fund during the year, the amount will be allocated on a pro-rata basis. At the end of the year, any unused savings will roll over to the next year.

NOTES

Your annual savings amount is allocated upfront. If you terminate your membership with the Scheme before the end of the year and you have used more than the contributions that you have paid, you will be requested to pay the difference to the Scheme.

Once you have exhausted your ASL, you will have to pay healthcare providers for day-to-day services out of your own pocket.

	CLASSIC NETWORK	CLASSIC
General practitioners (GPs) and specialists	Subject to ASL	Subject to ASL
Telehealth	Subject to ASL Scheme rates and managed care protocols apply Please call **0861 000 300** for more information	Subject to ASL Scheme rates and managed care protocols apply Please call **0861 000 300** for more information

	CLASSIC NETWORK	CLASSIC
Medicines Acute Over the counter (OTC) Preventative medicines	Subject to ASL R240 per event per day Paid from ASL – refer to page 13	Subject to ASL R240 per event per day Paid from ASL – refer to page 13
Chronic benefit Benefits are subject to registration onto the chronic management programme	Provider - Medipost pharmacy 26 conditions covered as per the chronic disease list and prescribed minimum benefits Refer to page 22 for more information on co-payments	Provider - Network pharmacy 26 conditions covered as per the chronic disease list and prescribed minimum benefits Refer to page 22 for more information on co-payments
Optometry Subject to ASL	Per beneficiary: 1 composite eye examination,a frame of up to R905 and 2 lenses every 24 months OR contact lenses of up to R1 530 instead of glasses per year Members may utilise positive savings for claim values above the annual optometry limits. Please call **0861 000 300** for more information	Per beneficiary: 1 composite eye examination, a frame of up to R905 and 2 lenses every 24 months OR contact lenses of up to R1 530 instead of glasses per year Members may utilise positive savings for claim values above the annual optometry limits. Please call **0861 000 300** for more information
Dentistry: Basic and specialised Please note that, while dentures are covered, there is a limit of 1 set of dentures every 4 years per beneficiary. General anaesthetic is available for children under the age of 8 for extensive basic treatment and this is limited to once every 24 months per beneficiary. Cover is available for the removal of impacted wisdom teeth in theatre but must be pre-authorised by emailing a detailed quotation and clear panoramic radiograph to the dental department.	Subject to ASL	Subject to ASL
Auxiliary services	Subject to ASL	Subject to ASL

ADDITIONAL BENEFITS (not paid from ASL)		
Chronic medicines	26 conditions – unlimited (page 60) – plus 10 conditions, subject to sub-limits:	26 conditions – unlimited (page 59) – plus 10 conditions, subject to sub-limits:
Non-CDL chronic medicine	M – R5 180 M1 – R10 250 M2 – R12 790 M3 – R13 845 M4 – R15 745 M5+ – R18 180	M – R5 180 M1 – R10 250 M2 – R12 790 M3 – R13 845 M4 – R15 745 M5+ – R18 180
Network provider	Medipost Pharmacy	Scheme network pharmacy
Co-payment for non-formulary medicine	20%	20%
Co-payment for use of non-network provider	30%	30%
Free Hello Doctor advice	Telephonic advice via Hello Doctor. Talk or text a doctor on your phone, any time, any where, any official language – for free. Refer to page 10 for detailed information	Telephonic advice via Hello Doctor. Talk or text a doctor on your phone, any time, any where, any official language – for free. Refer to page 10 for detailed information
Medical and surgical appliances General appliances per family per annum	R14 690	R14 690
Sub-limits to Appliance Benefit: Glucometer per beneficiary every 2 years	R865	R865
Nebuliser per family every 3 years	R865	R865
External Prosthesis per family per annum	R25 900	R25 900
MRI, CT, PET and radio isotope scans	R15 000 per scan Per family = 2 scans paid from risk benefits thereafter ASL Subject to pre-authorisation and managed care protocols	R15 000 per scan Per family = 2 scans paid from risk benefits thereafter ASL Subject to pre-authorisation and managed care protocols
	CLASSIC NETWORK	**CLASSIC**
Hearing aids	Subject to medical and surgical appliance limit every 3 years	Subject to medical and surgical appliance limit every 3 years
Hearing aid maintenance	R1 160 per beneficiary per annum Subjected to Medical and Surgical Appliance Benefit	R1 160 per beneficiary per annum Subjected to Medical and Surgical Appliance Benefit
Mental health	Subject to ASL	Subject to ASL

	CLASSIC NETWORK	CLASSIC
Extra consultations and medicine (Only once ASL reaches R300 limit. Medication limit R300)	Single member = 2 visits Family = 5 visits	Single member = 2 visits Family = 5 visits
Patient care programmes (Diabetes, HIV, oncology)	Subject to registration and managed care protocols	Subject to registration and managed care protocols

In-Hospital Benefits

IMPORTANT

Treatment performed in-hospital or falls within the Major Medical Benefits needs to be pre-authorised prior to commencement of treatment. Conditions such as cancer will require you to register onto the Patient Care Programme to access benefits. MHC will pay benefits in accordance with the Scheme Rules and clinical protocols per condition. The sub-limits specified below apply per year. If you join the Scheme after January your limits will be pro-rated.

SUBJECT TO PRE-AUTHORISATION AND MANAGED CARE PROTOCOLS	CLASSIC NETWORK	CLASSIC
In-hospital limits	Network hospital - Life Healthcare	Any hospital
State and private hospital	Unlimited 30% co-payment for using non-network provider	Unlimited
CO-PAYMENT FOR SPECIALISED PROCEDURES/TREATMENT (This co-payment is only applicable to benefit below and not the entire benefit)		
Procedure/treatment Gastroscopy, colonoscopy, sigmoidoscopy, arthroscopy, joint replacements, diagnostic laparoscopy, urological scopes and facet joint injections	If performed in hospital A co-payment of R1 200 will apply per admission which needs to be paid directly by the member to the treating practitioner If performed out of hospital Procedure will be paid at scheme rate subject to pre-authorisation and clinical protocols	If performed in hospital A co-payment of R1 200 will apply per admission which needs to be paid directly by the member to the treating practitioner If performed out of hospital Procedure will be paid at scheme rate subject to pre-authorisation and clinical protocols
GPs and specialists	At Scheme rate Specialists subject to preferred provider rates	At Scheme rate Specialists subject to preferred provider rates
To-take-out medicine	Up to 7 days	Up to 7 days
Organ transplants (non-PMB cases)	Per family = R71 770 (limit includes harvesting and transportation costs) National donor only	Per family = R71 770 (limit includes harvesting and transportation costs) National donor only
Internal prosthesis	Per family per annum = R40 800	Per family per annum = R40 800
Refractive eye surgery	Per beneficiary per eye = R6 170 maximum of R12 340 for both eyes once per lifetime	Per beneficiary per eye = R6 170 maximum of R12 340 for both eyes once per lifetime
Reconstructive surgery (as part of PMBs)	Per family = R71 660	Per family = R71 660

SUBJECT TO PRE-AUTHORISATION AND MANAGED CARE PROTOCOLS	CLASSIC NETWORK	CLASSIC
MRI, CT, PET and radio isotope scans	R15 000 per scan Per family = 2 scans paid from risk thereafter from ASL subject to motivation Subject to clinical protocols and pre-authorisation	R15 000 per scan Per family = 2 scans paid from risk thereafter from ASL subject to motivation Subject to clinical protocols and pre-authorisation
Alternate care instead of hospitalisation	Per family = 30 days to a maximum of R38 580 per event subject to clinical protocols and pre-authorisation	Per family = 30 days to a maximum of R38 580 per event subject to clinical protocols and pre-authorisation
Mental health (in- and out-of-hospital)	100% of Scheme rate subject to clinical protocols and pre-authorisation	100% of Scheme rate subject to clinical protocols and pre-authorisation
Alcohol and drug rehabilitation	100% of negotiated rate, at a South African National Council on Alcoholism and Drug Dependence (SANCA) approved facility	100% of negotiated rate, at a South African National Council on Alcoholism and Drug Dependence (SANCA) approved facility
Oncology in and out of hospital Non-PMB cases PMB cases	Per family = R500 000 per annum 20% co-payment after limit has been reached Subject to clinical protocols and pre-authorisation Unlimited	Per family = R500 000 per annum 20% co-payment after limit has been reached Subject to clinical protocols and pre-authorisation Unlimited
Pathology and basic radiology	At Scheme rate	At Scheme rate
Dialysis	Subject to use of preferred provider, clinical protocols and pre-authorisation	Subject to use of preferred provider, clinical protocols and pre-authorisation
General dentistry	Subject to ASL and dental protocols	Subject to ASL and dental protocols
Ambulance transport	Emergency – road and air Subject to use of the designated service provider, clinical protocols and pre-authorisation	Emergency – road and air Subject to use of the designated service provider, clinical protocols and pre-authorisation

THE OPTIMUM OPTION
At A Glance

This traditional and first-class plan provides members with comprehensive cover which includes extensive day-to-day benefits paid from the insured benefits and unlimited hospital cover. The option to choose if you would like a choice of providers.

Here's a high-level summary of benefits offered on the Optimum options:

Out-Of-Hospital Benefits

Unlimited GP and Specialists consults

Free emergency medical care via ER made EASY

Free and unlimited access to telephonic advice via Hello Doctor – any where, 24/7

Access to optical and dentistry benefits

Maternity Benefits

Free comprehensive maternity benefits via the Baby Bumps programme subject to registration onto the programme. Benefits include ante-natal care, scans, vitamins and paediatric visits

In-Hospital Benefits

Unlimited access to state facilities
Unlimited private hospital cover

AMBULANCE SERVICES

You have 24-hour access to emergency medical assistance - subject to use of the MHC designated service provider and authorisation

Medicine Benefit

Access to acute and preventative medicines Over the counter medicine subject to use of a network pharmacy/formulary.Chronic medicine for 26 conditions - medicines must be obtained from the Scheme's network pharmacy. Additional cover for non-CDL conditions and medicines

Don't forget to register onto the Chronic Programme

Chronic Benefits

You are covered for:

Addison's Disease
Asthma
Bipolar mood disorder
Bronchiectasis
Cardiac failure
Cardiomyopathy
Chronic Obstructive Pulmonary Disease (COPD)
Chronic Renal Disease
Coronary Artery Disease
Crohn's Disease
Diabetes Insipidus
Diabetes Mellitus Type 1
Diabetes Mellitus Type 11
Dysrhythmia
Epilepsy
Glaucoma
Haemophilia
Hyperlipidaemia
Hypertension
Hypothyroidism
Menopause
Multiple Sclerosis
Parkinson's Disease
Rheumatoid Arthritis
Schizophrenia
Systemic Lupus Erythematosus (SLE)
Ulcerative Colitis

Other
HIV/AIDS
Oncology

Wellness Benefits

Reduce your risk and stay healthy
The Wellness benefit allows for early detection and pro-active management of your health.

You are covered by the Scheme for:

Dexa bone density scan
Cholesterol test
Mammogram
Pap smear
Prostate specific antigen (PSA) testing
Tetanus diphtheria injection
Glucose test
TB Screening
Glaucoma screening
Pneumococcal and flu vaccines - high risk members

OPTIMUM *Option*

MONTHLY CONTRIBUTION		
MEMBER	**ADULT**	**CHILD**
R7 922	R6 744	R1 984

Out-Of-Hospital Benefits

Not sure what we mean? Refer to glossary on page 79

ANY PROVIDER	
Day-to-day limit	M – R29 270 M1 – R40 800 M2 – R47 450 M3+ – R55 700
General practitioners (GPs) and specialists	Subject to day-to-day limit
Telehealth	Subject to day-to-day limit Scheme rates and managed care protocols apply Please call 0861 000 300 for more information
Medicines	
Acute medicine	M – R13 250 M1 – R14 350 M2 – R16 900 M3 – R18 440 M4+ – R19 660
Over the counter (OTC)	R240 per event per day
Chronic benefit Benefits are subject to registration onto the chronic management programme	Provider - Any provider 26 conditions covered as per the chronic disease list and prescribed minimum benefits. Refer to page 22 for more information on co-payments
Optometry	Per beneficiary = 1 composite eye examination Per beneficiary = a frame of up to R1 425 and 2 lenses every 24 months OR Contact lenses of up to R2 280 instead of glasses per year
Dentistry	
Basic	Single member = R2 590 Family = R5 220
Specialised	Single member = R15 090 Family = R22 400

Auxiliary services	At a preferred provider, subject to auxiliary sub-limit and day-to-day limits
Sub-limits	Single member = R5 635 Family = R17 015

ADDITIONAL BENEFITS (paid from risk benefits)

Chronic medicine Non-CDL chronic medicine limit	26 conditions – unlimited – plus 28 conditions, subject to sub-limits: M – R7 290 M1 – R14 580 M2 – R15 745 M3 – R18 180 M4 – R20 080 M5+ – R21 240
Co-payment for non-formulary medicine	20%
Free Hello Doctor advice	Telephonic advice via Hello Doctor. Talk or text a doctor on your phone, any time, any where, any official language – for free Refer to page 10 for detailed information.
Medical and surgical appliances – general Sub-limits to Appliance Benefit Glucometer per beneficiary every 2 years Nebuliser per family every 3 years	Per family = R10 990 R865 R865
Hearing aids Per beneficiary every 3 years Hearing aid maintenance	 Unilateral = R12 890 Bilateral = R25 890 R1 160 per beneficiary per annum
External Prosthesis	Per family per annum = R30 650
Patient care programmes (Diabetes, HIV, oncology)	 Subject to registration and managed care protocols

In-Hospital Benefits

IMPORTANT

Treatment performed in-hospital or falls within the Major Medical Benefits needs to be pre-authorised prior to commencement of treatment. Conditions such as cancer will require you to register onto the Patient Care Programme to access benefits. MHC will pay benefits in accordance with the Scheme Rules and clinical protocols per condition. The sub-limits specified below apply per year. If you join the Scheme after January your limits will be pro-rated.

ANY HOSPITAL Subject to pre-authorisation and managed care protocols	
Public and private hospital	Unlimited
CO-PAYMENT FOR SPECIALISED PROCEDURES/TREATMENT (This co-payment is only applicable to benefit below and not the entire benefit)	
Procedure/treatment Gastroscopy, colonoscopy, sigmoidoscopy, arthroscopy, joint replacements, diagnostic laparoscopy, urological scopes and facet joint injections	**If performed in hospital:** A co-payment of R1 200 will apply per admission which needs to be paid directly by the member to the treating practitioner **If performed out of hospital:** Procedure will be paid at Scheme rate subject to pre-authorisation and clinical protocols
GPs and specialists	Unlimited Specialist – subject to preferred provider rates
To-take-out medicine	Up to 7 days
Organ transplants (non-PMB cases)	Per family = R71 660 limit includes harvesting and transportation costs National donor only
Internal prostheses	Per family per annum = R49 670
Refractive eye surgery	Per beneficiary per eye = R6 170; maximum of R R12 340 for both eyes once per lifetime
Reconstructive surgery	Per family = R71 660
MRI, CT, PET and radio isotope scans	R15 000 per scan per family per annum = 2 scans from risk thereafter from the annual day-today limit subject to clinical protocols and pre-authorisation
Alternate care instead of hospitalisation	Per family = 30 days to a maximum of R43 545 per event subject to clinical protocols and pre-authorisation
Mental health (in- and out-of-hospital)	100% of Scheme rate – Subject to clinical protocols and pre-authorisation
Alcohol and drug rehabilitation	100% of negotiated rate, a South African National Council on Alcoholism and Drug Dependence (SANCA) approved facility Subject to clinical protocols
Oncology	Unlimited clinical protocols and pre-authorisation
Pathology and radiology	Unlimited subject to clinical protocols
Dialysis	Unlimited and subject to use of preferred provider, clinical protocols and pre-authorisation
General dentistry	Subject to day-to-day limit and sub-limits
Ambulance transport	Emergency road and air transport subject to use of the designated service provider, clinical protocols and pre-authorisation

IMPORTANT TO *Remember*

HOW TO GET THE MOST FROM YOUR OPTION

- Have an annual check-up at your general practitioner to make sure that you are healthy and, if there are any concerns, request your doctor to start treatment sooner rather than later.
- Remember to check if your option has network providers – using these providers will reduce or even prevent a co-payment.
- Where possible, use a day clinic for day procedures, e.g. for a tonsillectomy or adenoidectomy.
- Register on the chronic medicine programme as soon as you've been diagnosed with a chronic condition.
- Visit www.mhcmf.co.za for any new or updated information.

REMEMBER

It is important that you check whether the Scheme will pay for any procedure, treatment or medicine before accepting it. Failure to check upfront whether it is covered may result in you having to pay for certain services out of your own pocket. Exclusions to some of the prescribed minimum benefits (PMBs) may be applied upon joining the Scheme. The diagnosis and treatment of PMBs on the Custom and Essential options are paid in accordance with the registered rules of Scheme. These options are exempt from PMB legislation.

Member online access

(Web-based self-help facility)

Using the Scheme's self-help facility at www.mhcmf.co.za and the mobi app allows you to check your personal and medical scheme information. You can update your contact details, language preferences and other information and view your benefit information and claims statements.

Please follow these steps:

1. Open your internet browser (for example, Internet Explorer)
2. Go to www.mhcmf.co.za
3. On the Scheme's homepage in the menu bar, click on the login button and then on member login.
4. You can now view the online solutions box that will give you the option to log in, register or obtain a new username and password if you have forgotten your previous one. If you want to register or obtain a new username and password, fill out the required details.
5. Once you are logged in, you will see the Member Online homepage. You can check your personal membership information by clicking on any of the menu items; for example, click on the claims menu to view your latest claims information or update your communication details by clicking on the relevant section.

Network Providers

The Scheme has negotiated rates with preferred and designated service providers to ensure that these providers do not charge you more than the agreed rate. This will ensure that your benefits last longer and you get value for money. Depending on the option you selected, the network providers have agreed to charge negotiated rates, which means that you will not incur a co-payment unless you select a non-network provider.

Members on the Optimum, Classic and Hospicare options have the choice to select their own general practitioners and specialists for non-PMB treatment. It is recommended that one of the preferred providers is used, as this will reduce or eliminate out-of-pocket payments.

Members on the Custom, Classic Network and Hospicare Network options must use the Life Healthcare Group of hospitals as the network provider for in-hospital treatment; alternatively a 30% co- payment will apply.

On the Classic Network and Hospicare Network options, members must use the Medipost Pharmacy network for chronic medication to avoid incurring a 30% co-payment. Ask your doctor whether he or she will be willing to negotiate reduced rates in line with your benefit cover. Should you be admitted to hospital, make use of a network specialist; this will give you peace of mind that the specialist will charge Scheme rates.

SCHEME *Exclusions*

All medical schemes have a list of services and products that they will not pay for. The Scheme's exclusions are split into general and dental exclusions to make it easy for you to determine what will not be covered by the Scheme.

General exclusions

- Search and rescue
- Complications or the direct and indirect expenses that arise from receiving treatment that is excluded
- Purchase of patent food, including baby food, patent medicines, preparations of the type generally promoted to the public to increase consumption, cosmetics, proprietary preparations, biological substances, contraceptives and slimming preparations, medicines advertised to the public and domestic, biochemical or herbal remedies, except when prescribed by a homeopath, and anti-smoking treatment and substances
- Experimental, unproven or unregistered treatment or practices
- Expenses arising from, or connected to, misconduct, other operations/procedures of choice, other than circumcisions, and preventive procedures
- Treatment or operations for purely cosmetic purposes, obesity, including Pickwickian syndrome, infertility and artificial insemination, as described in the Human Tissue Act, Act 65 of 1983. Except for PMB conditions/treatment, consultations, investigations, examinations, the treatment of infertility and the artificial insemination is an exclusion.
- Treatment for Alzheimer's disease
- Frail care and sickbay care in retirement villages, old age homes or private residences
- Treatment rendered by naturopaths and any other person not registered with the South African Medical and Dental Council as a medical auxiliary or registered with the South African Nursing Council as a registered nurse
- Medical cover outside the borders of South Africa: the Scheme will cover medical treatment rendered in the Southern African Development Community only; treatment will be paid in accordance with
- the Scheme's prescribed rate and the Scheme will apply the South African currency exchange rate applicable on the date the treatment was rendered
- Members travelling outside the borders of South Africa to participate in non-professional or professional sports must ensure he or she takes out additional cover, as this will not be covered by the Scheme
- Reports, examinations and tests requested for emigration, immigration, visas, insurance policies, employment, scholastic abilities, readiness for school, admission to school and universities, court medical reports, muscle-function tests for fitness, fitness examinations and tests, adoption of children and retirement because of ill health
- All costs of whatsoever nature incurred for treatment of sickness conditions or injuries sustained by a member or a dependant and for which any other party is liable; the member is, however, entitled to such benefits as would have applied under normal conditions, provided that on receipt of payment in

- respect of medical expenses, the member will reimburse the Scheme any money paid out in respect of this benefit by the Scheme
- Breathing exercises for chronic airway diseases
- Toiletries, cleansing agents, anabolic steroids and sunblock
- Accounts for appointments not kept by members
- All complementary medicines, including vitamins that can be obtained without a prescription
- Aphrodisiacs
- Cochlear implants
- Ante- and post-natal exercises or classes, or mother-craft and breast-feeding instructions, unless it forms part of a birth management programme
- Costs that are higher than the annual maximum benefit due to the member and his or her dependants in a given calendar year
- Contact lens cleaning materials and spectacle/contact lens cases
- Experimental, unproven or unregistered treatment or practices
- Medical treatment in a research environment
- Maintenance is only covered for hearing aids as per individual plan benefit annexures
- Skin lesions, except where cancer is proven by submission of histology results
- No benefit will be paid for sunglasses or lenses for sunglasses
- Sleep clinics and holidays for recuperative purposes
- Operations, medicines, treatment and procedures for gender alteration or realignment for personal reasons and not directly caused by or related to illness, accident or disease
- Furthermore, any medical condition or complication that arises at a later stage, whether directly or indirectly, as a result of the original, excluded treatment, is similarly excluded from benefitsunless complications qualify as a prescribed minimum benefit
- Any condition that arises from the deliberate refusal of medical treatment, except in the case of terminally ill patients
- Reversal of vasectomies/sterilisation
- Pain relief machines
- Hyperbaric oxygen therapy
- Professional speed contests or professional speed trials (professional is defined as the beneficiary's main form of income is derived from taking part in these contests)
- Prophylactic treatment precribed for malaria by a medical practioner

Dental exclusions

- The cost of general dentistry performed in hospital
- The cost of gold, metal or other inlays in a denture or crown
- Fee for after-hours visits that the Scheme considers as convenience visits
- Bleaching of vital teeth
- Unregistered items and items listed as 'by agreement' or 'not applicable' in the tariff code listing
- Lingual orthodontic treatment
- Services that deviate from the available guidelines of the Department of Health and that are deemed to be excluded from benefits after evaluation of the available information
- Gum guards for sport purposes
- Laboratory costs that, according to the Scheme's norms and judgement, seem to be above the general cost claimed by other dental service providers and laboratories treating similar conditions

- Services or procedures that are regarded by the Scheme as cosmetic, when alternative functional services exist (in which case the benefit will be excluded entirely or in part and/or paid in accordance with the cost of such functional alternative service)
- The cost of a written report compiled by a dental practitioner or specialist for which prior authorisation was not granted by the Scheme

Any treatment listed below:

1. Any specialised treatment listed in the Scheme rules as requiring pre-authorisation where no pre-authorisation was obtained
2. Orthodontic treatment for dependants older than 18 years old
3. Orthodontic procedures, including retainers, are limited to once in a lifetime
4. Electrognathographic recordings and other such electronic analysis
5. Metal base to full dentures, including the laboratory cost
6. Soft base to new dentures
7. Diagnostic dentures
8. Pontic on second molars
9. Provisional and emergency crowns and associated laboratory cost
10. Ozone therapy
11. Resin bonding for restorations charged as separate procedure
12. Dental bleaching and porcelain veneers
13. Laboratory-fabricated crowns and root canal treatment on primary teeth
14. Gingivectomies
15. Periodontal flap surgery and tissue grafting
    i. surgical tooth exposure for orthodontic reason in hospital
    ii. surgical tooth exposure that was not pre-authorised as part of an orthodontic treatment plan
    iii. orthodontic re-treatment or unauthorised initial treatment commencing on an orthodontic treatment plan
    iv. orthognathic (jaw correction) surgery and related hospital costs
    v. bone and other tissue regeneration procedures; cost of bone regeneration material (including laboratory costs)
    vi. multiple hospital admissions for extensive conservative (basic) dentistry in young children (only one admission per child every 24 months)
    vii. laboratory delivery fees
    viii. cost of mineral trioxide
    ix. cost of gold, precious metal, semi-precious metal and platinum foil
    x. in-hospital treatment for procedure not considered as invasive based on fear and anxiety in adults
    xi. surgery associated with dental implants, grafts, etc.
    xii. in-hospital dental implants, dentectomies, and apicectomies
    xiii. mouth guards and snoring appliances and the associated laboratory cost (including material)
    xiv. oral hygiene instructions; PerioChip

COMPLAINTS *And Disputes*

According to the Scheme rules, members may lodge a complaint with the Scheme in any of the following ways:

Contact: **0861 000 300**;
Email: complaints@mhcmf.co.za; or
Write: to Moto Health Care at PO Box 2338, Durban 4000

When you lodge a complaint, the Scheme will acknowledge receipt within 2 working days. There are, however, complaints that need clinical input and investigation and these claims would take longer to resolve. In these cases the Scheme will respond within 30 days.

THE HOW TO

How to file a complaint via the internal process:

1. Call the Customer Service Centre on **0861 000 300** and speak to a service consultant. The member must always obtain a reference number when making a complaint. This reference number is linked to the case (complaint) in the system.
2. If the complaint is not resolved, the member can send the query to the consultant's team leader and/or a customer relationship manager.
3. If the matter is still not resolved, the member may escalate the query to the Scheme's Fund Manager and finally the Principal Officer. At this level, a request may be referred to the Scheme's medical advisory panel for their consideration.
4. If the member is still not satisfied, the member can send a letter of appeal to the Scheme or its Medical Advisory Committee. This can be in the form of either a formal letter or an email – with information on the declined decision and further motivation or new clinical evidence.
5. If the decision made by the Medical Advisory Committee is not acceptable, the member can ask the Scheme's Board of Trustees to review the decision.

External complaint process

1. Once the member has exhausted the internal complaint process, the member may declare a dispute. On written request from the member wherein the full particulars of the complaint is detailed, including proof of all prior interaction with the Scheme and its contracted service providers, where applicable, the Principal Officer will call a meeting of the Dispute Committee to decide on the matter.
2. If the member is not satisfied with the ruling of the Dispute Committee, the member may lodge an appeal with the Council for Medical Schemes.

The Dispute Process

Please make use of all internal procedures available to you to lodge a complaint before appealing an outcome. The appeals process that must be followed, should you not be satisfied with the outcome of your complaint, is:

1. Request in writing that your complaint be escalated to the Disputes Committee.
2. If you are still not satisfied with the outcome of the Dispute Committee's ruling, you can lodge a complaint with the Registrar for Medical Schemes.

MHC'S *Partners*

We have contracted a network of service providers who provide various administrative and operational services to ensure that you get access to quality healthcare. They are as follows:

momentum carecross

- Primary care service management
- Designated service provider network management
- Preferred provider network management

DENTAL RISK COMPANY

- Dental provider network management
- Dental risk management
- Dental pre-authorisation

mediscor pbm

- Formulary management
- Pharmacy benefit management

europ assistance
you live we care

- Ambulance services

momentum health solutions

- Billing
- Case management
- Claims processing
- Contributions and debt management
- Disease management
- Managed care services
- Medicine management
- Membership correspondence services
- Pre-authorisation

PPN
Preferred Provider Negotiators

- Optometry provider network management
- Cataract surgery management

WHAT DO *We Mean?*

We have included a glossary to make the terminology in the benefit descriptions easy to understand. Please contact us should you need assistance or require a better understanding of the benefits and what they entail.

Annual savings limit

This is the portion of your monthly contribution that is allocated to a savings account that is held in the principal member's name. The money in this account is used to pay for out-of-hospital medical expenses.

Acute medicine

This is medicine that is prescribed for a short period of time to alleviate the symptoms of an acute illness or condition, such as antibiotics for an infection.

Alternate care

This is care approved instead of hospitalisation for services such as wound and palliative care upon submission of a treatment plan.

Beneficiary

A beneficiary is a principal member or a person registered as a dependant of a member.

Benefits

Your benefits are the amounts that are payable for medical services provided to you or your dependants in terms of the Scheme Rules.

Benefit limits

Your benefits are the amounts that are payable for medical services provided to you or your dependants in terms of the Scheme Rules.

Brand-name/Patented medication

Pharmaceutical companies incur high costs for research and development before a product is finally manufactured and released on the market. The company is given the patent to be the sole manufacturer of the specific medication brand for a number of years to recover these costs. This medication does not yet have generic equivalents.

Chronic disease list (CDL)

The CDL consists of 26 chronic conditions that are covered by the Scheme in terms of the regulations governing all medical schemes.

Chronic diseases

These are illnesses or conditions requiring medication for prolonged periods of time. The Medical Schemes Act 131 of 1998 provides a list of prescribed minimum benefits that indicates the minimum chronic conditions a medical scheme must cover.

Chronic medication

This refers to medication prescribed by a healthcare provider for a prolonged period of time. It is used for a medical condition that appears on the Scheme's list of approved chronic conditions.

Claim

A claim is a request for payment following medical treatment that has been provided by a healthcare provider, such as a general practitioner, specialist or hospital.

Consultation

This refers to an appointment with a healthcare provider, such as your general practitioner, specialist or physiotherapist for treatment.

Contribution

Your contribution is the fixed monthly amount that you pay to be registered as a member of the Scheme.

Co-payment

A co-payment is a portion of the cost of treatment or medication for which you are responsible, usually to pay for a portion of the cost of care that is not covered by a medical scheme.

Designated service provider (DSP)

This is a healthcare provider or group of providers chosen by the Scheme to provide diagnoses, treatment and care to members in respect of one or more prescribed minimum benefit conditions. This includes doctors, pharmacies and hospitals. When you choose not to use a DSP, you may have to pay a portion of the cost of the consultation or treatment from your own pocket.

Disease Treatment Pair (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.

Exclusions

Exclusions include medical treatment and care that are not covered by the Scheme.

General practitioners (GPs)

GPs are doctors who provide general or primary healthcare services, but do not offer a specialised service.

Generic medicine

This is medicine that has the same chemical ingredients, strength and form (such as a tablet or syrup) as the original, brand-name product. Generic medicine is as safe and effective as the original, brand-name product but is usually more cost-effective.

General waiting period

This is a period during which a beneficiary is not entitled to claim any benefits. This is normally a 3-month period.

Late-joiner penalty (LJP)

A LJP is imposed on the contributions of persons joining a medical scheme when they are 35 years of age or older and had not been members of a medical scheme before 1 April 2001 or have had a break in membership exceeding three consecutive months since 1 April 2001.

Moto Health Care (MHC) tariff

This is the rate at which healthcare providers will be paid for services rendered to Scheme members.

Medicine formulary

A formulary is a preferred list of prescription medicine that is covered by the Scheme.

Network providers

This is a list of service providers who have been contracted by the Scheme to provide medical care to members at an agreed rate.

Network pharmacy

For acute medicine, use the Scheme's network of pharmacies. To see if your pharmacy belongs to the network, contact the call centre on **0861 000 300** or visit the Scheme's website at www.mhcmf.co.za

Network hospitals

The Life Healthcare Group of hospitals is the preferred network of hospitals for the Custom, Classic Network and Hospicare Network options.

Non-Chronic Disease List

These are additional diseases that we cover over and above the 26 chronic conditions.

Overall annual limit

This limit is the overall maximum benefit that members and their registered dependants are entitled to according to the Scheme Rules. This is calculated annually to coincide with the Scheme's financial year.

Prescribed minimum benefits

This is a list of conditions that medical schemes have to cover in full according to the Medical Schemes Act.

Preventative care benefits

This is treatment that is given to prevent or reduce the risk of developing a medical condition.

Pre-authorisation

Pre-authorisation is the process of informing the Scheme of a planned procedure so that cover for the procedure can be assessed. Keep in mind that pre-authorisation is not a guarantee of payment.

Primary care network

This is a group of healthcare professionals that delivers primary care services, for example general practitioners, dentists and optometrists. Members on the Custom and Essential options are required to obtain out-of-hospital benefits from these healthcare providers.

Preferred provider

See network providers.

Principal member

A principal member is the main member that is registered on the Scheme.

POPIA

Protection of Personal Information Act.

Registered dependant

A registered dependant is a person who is dependent on the principal member and is registered by the Scheme to share in the benefits provided to the principal member.

Scheme rate

This rate is the price agreed upon by the Scheme and healthcare service providers for the payment of services that are provided to members of the Scheme.

Shared limit or sub-limit

This is a benefit that applies to 2 or more benefit categories. An example is the general dentistry limit and the day-to-day limit on the Optimum option. If members have used the full day-to-day limit, the general dentistry limit will also be depleted. If members use the general dentistry limit, they may still have day-to-day limits, but these will be reduced by what was spent on the general dentistry limit.

Specialists

Specialists are doctors who have specialised in a particular medical field, such as oncology, paediatrics or gynaecology.

Waiting period

A waiting period is a period during which contributions are payable, but where the member is not entitled to benefits.

There are two kinds of waiting periods:

1. a general waiting period of up to 3 months
2. a condition-specific waiting period of up to 12 months where pre-existing health conditions are excluded; all medical costs during this period will be the member's responsibility.

CONTACT *Details*

OPERATING HOURS

Our call Centre is open from 07:00 to 17:00 weekdays and from 08:00 to 12:00 on Saturdays.

CONTACT	CONTACT NO.	EMAIL ADDRESS	FAX
Call Centre	0861 000 300	info@mhcmf.co.za	
Claims		AmbulanceClaims@europassistance.co.za	
Ambulance Emergency Number (Europ Assistance)	0861 009 353 011 991 8000		
Hospital Authorisations	0861 000 300	auths@mhcmf.co.za	031 580 0472
Authorisation for chronic medication (Optimum, Classic, Classic Network, Hospicare, Hospicare Network)	0861 000 300	chronic@mhcmf.co.za	031 580 0625
Authorisation for chronic medication for Custom and Essential Options	0861 000 300	carecrossmotoc@momentum.co.za	021 6731815
Claims	0861 000 300	claims@mhcmf.co.za	
Membership Applications and enquiries	0861 000 300	membership@mhcmf.co.za	031 580 0478
Confidential HIV Programme	0860 109 793	ha@mhcmf.co.za	012 675 3848
Oncology Treatment Programme	0861 000 300	oncology@mhcmf.co.za	
HealthSaver	0861 000 300	info@mhcmf.co.za	
Report Fraudulent activity	0800 000 436	mhcmf@tip-offs.com	
POPIA complaints	0861 000 300	popia@mhcmf.co.za	

MOTO HEALTH CARE WALK-IN CENTRES

Walk-In Centre's are open from 8:00 – 16:00. Contact **0861 000 300** for an appointment.

Western Cape	Bellville
Free State	Bloemfontein
Eastern Cape	Port Elizabeth
Kwazulu-Natal	Cornubia
Gauteng	Centurion and Braamfontein

WhatsApp us on **0861 000 300** or go to www.mhcmf.co.za and click on the help icon to use our web chat facility.

IMPORTANT *Notes*

MEMBERSHIP NUMBER	
GENERAL PRACTITIONER – FAMILY DOCTOR	
DENTIST	
AMBULANCE	0861 009 353
ALLERGIES	
ILLNESSES	

moto HEALTH CARE

taking care of our own

2023
MEMBER GUIDE

Taking care of our own at every stage of their ***health journey***