MEMBER GUIDE

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

2025

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
Include general practitioner (GP) and specialists visits, dentistry, optical and radiology. Private and state hospital cover plus take home medications.

High quality and world class service
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 - anytime, anywhere, in any of our 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 & 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. You get even more with comprehensive hospital and day-to-day cover for complete peace of mind.

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

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.

WELLNESS PROGRAMME

PREVENTATIVE BENEFITS AVAILABLE

MHC offers wellness and preventative care benefits to help all members lead healthier and happier lives. Preventative screening is an important way to detect medical conditions early. Having these specific tests (up to the specified number) does not affect your day-to-day benefits. The healthcare professional will guide you when you receive your test results where necessary. Information will be shared on measures 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. You may be contacted by one of our wellness or lifestyle coaches should you be 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		In line with the Department of Health protocols		Subject to use of a network provider
Flu vaccines		One flu vaccine per beneficiary per year	**731826** **300826**	Subject to use of a network provider
Pneumococcal vaccines	High risk and beneficiaries older than 60 years		**755826** **715858** **705032** **714999**	Subject to use of a 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 a network provider
Blood glucose testing (pathologist)	Principal members and adult beneficiaries	Once a year	**4057**	Subject to use of a network provider
Cholesterol test (pathologist)	Principal members and adult beneficiaries	Once a year	**4026** **4027** **4028** **4147**	Subject to use of a network provider
Clinical breast screening	High risk members			Subject to pre-authorisation and use a network provider
Pap smear (GP)	Women 15 years and older	Once a year	**4566**	Subject to use of a 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 a network provider
TB screening (pathologist)	All beneficiaries		**3916**	Subject to use of a network provider
Tetanus diphtheria injection	All beneficiaries	As needed		Subject to pre-authorisation

ESSENTIAL OPTION : Early Detection Tests				
What does the programme cover?	**Age covered**	**Frequency**	**Tariff code**	**Comment**
Human Papilloma Virus (HPV) Vaccination	All females between ages 9 and 26 years All males between 9 and 18 years All high-risk woman (after discussion with their physicians) between the ages 26 and 45 years.	Two vaccines per beneficiary per lifetime	**3006049** **710249** **710020**	Subject to pre- authorisation and use of a network provider
Colorectal Screening	High risk lives of 50 years and over	Once a year	**4352**	Subject to use of a network provider
CUSTOM OPTION : Early Detection Tests				
What does the programme cover?	**Age covered**	**Frequency**	**Tariff code**	**Comment**
Blood pressure testing				Subject to use of a network provider
Blood glucose testing (pathologist)	Principal members and adult beneficiaries	Once a year	**4057**	Subject to use of a network provider
Cholesterol test (pathologist)	Principal members and adult beneficiaries	Once a year	**4026** **4027** **4028** **4147**	Subject to use of a network provider
Mammogram	Women 38 years and older	Once every two years	**34100** **34101**	Subject to pre-authorisation and use of a network provider
Pap smear (GP and gynaecologist)	Women 15 years and older	Once a year	**4566**	Subject to use of a network provider
Human Papilloma Virus (HPV) Vaccination	All females between ages 9 and 26 years All males between 9 and 18 years All high-risk woman (after discussion with their physicians) between the ages 26 and 45 years.	Two vaccines per beneficiary per lifetime	**3006049** **710249** **710020**	Subject to pre- authorisation and use of a 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 a network provider
TB screening (pathologist)	All beneficiaries		**3916**	Subject to use of a network provider
Colorectal Screening	High risk lives 50 years and older	Once a year	**4352**	Subject to use of a network provider

PREGNANCY	
ESSENTIAL OPTION	
Antenatal 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
CUSTOM OPTION : Subject to the Specialist Limit and use of a Network Provider	
Ante-natal care (GP)	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 and HIV/AIDS. Please call 0861 000 300 for more information.	
MATERNITY PROGRAMME	
Subject to registration on the Maternity Management Programme (Baby Bumps) between 12 and 20 weeks of pregnancy	

CLASSIC + CLASSIC NETWORK OPTIONS : Please call 0861 000 300 for more information

PREVENTATIVE CARE

What does the programme cover?	Age covered	Frequency	Tariff code	Comment
One basic dental consult	All beneficiaries	Once a year	**8101** **8109** **8110**	Subject to pre-authorisation
Fissure sealants	Children under the age of 16	Once in a lifetime	**8163**	Subject to pre-authorisation
Fluoride treatment	Children under the age of 16	Once a year	**8161**	Subject to pre-authorisation
CLASSIC + CLASSIC NETWORK AND OPTIMUM OPTIONS				
Baby immunisations		In line with the Department of Health protocols		Subject to pre-authorisation

CLASSIC + CLASSIC NETWORK AND OPTIMUM OPTIONS

What does the programme cover?	Age covered	Frequency	Tariff code	Comment
Flu vaccines	High risk and beneficiaries older than 65 years	Once per beneficiary per year	**732826** **300826**	Subject to pre-authorisation
Pneumococcal vaccines	High risk and beneficiaries older than 60 years	Once per beneficiary per year	**755826** **714999** **715858** **705032**	Subject to pre-authorisation

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 at a PPN network provider 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
Pap smear (GP)	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 years 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
Human Papilloma Virus (HPV) Vaccination	All females between ages 9 and 26 years All males between 9 and 18 years All high-risk woman (after discussion with their physicians) between the ages 26 and 45 years.	Two vaccines per beneficiary per lifetime	3006049 710249 710020	Subject to pre-authorisation

Contraceptives	For female beneficiary up to the age of 45	R1 500 annual limit	Pill (oral), devices and injectables	In formulary medication only Subject to pre-authorisation
Colorectal Screening	High risk lives 50 years and older	Once a year	4352	Subject to pre-authorisation
Dental benefits for children	Children under the age of 16	Once a year	8161 8163	Subject to pre-authorisation

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

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

Antenatal visits (Midwives, GP or Gynaecologists)	12 visits per pregnancy (excludes exercises)
Paediatric visit	2 per pregnancy
Pregnancy vitamins	Subject to formulary
Pathology tests	1 test per pregnancy: Full blood count, blood group, rhesus (Rh antigen), IgG (specific antibody titer), VDRL (Venereal Disease Research Laboratory), glucose strip test Urine test - microscopic culture and sensitivity test
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 lets you talk to your doctor on your phone, any time, any where.

hello doctor
Powered by momentum

REQUEST A CALL OR SEND YOUR QUESTION VIA TEXT.

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www.hellodoctor.co.za

DIAL *120*1019#

from your phone and follow the prompts to request a call.

Works on all phones

Trusted help is just a tap away

Get access to quality healthcare without leaving home or wherever you are. **Talk to a doctor on your phone, anytime, anywhere, in any of our official language – for free.**

Hello Doctor is 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 password (OTP) 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 contact number and a doctor will call you back.

Hello Doctor does not charge any service fees. All you need is data or a Wi-Fi connection to use the app and as our doctors call you, you won't need to use your airtime

Hello Doctor offers

DOCTOR ACCESS

Speak to a doctor over the phone, or chat via text message. All information shared is completely private and confidential.

HEALTH EDUCATION

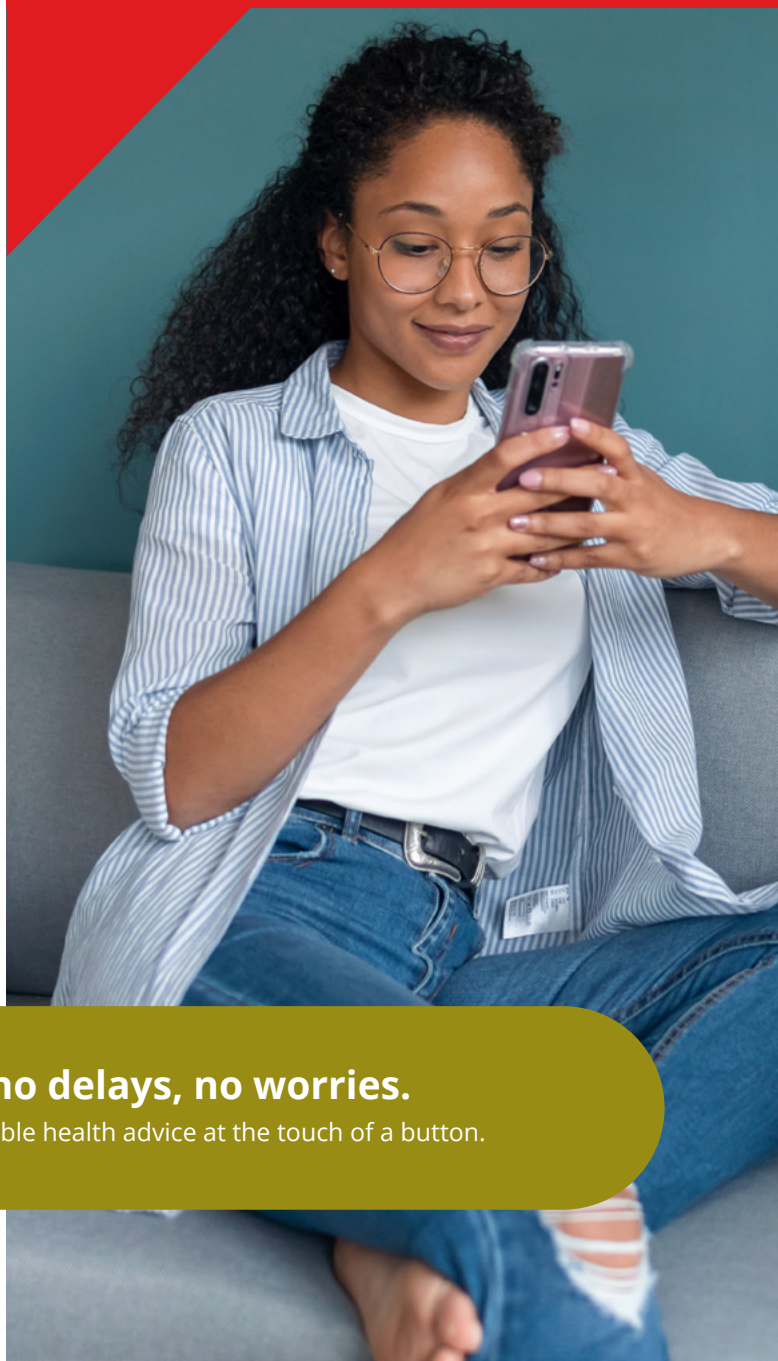
Get free daily advice with Hello Doctor's health tips and health coaching. Subscribe to any category that interests you and walk the journey to better health.

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

Download the App today!

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.

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

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 a specific benefit category and sub category
Access dashboards that provide you with an overview of your information in real time	Understand and manage your health risk	View the history of medication dispensed by providers

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

- Oral contraception, injectables and approved devices once your contraceptive limit has been reached
- Treatment for sexual dysfunction
- Slimming preparations
- Vitamins
- Treatment that assists with smoking cessation

Remember to ask your GP for a script and hand it in at your pharmacy

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.

Emergency circumstances 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.

PLEASE NOTE

All MHC 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 77 for contact details.

DISCLAIMER:

As a MHC 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 MHC 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 postnatal (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 option you choose.

Vitamins
Only pregnancy related vitamins are covered.

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.

Paediatric Visits
Your baby is covered up to two visits. Cover depends on the option 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 option of choice.

MHC offers members an opportunity to use Network Hospitals on some options, in exchange for lower contributions. To prevent unnecessary co-payments and out of pocket expenses, click onto www.mhcmf.co.za 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

Belly Babies provides 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.

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!

PRESCRIBED MINIMUM BENEFITS 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

To qualify for Prescribed Minimum Benefit (PMB) benefits; the treatment must match the treatments in the defined PMB benefits. You must use designated service providers (DSPs) in our network if applicable to your Option being Essential, Custom Hospicare Network and Classic Network Options.

In emergencies. where appropriate and according to the rules of the Scheme, you may be transferred to a hospital or other service provider (in our network) once your condition has stabilised. Should your treatment not meet the above criteria, the Scheme can apply co-payments or pay for PMBs at Scheme rates.

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 or 0861 000 300 for emergency transportation via ambulance.

You get extensive cover for chronic conditions

MHC members living with a chronic illness need to register on the Chronic Care Programme. The programme covers all or some of the 26 chronic conditions on the Chronic Disease List (CDL). Registering on the programme gives you benefits relating to your condition that do not affect your day-to-day or savings limits.

Refer to page 22 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 Chronic Conditions

On the Optimum plan we cover an additional 28 conditions; Classic and Classic Network options cover 10 conditions, Custom 2 additional conditions and Essential has 1.

How do we pay for medicine?

We pay for medicine up to the maximum of the MHC rate including the fee for dispensing it.

CHRONIC DIEASE LIST CONDITIONS COVERED

ESSENTIAL OPTION	OPTIMUM OPTION CLASSIC OPTION & CLASSIC NETWORK OPTION HOSPICARE & HOSPICARE NETWORK OPTION	CUSTOM OPTION
• Addison's Disease • Asthma • Bronchiectasis • Cardiac Failure • Cardiomyopathy • Chronic Obstructive Pulmonary Disease • Coronary Artery Disease • Diabetes Insipidus • Diabetes Mellitus Type I • Diabetes Mellitus Type II • Epilepsy • Glaucoma • Hyperlipidaemia • Hypertension • Hypothyroidism • Menopause	• Addison's disease • Asthma • Bipolar Mood Disorder • Bronchiectasis • Cardiac failure • Cardiomyopathy • Chronic obstructive pulmonary disorder • Chronic renal disease • Coronary artery disease • Crohn's disease • Diabetes insipidus • Diabetes Mellitus Type I • Diabetes Mellitus Type II • Dysrhythmias • Epilepsy • Glaucoma • Haemophilia • Hyperlipidaemia • Hypertension • Hypothyroidism • Multiple sclerosis • Parkinson's disease • Rheumatoid arthritis • Schizophrenia • Systemic lupus erythematosus • Ulcerative colitis	• Addison's disease • Asthma • Bronchiectasis • Cardiac Failure • Cardiomyopathy • Chronic Obstructive Pulmonary Disease • Coronary Artery Disease • Crohn's Disease • Diabetes Insipidus • Diabetes Mellitus Type I • Diabetes Mellitus Type II • Dysrhythmias (PMB) • Epilepsy • Glaucoma • Hyperlipidaemia • Hypertension • Hypothyroidism • Multiple Sclerosis • Parkinson's disease • Rheumatoid arthritis • Schizophrenia • Systemic lupus erythematosus • Ulcerative colitis

WHERE TO OBTAIN YOUR MEDICATION

The plans listed below have preferred service providers 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 Providers.

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 TO 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
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
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: info@medipost.co.za
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.

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

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	Deplete your chronic medication benefit **before the end of the year**
Enquire about your specific condition's chronic formulary **(on www.mhcmf.co.za or the call centre on 0861 000 300)**	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 end of the year**
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 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 able to get the care they need when they need it. Members will be assigned a personal wellness coach who will assist them every step of the way. Wellness coaches will develop a tailor-made care path based on your unique healthcare needs which can 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, even unlocking 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 enrollees have additional benefits for dieticians. Upon registration onto the programme, you will be allocated a 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

We 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 the completed form or email it 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. This benefit is subject to Scheme rules and clinical protocols.

ONCOLOGY CARE

If you are diagnosed with cancer, register on the oncology programme as soon as possible. Once your treatment has been approved you are covered for additional benefits offered. Approved treatment will 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.

Call 0861 009 353 for the emergency operations centre to 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 until the ambulance provider has transferred the member to the hospital.
- Emergency pre-arrival instructions provided by the registered agents e.g. CPR.

EMERGENCY TRANSPORTATION BY AIR OR ROAD AMBULANCE DEPENDING ON THE OPTION YOU CHOOSE

The procedure you should follow is:

1. Dial 0861 009 353.
2. Give your name, the telephone number you are calling from and the ID of the patient (if available).
3. Provide a brief description of what has happened and how serious the situation is.
4. Provide the address or location of the incident to help paramedics get there.
5. Do not put down the phone until the person on the other side has disconnected the call.
6. The person phoning for the ambulance will receive an SMS asking to provide the exact location of the patient
7. AN SMS/ WhatsApp will be sent with your reference number.

IMPORTANT POINTS

Please ensure that all your registered dependants are aware of this service. Inform your child's school that they are your dependant on the Scheme and make sure they are aware of the emergency 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 obtained from: The Contact Centre: 0861 000 300 or website www.mhcmf.co.za	2	**If YES complete the continuation form which can be obtained from:** The Contact Centre: 0861 000 300 or website www.mhcmf.co.za
Ensure that all the required documentation is submitted together with the fully completed application form **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 representative 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
- if the principal member passes away, the member's surviving spouse and/or children may continue as beneficiaries on the Scheme, provided that one of the beneficiaries (spouse/eldest child) are converted to the principal member on the contract.
- 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 that MHC has your email address and other contact information of dependants 18 years and older.

Register your new baby in time!

- Complete the registration form available on the website: www.mhcmf.co.za and enclose a certified copy of the birth certificate/confirmation of birth from the hospital.
- Forward it to the Scheme at membership@mhcmf.co.za within 30 days of the birth of your child.

Update your membership details should the following changes occur:

- address, telephone/mobile 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 a contribution statement is sent to members who pay contributions directly to the Scheme.

A monthly contribution statement is sent to all employers. The contribution statement sets out the monthly contribution due. This statement assists your employer or individual members to ensure that your contributions are up to date.

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

Registration of adult dependants older than 35 years are subject to late joiner penalties if there is no evidence of previous medical scheme coverage.

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 may happen when you move between dealerships at the same employer.
- A backdated salary increase moved you into a higher contribution category.
- You added a new dependant and this change was not effected in time for the next contribution payment.
- Your employment ended with one employer and you started employment with another employer.
- When a dependant reaches the age of 21, their contribution changes from a child to an adult. Timeous notification to the Scheme is important.
- A late joiner penalty has been applied.
- When a full-time student dependant reaches the age of 23, their contribution changes from a child to an adult.

If you need help with paying your contributions, please contact the Scheme or speak to your employer for assistance.

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.

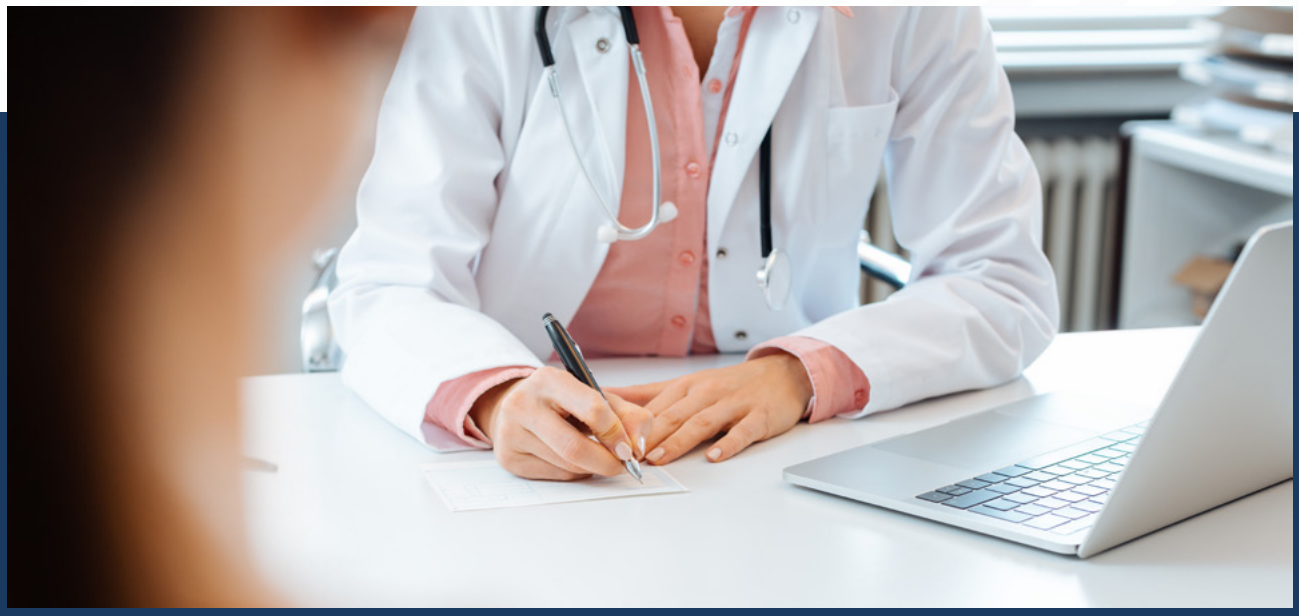
CHANGING BENEFIT OPTIONS EACH YEAR

Choose the right option for your family

What is important when choosing a medical scheme for you, your family or your employees? It is critical to ensure that your medical cover is adequate and effectively meets your needs to prevent out-of-pocket expenses. Choose the option that best suits your unique situation. To help you get started on your journey to choose a medical aid option, it is important to determine the amount you can afford.

Ask yourself:

- What is my health status?
  - — If you have ongoing health problems, you may consider full medical cover option rather than a hospital option.
  - — If you are healthy, but have eye or dental problems, look for an option that makes adequate provision for this.
- How often do you visit a doctor?
  - — If you visit your GP often, a comprehensive option may suit you better.
  - — If you seldom use your medical benefits, and are willing to pay for day-to-day out of hospital benefits yourself, a hospital option may be more suitable.
- Do you have any chronic ailments?
  - — If yes, look for an option that offers cover for your chronic condition.
- Do you need specialist visits covered?
- Are you planning to start or expand on your family in the near future?
- What is your budget?
  - — Your finances will determine the option you can afford.
- Compare the different costs of each option; 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. 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 option that suits your financial and healthcare needs. You are required to notify the Scheme of changes before 31 December 2024 by emailing your completed option change form to **Optionchange@mhcmf.co.za.**

Easy steps to select your option for 2025

How do I inform Moto Health Care of my option choice?

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

How do I submit the option change form?

Email: Optionchange@mhcmf.co.za

How do I follow up?

If you emailed your form the reference number provided can be used to follow-up
Call Centre: 0861 000 300.

CLAIM PROCEDURE

Who can claim?

Both 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 the 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 membership number quoted
- 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:
Email: info@mhcmf.co.za or claims@mhcmf.co.za

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 it is submitted after 4 months.

Claims received after you have resigned from the scheme

When you resign from your employer, your membership ends and you cannot access healthcare services. If you or your healthcare provider claims for healthcare services after you resigned from the Scheme, the claim will not be paid.

Scheme exclusions

Services rendered for a Scheme or option exclusion will be rejected. These exclusions may be viewed on page 67 as well as on the **website: www.mhcmf.co.za**

FRAUD, WASTE & ABUSE

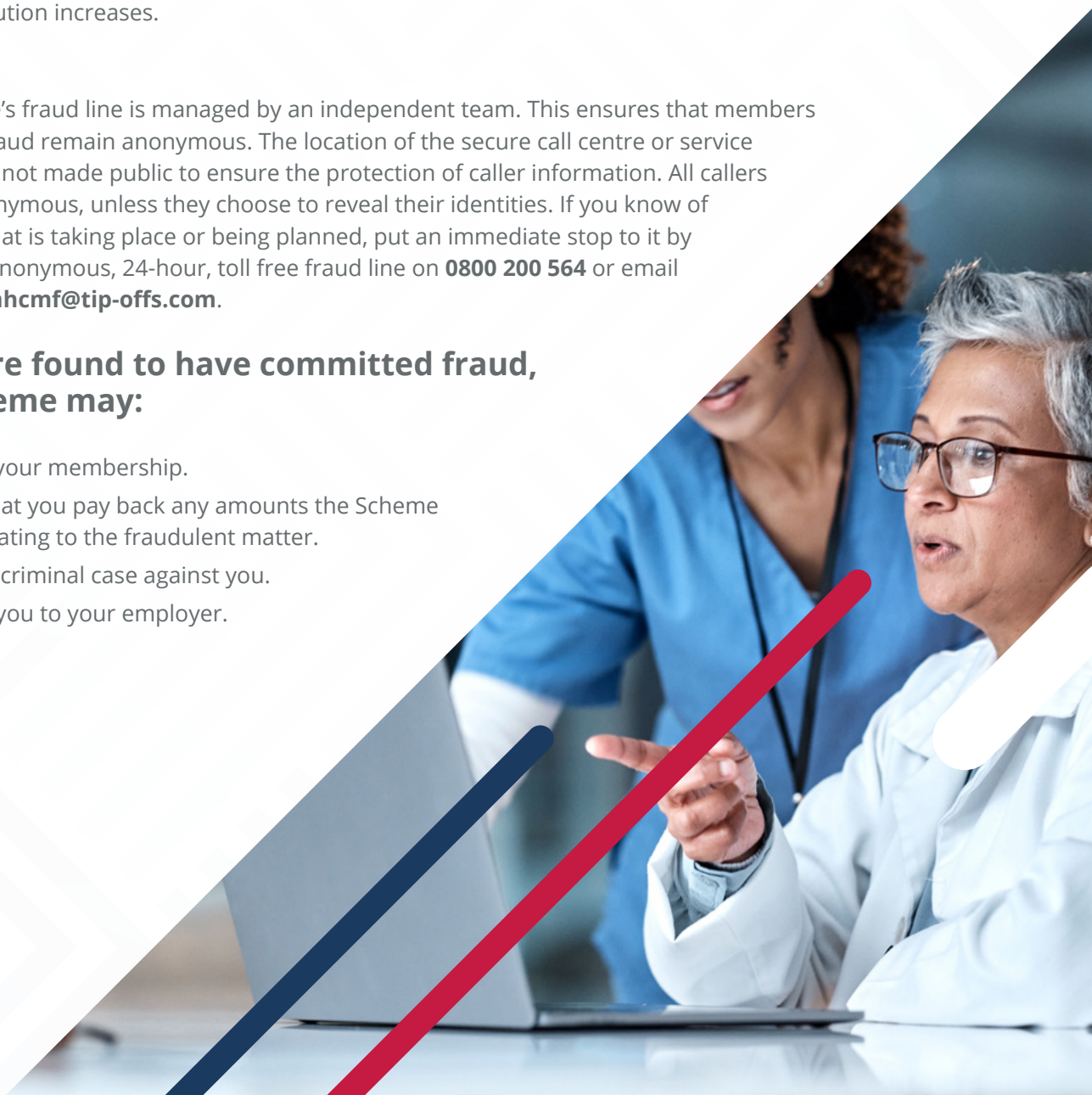
Some fraudulent and wasteful activities involve the following:

- Collusion between members and healthcare providers for 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. This occurs when a member fails to inform the medical scheme about previous and existing health conditions.
- Card farming occurs when members share their medical scheme details with non-members. An example being registering only one child on the medical scheme, but all the children access the benefits of that one child who is covered.
- Fraud, waste and abuse cost medical schemes billions of Rands each year, and are contributory to contribution increases.

The Scheme's fraud line is managed by an independent team. This ensures that members reporting fraud remain anonymous. The location of the secure call centre or service providers is not made public to ensure the protection of caller information. 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 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 for the Custom and Essential options
- Additional GP consultations on the Classic and Classic Network options once your savings are depleted
- To access preventative care benefits

Ask your healthcare practitioner for a full description of:

- The reason for the scan
- The medical diagnosis
- The planned procedure
- All the tariff and ICD-10 codes that the doctor intends to claim
- Additional information may be requested by the pre-authorisation department, when necessary
- 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 of the admission. Your relatives/family/friends or hospital may phone to obtain a pre-authorisation number if you are unable 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?

Chronic medication

The Chronic Medicine Management Programme is designed to manage appropriate, high-quality and cost-effective medicine from the Chronic Medicine Benefit.

A formulary is a list of medications for your condition which MHC will fund on your option.
The formulary will assist your doctor in prescribing a medication which would not have a co-payment.

Members on the Essential and Custom options, who require chronic medication, will be assisted by the prescribing network provider.

Once registered, you will receive a letter reflecting the following information:

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

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

Pre-authorisation for a scope

When you are having a planned scope, it is important to call 0861 000 300 at least 48 hours (two days) before for approval. The pre-authorisation team will confirm your benefits and whether or not a
co-payment will apply.

2025

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 generous primary care benefits; unlimited public hospital cover. 16 Chronic conditions and stabilisation in a private hospital.

Brief description of benefits offered on the Essential option:

Medicine Benefit

Unlimited acute medicines from formulary and Network GP or Pharmacy

Over the counter medicine from a network pharmacy within formulary

Chronic medication obtained from a network pharmacy or GP within formulary

In-Hospital Benefits

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

AMBULANCE SERVICES
24-hour access to road ambulance

Out-Of-Hospital Benefits

Unlimited GP consults, Optical, Dentistry, Pathology and Radiology benefits

Access to network specialists.

Free and unlimited access to telephonic advice via Hello Doctor.

11 additional procedures available from network providers

Maternity Benefits

Free 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

Chronic Benefits

You are covered for 15 CDL conditions in 2025 as well as:

- Menopause

OTHER:

- HIV/AIDS
- Oncology

Wellness Benefits

The wellness benefit allows for early detection and pro-active management of your health. You are covered when referred by a Network Provider for:

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

Don’t forget to register onto the Chronic Programme

ESSENTIAL OPTION

MONTHLY CONTRIBUTION			
SALARY BAND	MEMBER	ADULT	CHILD
R0 – R3 618	R482	R289	R194
R3 619 – R7 766	R513	R308	R194
R7 767 – R11 383	R734	R445	R289
R11 384 +	R847	R513	R344

OUT-OF-HOSPITAL BENEFITS

Not sure what we mean? Refer to glossary on page 73

PRIMARY CARE NETWORK ONLY	
General practitioners (GPs)	Unlimited at the primary care network service provider
Specialist Limit	M = R1 845 M+ = R3 685 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 AT A PRIMARY CARE NETWORK SERVICE PROVIDER	
Acute	Unlimited at the primary care network provider – subject to network formulary
Over-the-counter (OTC)	Single member = 3 prescriptions Family = 5 prescriptions
Chronic	16 conditions covered subject to formulary which can be viewed on the website (see page 20) 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 PMB'S.

Claims on this option are paid at Scheme rate, up to limits and/or sub limits in accordance with the exemption received from the Council for Medical Schemes. Exclusions including option specific exclusions can be viewed on the Schemes 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 R647 R247 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 = R7 100

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).

Medical and surgical appliances (in- and out-of-hospital)	The following appliances are subject to the annual limit of R3 100 per family subject to motivation and pre-authorisation
Glucometers	R915 per beneficiary every 2 years
Nebulisers	R915 per family every 3 years
Other Appliances – once every 4 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 page 42.
Free Hello Doctor advice	Telephonic advice via Hello Doctor. Talk or text a doctor on your phone, anytime, anywhere, 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 105
Paedriatric visits	1 visit per family subject to the Specialist benefit limit
Wellness Benefit	Refer to pages 5 to 9 for the detailed benefits on free early detection, preventative and ante-natal care.

IMPORTANT

Treatment performed in-hospital needs to be pre-authorised prior to commencement of treatment. Some conditions 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.

IN-HOSPITAL BENEFITS

Public hospital	Unlimited treatment in accordance with Scheme protocols
Private hospital	Resuscitation and stabilisation only
	Antenatal care available from a primary care network provider for the first 20 weeks
Subject to pre-authorisation within 48 hours of admission and managed care protocols	Unlimited at the primary care network provider – subject to network formulary
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 = R11 020 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
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 PMB'S.

Claims on this option are paid at Scheme rate, up to limits and/or sub limits in accordance with the exemption received from the Council for Medical Schemes. Exclusions including option specific exclusions can be viewed on the Schemes website - www.mhcmf.co.za

THE CUSTOM OPTION AT A GLANCE

Targeted at young and healthy members. The Custom Option provides you and your dependants an opportunity to make health part of your journey. Comprehensive primary care benefits; limited private hospitalisation; unlimited public hospitalisation. 24 CDL conditions and 2 non-CDL conditions covered and stabilisation in a private hospital.

Brief description of benefits offered on the Custom option:

Medicine Benefit

Unlimited acute medicines from formulary and Network GP or Pharmacy

Over-the-counter medicine from a network pharmacy within formulary

Chronic medication obtained from a network pharmacy or GP within formulary

In-Hospital Benefits

Unlimited access to state facilities

Private hospital cover subject to an annual limit

AMBULANCE SERVICES
24-hour access to road ambulance

Out-Of-Hospital Benefits

Unlimited GP consults, Optical, Dentistry, Pathology and Radiology benefits

Free and unlimited access to telephonic advice via Hello Doctor

Trauma events not requiring hospitalization (payable from the available Overall Annual Limits)

Maternity Benefits

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

Antenatal care via the network provider

Maternity scans

Flu vaccination per pregnancy

Monthly pregnancy vitamins

Paediatric visits at a network provider

Chronic Benefits

You are covered for 23 CDL conditions as well as:

- Depression
- Menopause

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 when referred by a network provider for:

- Baby immunisation – DoH schedule
- Blood glucose test
- Cholesterol test
- Mammogram
- Pap smear
- Colorectal Screening
- HPV Vaccine
- Pneumococcal vaccination high-risk members
- Prostate specific antigen (PSA) testing
- Flu vaccines
- TB Screening

Don’t forget to register onto the Chronic Programme

CUSTOM OPTION

MONTHLY CONTRIBUTION			
SALARY BAND	MEMBER	ADULT	CHILD
R0 – R3 855	R1 324	R1 060	R339
R3 856 – R6 950	R1 393	R1 109	R352
R6 951 – R10 157	R1 525	R1 224	R382
R10 158 – R12 547	R1 743	R1 399	R445
R12 548 – R16 955	R2 428	R1 945	R609
R16 956 +	R2 671	R2 139	R669

OUT-OF-HOSPITAL BENEFITS

Not sure what we mean? Refer to glossary on page 73

PRIMARY CARE NETWORK ONLY	
General Practitioners (GPs)	Unlimited at the primary care network service provider
Specialist Limit	M = R4 775 M+ = R9 560 Subject to network GP referral, pre-authorisation and managed care/ Scheme protocols
PRESCRIBED MEDICINES AT A NETWORK SERVICE PROVIDER	
Acute	Unlimited at the primary care network provider – subject to network formulary
Over-the-counter (OTC)	Single member = 5 prescriptions Family = 7 prescriptions
Chronic	23 CDL conditions (see page 20) 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 R647 R247 towards a frame outside the standard range Subject to use of primary care network service provider and protocols
Pathology and Radiology Out-of-hospital	Pathology and radiology - subject to network GP referral and formulary tests

Dentistry Basic - per beneficiary per annum 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 Per adult beneficiary – 1 set of plastic dentures every 24 months
MRI, CT, PET and radio isotope scans	Sub-limit per beneficiary = R3 665, subject to specialist limit
External prostheses	R12 250 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 R8 565 per family Subject to motivation and pre-authorisation Please call 0861 000 300 for assistance
Glucometers Nebulisers Other appliances – once every 4 years	R915 per beneficiary every 2 years R915 per family every 3 years ubject to clinical protocols Please note hearing aids are not covered on the Custom option
PRIMARY CARE NETWORK ONLY	
Free Hello Doctor advice	Telephonic advice via Hello Doctor. Talk or text a doctor on your phone, anytime, anywhere, any official language – for free Refer to page 10 for detailed information
Out of network GP or emergency visits	Per family = 3 visits to a maximum of R1 105 Approved Ttrauma events not requiring hospitalisation are payable from the Overall Annual limit. Clinical protocols and policies applicable
Wellness Benefit	Refer to pages 5 to 9 for the detailed benefits on free early detection, preventative care, ante-natal care and patient care programmes.

THIS OPTION IS EXEMPT FROM PMB'S.
Claims on this option are paid at Scheme rate, up to limits and/or sub limits in accordance with the exemption received from the Council for Medical Schemes. Exclusions including option specific exclusions can be viewed on the Schemes website - www.mhcmf.co.za

IMPORTANT

Treatment performed in-hospital needs to be pre-authorised prior to commencement of treatment. Some conditions 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.

IN-HOSPITAL BENEFITS

Overall Annual Limit (OAL)	Single member = R382 420 Family = R671 700 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 hospitals:** Custom Hospital Network	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 = R19 610 where approved during hospital admission subject to the overall annual limit
Alternative care instead of hospitalisation	Per family = 30 days to a maximum of R25 740
Mental health (in and out of hospital)	Subject to the overall annual limit and up to a sub-limit of R27 270 Subject to clinical protocols and pre-authorisation
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 = R85 800, subject to overall annual limit
Pathology	Per beneficiary = R8 980, subject to overall annual limit
Radiology	Per beneficiary = R8 980, subject to overall annual limit
Medical and surgical appliances (in and out of hospital)	Per family = R8 565 subject to overall annual limit
Sub-limits to Appliance Benefit	Glucometer (per beneficiary every 2 years) - R 915 Nebuliser (per family every 3 years) - R 915
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 PMB'S.
Claims on this option are paid at Scheme rate, up to limits and/or sub limits in accordance with the exemption received from the Council for Medical Schemes. Exclusions including option specific exclusions can be viewed on the Schemes 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 and 26 Chronic conditions.
Members on the Hospicare Network option can enjoy significant savings on their monthly contributions and still enjoy comprehensive benefits.

Brief description of benefits offered on the Hospicare and Hospicare Network options:

Medicine Benefit

Treatment for chronic conditions - subject to an approved treatment plan

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

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 road and air emergency medical assistance

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.

Maternity Benefits

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

Benefits include antenatal 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 more

Chronic Benefits

You are covered for the 26 CDL conditions as well as:

OTHER

- HIV/AIDS
- Oncology

Don’t forget to register onto the Chronic Programme

HOSPICARE OPTION

MONTHLY CONTRIBUTION			
OPTION	MEMBER	ADULT	CHILD
Hospicare Network	R2 611	R2 213	R652
Hospicare	R3 024	R2 558	R751

OUT-OF-HOSPITAL BENEFITS

Not sure what we mean? Refer to glossary on page 73

	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 20)	26 conditions (see page 20)
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, anytime, anywhere, in all official language – for free Refer to page 10 for detailed information	Telephonic advice via Hello Doctor. Talk or text a doctor on your phone, anytime, anywhere, in all 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

IMPORTANT

Treatment performed in-hospital 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.

IN-HOSPITAL BENEFITS

ADDITIONAL BENEFITS	HOSPICARE NETWORK	HOSPICARE
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.

CLASSIC AND CLASSIC NETWORK OPTION AT A GLANCE

This new generation savings option provides members with the flexibility and independence to manage their own day- to-day expenses rich hospital cover; 26 CDL and 10 non-CDL conditions. Members on the Classic Network option can enjoy significant savings on their monthly contributions and still enjoy comprehensive benefits.

Brief description of benefits offered on the Classic and Classic Network options:

Chronic Benefits

You are covered for 10 non-CDL conditions and other:

- HIV/AIDS
- Oncology

In-Hospital Benefits

Unlimited access to state facilities
Unlimited private hospital cover

AMBULANCE SERVICES
You have 24-hour access to road and air emergency medical assistance

Out-Of-Hospital Benefits

GP and specialist consults, optical, dentistry and other benefits

Emergency medical care via ER made EASY

Free and unlimited access to telephonic advice via Hello Doctor

Maternity Benefits

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

Benefits include antenatal care, scans, vitamins and paediatric visits

Medicine Benefit

Access to acute and preventative medicines and over-the-counter medicine

Chronic medicine for 26 conditions - medicines must be obtained from the Scheme's network pharmacy. Plus, cover for 10 non-CDL conditions and medicines

- Acne
- Allergic rhinitis
- Ankylosing spondylitis
- Depression
- Eczema
- Gastro-oesophageal reflux disease (GORD)
- Gout prophylaxis
- Osteoporosis
- Osteoarthritis
- Psoriasis

Wellness Benefits

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
- HPV Vaccine
- Contraception
- Basic dentistry
- Colorectal Screening
- Glucose test
- TB Screening
- Glaucoma screening
- Pneumococcal and flu vaccines - high risk
- Health risk assessment

Don't forget to register onto the Chronic Programme

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 752	R6 576	R1 944
Classic	R9 096	R7 716	R2 280
MONTHLY CONTRIBUTION			
OPTION	**MEMBER**	**ADULT**	**CHILD**
Classic Network	R4 306	R3 653	R1 077
Classic	R5 050	R4 286	R1 264

NOTES

Your total ASL is available from the beginning of the year. If you terminate your membership before the end of the year and you have used more than the ASL allocation, you will be requested to reimburse the difference to the Scheme. Once you have exhausted your ASL, you will need to pay healthcare providers for day-to-day services.

OUT-OF-HOSPITAL BENEFITS

Not sure what we mean? Refer to glossary on page 73

Day-to-day benefits on the Classic and Classic Network options are subject to your Annual Savings Limit (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 additional day-to-day claims. A portion of your monthly contribution is allocated to your ASL. The ASL amount is calculated for a period of 12 months or if you join the Fund during the year, the amount will be calculated on a pro-rata basis. At the end of the year, any unused savings will carry over to the next year.

	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 Contraceptives: oral, devices and injectables Devices subject to pre-authorisation	 Subject to ASL R265 per beneficiary per day Paid from ASL – refer to page 13 R1500 per female beneficiary up to the age of 45 years per annum	 Subject to ASL R265 per beneficiary per day Paid from ASL – refer to page 13 R1500 per female beneficiary up to the age of 45 years per annum
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 20 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 20 for more information on co-payments
Optometry Subject to ASL	Per beneficiary: 1 composite eye examination, a frame of up to R1 045 and 2 lenses every 24 months OR contact lenses of up to R1 530 instead of glasses per year Members may request frames and lens enhancements to be paid from their savings if the amount exceeds the above amounts 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 R1 045 and 2 lenses every 24 months OR contact lenses of up to R1 530 instead of glasses per year Members may request frames and lens enhancements to be paid from their savings if the amount exceeds the above amounts 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 20) – plus 10 conditions, subject to sub-limits:	26 conditions – unlimited (page 20) – plus 10 conditions, subject to sub-limits:
Non-CDL chronic medicine	M R5 750 M1 R11 370 M2 R14 195 M3 R15 350 M4 R16 690	M R5 750 M1 R11 370 M2 R14 195 M3 R15 350 M4 R16 690
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%

	CLASSIC NETWORK	CLASSIC
Free Hello Doctor advice	Telephonic advice via Hello Doctor. Talk or text a doctor on your phone, anytime, anywhere, 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, anytime, anywhere, any official language – for free. Refer to page 10 for detailed information
Medical and surgical appliances General appliances per family per annum	R16 300	R16 300
Sub-limits to Appliance Benefit: Glucometer per beneficiary every 2 years	R920	R920
Nebuliser per family every 3 years	R920	R920
Sub-limit: Hearing aid maintenance (per beneficiary per annum)	R1 230	R1 230
External Prostheses per family per annum	R28 740	R28 740
MRI, CT, PET and radio isotope scans	R16 650 per scan Per family = 2 scans paid from risk benefits thereafter ASL Subject to pre-authorisation and managed care protocols	R16 650 per scan Per family = 2 scans paid from risk benefits thereafter ASL Subject to pre-authorisation and managed care protocols
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 230 per beneficiary per annum Subject to Medical and Surgical Appliance Benefit	R1 230 per beneficiary per annum Subject to Medical and Surgical Appliance Benefit
Mental health	Subject to ASL	Subject to ASL
Extra consultations and medicine (Only once ASL reaches a balance of R300 or less. 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

IMPORTANT

Treatment performed in-hospital 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.

IN-HOSPITAL BENEFITS

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)		

SUBJECT TO PRE-AUTHORISATION AND MANAGED CARE PROTOCOLS	CLASSIC NETWORK	CLASSIC
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 = R76 070 (limit includes harvesting and transportation costs) National donor only	Per family = R76 070 (limit includes harvesting and transportation costs) National donor only
Internal prostheses	Per family per annum = R45 275	Per family per annum = R45 275
Refractive eye surgery	Per beneficiary per eye = R6 540 maximum of R13 080 for both eyes once per lifetime	Per beneficiary per eye = R6 540 maximum of R13 080 for both eyes once per lifetime
Reconstructive surgery (as part of PMBs)	Per family = R75 950	Per family = R75 950
MRI, CT, PET and radio isotope scans	R16 650 per scan Per family = 2 scans paid from risk thereafter from ASL subject to motivation Subject to clinical protocols and pre-authorisation	R16 650 per scan Per family = 2 scans paid from risk thereafter from ASL subject to motivation Subject to clinical protocols and pre-authorisation
Alternative care instead of hospitalisation	Per family = 30 days to a maximum of R42 815 per event subject to clinical protocols and pre-authorisation	Per family = 30 days to a maximum of R42 815 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 DSP, clinical protocols and pre-authorisation	Subject to use of DSP, 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 option provides members with comprehensive cover, which includes extensive day-to-day benefits; unlimited private hospitalisation; 26 CDL plus 28 non-CDL conditions. The option to choose if you would like a choice of providers.

Brief description of benefits offered on the Optimum option:

Medicine Benefit

ACCESS TO:

- Acute and preventative medicines
- Over-the-counter medicine
- Chronic medicine for 26 conditions
- Additional cover for 28 non-CDL conditions and medicines

In-Hospital Benefits

Unlimited hospital cover

AMBULANCE SERVICES

You have 24-hour access to road and air emergency medical assistance

Out-Of-Hospital Benefits

GP and Specialists consults optical, dental and other benefits

Emergency medical care via ER made EASY

Free and unlimited access to telephonic advice via Hello Doctor

Maternity Benefits

Comprehensive maternity benefits via the Baby Bumps programme subject to registration onto the programme

Benefits include antenatal care, scans, vitamins and paediatric visits

Chronic Benefits

You are covered for the 26 CDL conditions as well as:

- Acne
- Allergic rhinitis
- Ankylosing spondylitis
- Attention deficit hyperactivity disorder (ADHD)
- 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

OTHER:

- HIV/AIDS
- Oncology

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.

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:

- Glaucoma
- Health Risk Assessment
- Dexa bone density scan
- Cholesterol test
- Mammogram
- Pap smear
- Prostate specific antigen (PSA) testing
- HPV Vaccine
- Colorectal Screening
- Contraception
- Pneumococcal and flu vaccine for high risk members
- TB screening
- Tetanus diptheria injection
- Blood glucose test

OPTIMUM OPTION

MONTHLY CONTRIBUTION		
MEMBER	**ADULT**	**CHILD**
R9 287	R7 905	R2 326

OUT-OF-HOSPITAL BENEFITS

Not sure what we mean? Refer to glossary on page 73

All sub limits set out below are subject to the day to day limit.

ANY PROVIDER All sub-limits set out below are subject to the day-to-day limits.	
Day-to-day limit	M R32 480 M1 R45 275 M2 R52 655 M3+ R61 815
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 R14 040 M1 R15 210 M2 R17 910 M3 R19 540 M4+ R20 830
Over-the-counter (OTC)	R265 per beneficiary per day
Contraceptives: oral, devices and injectables Devices subject to pre-authorisation	R1500 per female beneficiary up to the age of 45 years per annum
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 20 for more information on co-payments
Optometry	Per beneficiary = 1 composite eye examination Per beneficiary = a frame of up to R1 650 and 2 lenses every 24 months OR Contact lenses of up to R2 280 instead of glasses per year

DENTISTRY	
Basic	Single member = R2 985 Family = R6 010
Specialised	Single member = R15 800 Family = R23 455
Auxiliary services Sub-limits	At a preferred provider, subject to auxiliary sub-limit and day-to-day limits Single Member = R5 975 Family = R18 030
ADDITIONAL BENEFITS (PAID FROM RISK BENEFITS)	
Chronic medicine Non-CDL chronic medicine limit	26 conditions – unlimited – plus 28 conditions, subject to sub-limits: M R 8 080 M1 R16 170 M2 R17 460 M3 R20 150 M4+ R21 280
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 = R12 200 R920 R920
Hearing aids Per beneficiary every 3 years Hearing aid maintenance	 Unilateral = R13 720 Bilateral = R27 440 R1 230 per beneficiary per annum
External Prosthesis	Per family per annum = R34 000
Patient care programmes (Diabetes, HIV, oncology)	 Subject to registration and managed care protocols

IMPORTANT

Treatment performed in-hospital 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.

IN-HOSPITAL BENEFITS

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 = R76 070 limit includes harvesting and transportation costs National donor only
Internal prostheses	Per family per annum = R55 125
Refractive eye surgery	Per beneficiary per eye = R6 540; maximum of R R13 080 for both eyes once per lifetime
Reconstructive surgery	Per family = R75 950
MRI, CT, PET and radio isotope scans	R16 650 per scan per family per annum = 2 scans from risk thereafter from the annual day-to-day limit subject to clinical protocols and pre-authorisation
Alternative care instead of hospitalisation	Per family = 30 days to a maximum of R48 320 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 DSP, 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 so 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 are diagnosed with a chronic condition.
- Visit www.mhcmf.co.za for any new or updated information.

IMPORTANT

Treatment performed in-hospital 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.

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 and other information and view your benefit information and claims statements.

Please follow these steps:

1. Open your internet browser (for example, Google)
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.

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 for chronic medication to avoid incurring a 30% co-payment. 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. You may request a quote for your planned procedure, which you can email to auths@mhcmf.co.za who will confirm the codes and 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. These are general exclusions applicable

IMPORTANT

Treatment performed in-hospital 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.

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, medicines advertised to the public and domestic, biochemical or herbal remedies, except when prescribed by a homeopath,
- Slimming preparations, anti-smoking treatment and substances except for the Classic + Classic Network options (where the benefit may be paid from the members accumulated savings)
- Contraception except for the Classic + Classic network and Optimum options
- 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 (SADC) only; treatment will be paid in accordance with the Scheme's prescribed rate and the the South African currency exchange rate applicable on the date the treatment was rendered will apply

- 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 benefits unless 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 prescribed for malaria by a medical practitioner

Dental exclusions

Unless otherwise decided by the Board of Trustees, costs and or expenses incurred by the member and or any dependant in connection with any of the following dental treatment will not be paid by the Fund:

The following Dental services are excluded:

- Treatment mentioned in the Rules of the applicable benefit options where authorisation is required;
- The cost of general dentistry performed in hospital for beneficiaries older than 8 years;
- The cost of gold, metal or other inlays in a denture ; crown and or natural tooth/teeth;
- Fee for after-hours visits that the Fund considers as convenience visits;
- Bleaching;
- Unregistered items and items listed as “by agreement” or “not applicable” in the tariff code listing.
- Lingual orthodontic treatment;
- Services which deviate from the available guidelines of the Department of Health and which are deemed to be excluded from benefits after evaluation of the available information;
- Gum guards for sport purposes;
- Laboratory costs, which according to the Fund’s norms and judgement, seem to be above the general cost claimed by other dental service providers and dental laboratories treating similar conditions;
- Services or procedures which are regarded by the Fund 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 Fund.

Treatment listed below:

- Any specialised treatment listed by the scheme rules as requiring prior authorisation and no authorisation was prior obtained
- Orthodontic Treatment for beneficiaries older than 18 years of age
- Orthodontic procedures are limited to once in a life time including retainers
- Electrognathographic recordings and other such electronic analyses
- Metal base to full dentures, including the laboratory cost
- Soft base to new dentures
- Diagnostic dentures
- Provisional and emergency crowns and associated laboratory cost
- Pontics on 2nd molars
- Ozone therapy
- Resin bonding for restorations charged as separate procedure
- Porcelain veneers
- Laboratory fabricated crowns and root canal treatment on primary teeth
- Gingivectomies
- Periodontal flap surgery and tissue grafting

- Surgical tooth exposure that was not pre-authorised as part of an orthodontic treatment plan
- Orthodontic re-treatment or unauthorised initial treatment commencing an orthodontic treatment plan
- Orthognathic (jaw correction) surgery and related hospital cost
- Multiple hospital admissions for extensive conservative (basic) dentistry in young children. Only 1 admission per child every 24 months
- Laboratory delivery fees
- Cost of Mineral Trioxide
- Cost of gold, precious metal, semi-precious metal and platinum foil
- In-hospital treatment for procedure not considered as invasive based on fear and anxiety in adults
- Mouth guards and snoring appliances and the associated laboratory cost (including material)
- Oral hygiene instructions; perio chip

COMPLAINTS AND DISPUTES

MEMBERS MAY LODGE A COMPLAINT WITH THE SCHEME IN ANY OF THE FOLLOWING WAYS:

Contact: 0861 000 300;
Email: complaints@mhcmf.co.za;

Upon receipt of your complaint, the Scheme will acknowledge receipt within 2 working days. Complaints that need clinical input and investigation take longer to resolve. The Scheme will respond within 30 days.

How to:

File a complaint

1. Call the Customer Service Centre on 0861 000 300 and speak to a service consultant; remember to obtain a reference number when making the complaint OR email and remember to take note of the reference number which you receive back.
2. If the member is not satisfied with the outcome of the complaint, the member can send a letter of appeal to the Scheme. This can be in the form of either a formal letter or an email, with information on the declined decision.
3. 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.

Dispute Process

1. Once the member has exhausted the complaint process with the Scheme, the member may declare a dispute. On written request from the member, the Principal Officer may convene 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.

MHC'S PARTNERS

We have contracted a network of service providers who provide contractual specialist services ensuring access to quality healthcare.

DENTAL RISK COMPANY
"Dentistry at work"

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

mediscor pbm
Pharmaceutical Benefit Management
Solutions Together

- Medicine Formulary management

europ assistance
you live we care

- Ambulance services

momentum health

- Administration services
- Managed care services
- Primary care service management

PPN
Preferred Provider Negotiators

- Optometry provider network management

WHAT DO WE MEAN?

We have included a glossary to make the terminology in this member guide 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 (ASL)

This is the portion of your monthly contribution that is allocated to a savings account 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.

Alternative care

This is care approved instead of hospitalisation for services such as wound 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 available 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 specified number of years to recover these costs. This medication does not yet have generic equivalents.

Capitation options

Options that provide cost-effective and specified health care coverage at a prescribed network of service providers. These options may be income based and offer access to network GPs, limited access to specialists and limited cover for conservative dentistry.

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. Your employer deducts your contribution from your salary or if you are a continuation member, you will be debited directly each month.

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 contracted 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 from your own pocket.

Dependant

This is a member's spouse or partner, who is not a member or a registered dependant of a member of a medical scheme; a dependant child who is not a member or a registered dependant of a member of a medical scheme; a member's immediate family who is financially dependent of a member of a medical scheme.

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.

Facility fee

Facility fees are the extra costs charged by hospitals to members when they provide services in an outpatient location. For instance, members may be expected to pay a facility fee for consulting a physician in a hospital-operated outpatient facility.

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 (PMBs)

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.

Principal member

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

POPIA

Protection of Personal Information Act 4 of 2013.

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

CONTACT	CONTACT NO.	EMAIL ADDRESS
Call Centre	0861 000 300	info@mhcmf.co.za
Ambulance Emergency Number (Europ Assistance)	0861 009 353	info@europassistance.co.za
Hospital authorisations	0861 000 300	auths@mhcmf.co.za
Authorisation for chronic medication (Optimum, Classic + Classic Network, Hospicare + Hospicare Network)	0861 000 300	chronic@mhcmf.co.za
Authorisation for chronic medication (Custom and Essential Options)	0861 000 300	chronic@mhcmf.co.za
Claims	0861 000 300	claims@mhcmf.co.za
Membership applications and enquiries	0861 000 300	membership@mhcmf.co.za
Confidential HIV Programme	0860 109 793	ha@mhcmf.co.za
Oncology Treatment Programme	0861 000 300	oncology@mhcmf.co.za
HealthSaver	0861 000 300	info@mhcmf.co.za
Fraud line	0800 000 436	mhcmf@tip-offs.com
POPIA	0861 000 300	popia@mhcmf.co.za
Medipost	012 426 4000	info@medipost.co.za
MOTO HEALTH CARE WALK-IN CENTRES 2025		
Western Cape	Momentum, 2nd Floor, Birkdale House 2, Riverpark offices, Parklane road, Mowbray	
Eastern Cape	Momentum, Waterfront Business Park, Unit 5, 1st Floor, 1 Pommern Street, South End, Gqeberha, 6001	
Kwazulu-Natal	201 Umhlanga Ridge Boulevard, Cornubia, Durban, 4302	
Gauteng	1. Momentum Metropolitan ,268 West Avenue, Centurion 0157 2. Traduna Building, 118 Jorissen Street, Braamfontein, 2017	

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

MEMBER GUIDE

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

2025