CAPE MEDICAL PLAN

We Care

HEALTH BENEFITS 2023

OUR THREE PLANS, IN SHORT

HEALTHPACT PREMIUM

You want straightforward healthcare for your family with **comprehensive and affordable cover for big events** or emergencies that require **hospitalisation.** You are happy to manage most of your own day-to-day expenses. Unlike other plans on the market that only offer hospital cover, this product also makes **a number of non-hospital benefits** available to you.

Principal member	Adult beneficiary	Minor beneficiary
R2,842	R2,842	R501

HEALTHPACT SILVER

You want affordable hospital cover **and** day-to-day benefits. Along with **good hospital cover, you will have a Medical Savings Account (MSA) for day-to-day expenses.** In addition to the MSA, this product also provides a number of **built-in, fixed and specified day-to-day benefits.**

It's important to note that these **built-in day-to-day benefits** are **fixed and specified** and form part of the **insured risk** section of this product, **not the MSA.** These benefits **do not roll over** to the next year, unlike the available balance in the MSA.

Principal member	Adult beneficiary	Minor beneficiary
R2,805 (includes R335 to MSA)	R2,805 (includes R335 to MSA)	R421 (includes R50 to MSA)

HEALTHPACT SELECT

You want the best of both worlds and are willing to pay more for this flexibility. You will receive excellent **in- and out-of-hospital** cover with the best possible care and facilities should the need arise. Included in this product is **hospital cover, a Medical Savings Account (MSA) for day-to-day expenses, and a versatile pool of funding for additional day-to-day requirements.**

The **additional day-to-day benefits** mentioned above are different to those on the HealthPact Silver plan in that they are **versatile and flexible, and therefore not specified.**

It's important to note that these **additional day-to-day benefits** form part of the **insured risk** section of this product, **not the MSA.** They are **pre-funded** at the start of each year but **do not roll over** to the next year, unlike the available balance in the MSA. Due to this benefit being flexible and versatile, you are able to choose what type of medical consultation, treatment or procedure you want to spend this **pool of funds** on.

The additional day-to-day pool is R4,800 per adult and R1,200 per child.

Principal member	Adult beneficiary	Minor beneficiary
R7,987 (includes R336 to MSA)	R7,987 (includes R336 to MSA)	R1,290 (includes R55 to MSA)

CONDITIONS OF COVER

Pre-authorisation and authorisation for emergencies
With the exception of medical emergencies, **all planned medical procedures** (including prostheses) are subject to CMP case management and protocols and to obtaining pre-authorisation in writing 2 to 4 days prior to the planned event. Members will be required to sign the accepted quote.

If you will be requiring **airlifting services,** you will need to get **pre-authorisation** for this.

In the case of **medical emergencies,** including emergency road transport services, **authorisation will still be compulsory** and must be requested within 72 hours of the incident.

Any medical treatment that extends beyond what is described in our formularies and protocols may result in a payment shortfall. To help protect our members from over-inflated prices, protocols and authorisations have been put into place by our Member Relations Management (MRM) division.

This is done by guiding our members through the correct procedures to follow when dealing and negotiating with selected service providers, and by making sure that the best course of treatment is followed for the diagnosed condition. Referral to a specialist (who is not the primary treating doctor) whilst in hospital will require a separate authorisation through Managed Care.

To obtain authorisation or pre-authorisation, please call 021 937 8300 or email managedcare@cmp.co.za during office hours.

Payment shortfall
If benefits claimed are in **excess of services, tariffs or available benefits specified,** the member will be liable for any **payment shortfalls.** These shortfalls will either be from their **back pocket** if they are on HealthPact Premium, from their **Medical Savings Account (MSA)** if they are on HealthPact Silver or Select, from their **fixed and specified day-to-day benefits** on HealthPact Silver, or from their **versatile and flexible day-to-day pool of funds** if they are on HealthPact Select. PMB rules (below) apply.

Co-payment
For non-PMB procedures, cover is subject to a R1,500 **co-payment** on radiologist procedures, R300 on mammograms and R1,000 **per scope** used, **per procedure** on endoscopic procedures, limited to arthroscopies; appendicectomies; gynaecology or urology procedures; inguinal, umbilical, incisional or ventral hernia repairs; colectomies; colonoscopies; gastroscopies; hysteroscopies; sympathectomies; sigmoidoscopies; vaginal hysterectomies and cystoscopies.

Dentist referral
Cover is subject to a referral from a **general dentist,** on the basis that the procedure itself is impossible to perform outside of a hospital and is not classified as a PMB (refer to benefit exclusion list 12.20 to 12.24 and 12.26 in the HealthPact Premium and HealthPact Silver benefit sets, and refer to benefit exclusion list 13.20 to 13.25 in the HealthPact Select benefit set). Dental protocols apply.

Preferred Provider
Cover is subject to services obtained at a **Preferred Provider** (service providers appointed by CMP to diagnose, treat and care for our members). Treatment for Prescribed Minimum Benefit (PMB) conditions is provided by **government/state facilities** in the Western Cape and Gauteng, or a CMP-nominated service provider.

This doesn't mean that you will definitely have to go to a state facility. The Scheme must **first** be given the opportunity to advise about access to a state facility, and if the state facility is unable to take on the case and can prove they can't, **then** we will suggest or nominate a private service provider that will charge the CMP tariff/rate. If you choose not to use our Preferred Provider, you will have to pay a portion of the bill as a co-payment and/or payment shortfall.

Chronic medication is provided by any Clicks Pharmacy, government/state facility, **or any other pharmacy, but the CMP dispensing fee is capped at a negotiated rate.**

Pathology must be performed by South African National Accreditation System (SANAS)-accredited pathologists (refer page 6 of this Brochure).

In-hospital psychiatry is provided by a public sector facility (government/state), or a CMP-nominated service provider.

OUR THREE PLANS, IN DETAIL

IN-HOSPITAL COVER

BENEFIT	HEALTHPACT PREMIUM	HEALTHPACT SILVER	HEALTHPACT SELECT
Overall annual limit Benefits must be authorised	Unlimited Authorised admission to hospital	Unlimited Authorised admission to hospital	Unlimited Authorised admission to hospital
Hospital accommodation Ward fees, operating theatres, unattached theatres and day hospitals	Up to 100% of the CMP tariff or Agreed Tariff in intensive care, specialised intensive care, high care and general wards.	Up to 100% of the CMP tariff or Agreed Tariff in intensive care, specialised intensive care, high care and general wards.	Up to 100% of the CMP tariff or Agreed Tariff in intensive care, specialised intensive care, high care and general wards.
Emergency room treatment Outpatient services	No cover – except for PMBs.	Payable from MSA – except for PMBs.	Payable from MSA, thereafter from day-to-day pool – except for PMBs.
Hospitalisation/ institutionalisation for the treatment of mental illnesses, and alcoholism and drug addiction	No cover – except for PMBs.	Payable from MSA – except for PMBs.	Payable from MSA, thereafter from day-to-day pool – except for PMBs.
Treatment in lieu of hospitalisation Registered step-down facilities, hospices, registered nurses and rehabilitation centres when hospitalisation is not clinically appropriate	100% of the CMP tariff for hospices and registered nurses, limited to 15 days per beneficiary per year.	100% of the CMP tariff for hospices and registered nurses, limited to 15 days per beneficiary per year.	100% of the CMP tariff for hospices and registered nurses, limited to 15 days per beneficiary per year.
Emergency services Provided by a registered ambulance service	100% of the CMP tariff – except for PMBs.	100% of the CMP tariff – except for PMBs.	100% of the CMP tariff – except for PMBs.
Blood transfusions In-hospital	100% of cost, up to 100% of the CMP tariff.	100% of cost, up to 100% of the CMP tariff.	100% of cost, up to 100% of the CMP tariff
Materials and devices Used in-hospital	100% of cost, up to the Single Exit Price/Agreed Tariff/ pre-authorised tariff.	100% of cost, up to the Single Exit Price/Agreed Tariff/ pre-authorised tariff.	100% of cost, up to the Single Exit Price/Agreed Tariff/ pre-authorised tariff.
Medicines Dispensed and used in-hospital	100% of cost, up to the Single Exit Price for approved medicines.	100% of cost, up to the Single Exit Price for approved medicines.	100% of cost, up to the Single Exit Price for approved medicines.
Supplementary services e.g. physio-, occupational- and speech therapists, and dieticians All services must be authorised	100% of the CMP tariff.	100% of the CMP tariff.	100% of the CMP tariff.
Consultations, procedures and operations performed by General Practitioners	200% of the CMP tariff.	100% of the CMP tariff.	200% of the CMP tariff.
Consultations, procedures and operations performed by registered medical specialists Written referral required	200% of the CMP tariff.	100% of the CMP tariff.	200% of the CMP tariff.
Laparoscopic and endoscopic procedures performed in hospital Written referral required	200% of the CMP tariff with a co-payment of R1,000 per scope used, per procedure.	100% of the CMP tariff with a co-payment of R1,000 per scope used, per procedure.	200% of the CMP tariff with a co-payment of R1,000 per scope used, per procedure.

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OUT-OF-HOSPITAL COVER

CONSULTATIONS AND PROCEDURES

BENEFIT	HEALTHPACT PREMIUM	HEALTHPACT SILVER	HEALTHPACT SELECT
General Practitioner consultations and procedures Any **procedure** performed by a General Practitioner requires **pre-authorisation**	One GP consultation per beneficiary, per year, at 100% of the CMP tariff – except for PMBs.	Up to two GP visits per beneficiary per year, at 100% of the CMP tariff, thereafter payable from MSA – except for PMBs.	200% of the CMP tariff, payable from MSA, thereafter from day-to-day pool – except for PMBs.
Registered medical specialist consultations and procedures Written referral required	No cover – except for PMBs.	Payable from MSA – except for PMBs.	Payable from MSA, thereafter from day-to-day pool – except for PMBs.
Laparoscopic and endoscopic procedures Written referral required	200% of the CMP tariff with a co-payment of R1,000 per scope used, per procedure.	100% of the CMP tariff with a co-payment of R1,000 per scope used, per procedure.	200% of the CMP tariff with a co-payment of R1,000 per scope used, per procedure.
Supplementary services e.g. physio-, occupational- and speech therapists, and dieticians	No cover – except for PMBs.	Payable from MSA – except for PMBs.	Payable from MSA, thereafter from day-to-day pool – except for PMBs.

DENTISTRY, ORTHODONTICS AND ORAL SURGERY

BENEFIT	HEALTHPACT PREMIUM	HEALTHPACT SILVER	HEALTHPACT SELECT
General dental practitioner consultations	No cover.	100% of the CMP tariff, limited to R616 per beneficiary per year, thereafter payable from MSA – except for PMBs.	Payable from MSA, thereafter from day-to-day pool – except for PMBs.
General dental practitioner procedures In-hospital, and according to Dental Protocols	100% of cost, up to 120% of the CMP tariff for procedures and operations which require hospitalisation – except for PMBs.	100% of cost, up to 100% of the CMP tariff for procedures and operations which require hospitalisation – except for PMBs.	100% of cost, up to 120% of the CMP tariff for procedures and operations which require hospitalisation – except for PMBs.
Orthodontic treatment	No cover.	Payable from MSA.	Payable from MSA, thereafter from day-to-day pool.
Maxillo-facial surgeons In-hospital procedures Written referral required	120% of the CMP tariff – except for PMBs.	100% of the CMP tariff – except for PMBs.	120% of the CMP tariff – except for PMBs.
Maxillo-facial surgeons and orthodontists Dental implants, general dental treatment, orthodontic treatment, orthognathic procedures, periodontic and prosthodontic treatment, and according to Dental Protocols	No cover.	Payable from MSA.	Payable from MSA, thereafter from day-to-day pool.

MATERNITY AND PAEDIATRICS

BENEFIT	HEALTHPACT PREMIUM	HEALTHPACT SILVER	HEALTHPACT SELECT
Maternity confinements Birth or delivery	200% of the CMP tariff (only medically necessary caesareans are covered) – except for PMBs.	100% of the CMP tariff (only medically necessary caesareans are covered) – except for PMBs.	200% of the CMP tariff, with cover for elective caesareans – except for PMBs.
Antenatal consultations and foetal scans In- or out-of-hospital Provided by a registered gynaecological or radiology practice	200% of the CMP tariff, limited to R2,669 per family per year – except PMBs.	100% of the CMP tariff, limited to R2,669 per family per year, thereafter payable from MSA – except for PMBs.	200% of the CMP tariff, limited to R3,338 per family per year, thereafter payable from MSA and then from day-to-day pool – except for PMBs.
Paediatrician consultations	200% of the CMP tariff, limited to R2,260 per child per year – except for PMBs.	100% of the CMP tariff, limited to R1,065 per child per year, thereafter payable from MSA – except for PMBs.	200% of the CMP tariff, payable from MSA, thereafter from day-to-day pool – except for PMBs.
Paediatrician procedures and operations	200% of the CMP tariff.	100% of the CMP tariff.	200% of the CMP tariff.

DIAGNOSTICS – X-RAYS, RADIOLOGY AND PATHOLOGY

BENEFIT	HEALTHPACT PREMIUM	HEALTHPACT SILVER	HEALTHPACT SELECT
Radiologist procedures Angiograms, CT scans, duplex doppler scans, interventional radiology, MRI scans, and nuclear medical investigations Written referral required	100% of the CMP tariff, limited to R13,951 per beneficiary per year, with a co-payment of R1,500 per event (on all procedures) – except for PMBs.	100% of the CMP tariff, limited to R13,951 per beneficiary per year, with a co-payment of R1,500 per event (on all procedures). Thereafter payable from MSA – except for PMBs.	100% of the CMP tariff, limited to R13,951 per beneficiary per year, with a co-payment of R1,500 per event (on all procedures). Thereafter payable from MSA, and then from day-to-day pool – except for PMBs.
Black and white x-rays In-hospital	100% of the CMP tariff.	100% of the CMP tariff.	100% of the CMP tariff.
Black and white x-rays Out-of-hospital	No cover – except for PMBs.	Payable from MSA – except for PMBs.	Payable from MSA, thereafter from day-to-day pool – except for PMBs.
Mammograms Provided by a registered radiology practice	100% of the CMP tariff, with a co-payment of R300, per female beneficiary over the age of 49 years, once every 24 months, limited to R1,797 – except for PMBs.	100% of the CMP tariff, with a co-payment of R300, per female beneficiary over the age of 49 years, once every 24 months, limited to R1,797. Thereafter payable from MSA – except for PMBs.	100% of the CMP tariff, with a co-payment of R300, per female beneficiary over the age of 49 years, once every 24 months, limited to R1,797. Thereafter payable from MSA, and then from day-to-day pool – except for PMBs.

DIAGNOSTICS – X-RAYS, RADIOLOGY AND PATHOLOGY continued

BENEFIT	HEALTHPACT PREMIUM	HEALTHPACT SILVER	HEALTHPACT SELECT
Bone density benefit Provided by a registered radiology practice	100% of the CMP tariff, per beneficiary, over the age of 50, once every 5 years – except for PMBs.	100% of the CMP tariff, per beneficiary, over the age of 50, once every 5 years. Thereafter payable from MSA – except for PMBs.	100% of the CMP tariff, per beneficiary, over the age of 50, once every 5 years. Thereafter payable from MSA, and then from day-to-day pool – except for PMBs.
Pathology services In- and out-of-hospital With Pathcare and Lancet Laboratories and must be **SANAS-accredited** Written referral required	**In- and out-of-hospital** pathology is covered in full as long as you use Pathcare or Lancet Laboratories, who are **SANAS-accredited.** **In-hospital** pathology services performed by a service provider **other than** Pathcare or Lancet Laboratories will only be covered from your **insured benefits** during the first 24 hours of an emergency admission, **and** only when approved by CMP **and** performed by a **SANAS-accredited** pathologist. Any **out-of-hospital** pathology will be for your own account if you **don't use** a Preferred Provider (Pathcare or Lancet Laboratories).	**In- and out-of-hospital** pathology is covered in full as long as you use Pathcare or Lancet Laboratories, who are **SANAS-accredited.** **In-hospital** pathology services performed by a service provider **other than** Pathcare or Lancet Laboratories will only be covered from your **insured benefits** during the first 24 hours of an emergency admission, **and** only when approved by CMP **and** performed by a **SANAS-accredited** pathologist. Any **out-of-hospital** pathology will be paid from available funds in your Medical Savings Account (MSA) if you **don't use** a Preferred Provider (Pathcare or Lancet Laboratories).	**In- and out-of-hospital** pathology is covered in full as long as you use Pathcare or Lancet Laboratories, who are **SANAS-accredited.** **In-hospital** pathology services performed by a service provider **other than** Pathcare or Lancet Laboratories will only be covered from your **insured benefits** during the first 24 hours of an emergency admission, **and** only when approved by CMP **and** performed by a **SANAS-accredited** pathologist. Any **out-of-hospital** pathology will be paid from available funds in your Medical Savings Account (MSA) or your day-to-day benefits, if you **don't use** a Preferred Provider (Pathcare or Lancet Laboratories).
COVID-19 testing Medically necessary PCR test for the detection of COVID-19	The scheme covers COVID-19 testing as part of our pathology services. The scheme will cover medically necessary PCR tests for the detection of COVID-19 that are performed by Pathcare or Lancet Laboratories. There must be a doctor's referral. The scheme will not cover COVID-19 tests that a beneficiary needs for any type of travel or leisure purposes, or testing that is required in place of a vaccination. The member will have to fund these tests themselves. Testing required before admission to a medical facility, when an authorised procedure is to be performed, will be covered if carried out by Pathcare or Lancet Laboratories.		

PROSTHESES, DIALYSIS, ORGAN TRANSPLANTS AND ONCOLOGY (MUST BE AUTHORISED)

BENEFIT	HEALTHPACT PREMIUM	HEALTHPACT SILVER	HEALTHPACT SELECT
Prostheses and implants, excluding hearing devices and dental implants Refer to Prostheses and Implants price list	If introduced internally as an integral part of an operation, 100% of the cost, limited to R51,145 per beneficiary per year.	If introduced internally as an integral part of an operation, 100% of the cost, limited to R51,145 per beneficiary per year.	If introduced internally as an integral part of an operation, 100% of the cost, limited to R51,145 per beneficiary per year.
External prostheses and surgical appliances	No cover – except for PMBs.	100% of cost, payable from MSA – except for PMBs.	Payable from MSA, thereafter from day-to-day pool – except for PMBs.
Chronic renal dialysis	Provided that PMB level of care criteria are met, covered at 100% of the CMP tariff.	Provided that PMB level of care criteria are met, covered at 100% of the CMP tariff.	Provided that PMB level of care criteria are met, covered at 100% of the CMP tariff.

PROSTHESES, DIALYSIS, ORGAN TRANSPLANTS AND ONCOLOGY (MUST BE AUTHORISED) continued

BENEFIT	HEALTHPACT PREMIUM	HEALTHPACT SILVER	HEALTHPACT SELECT
Organ transplants	Provided that PMB level of care criteria are met, covered at 100% of the CMP tariff.	Provided that PMB level of care criteria are met, covered at 100% of the CMP tariff.	Provided that PMB level of care criteria are met, covered at 100% of the CMP tariff.
Oncology treatment	Provided the formularies and treatment protocols of CMP and the SA Oncology Consortium (SAOC) tier guidelines are applied in accordance with an agreed treatment plan, covered at 100% of the CMP tariff, as per the SA Oncology Consortium's **Primary Level of Care** treatment guidelines.	Provided the formularies and treatment protocols of CMP and the SA Oncology Consortium (SAOC) tier guidelines are applied in accordance with an agreed treatment plan, covered at 100% of the CMP tariff, as per the SA Oncology Consortium's **Primary Level of Care** treatment guidelines.	Provided the formularies and treatment protocols of CMP and the SA Oncology Consortium (SAOC) tier guidelines are applied in accordance with an agreed treatment plan, covered at 100% of the CMP tariff, as per the SA Oncology Consortium's **Primary Level of Care and Standard Level of Care** curative treatment guidelines.
Anti-emetics, vitamins and cosmetic and prosthetic appliances forming part of oncology treatment	No cover – except for PMBs.	Payable from MSA – except for PMBs.	Payable from MSA, thereafter from day-to-day pool – except for PMBs.

PRESCRIBED MEDICATION

BENEFIT	HEALTHPACT PREMIUM	HEALTHPACT SILVER	HEALTHPACT SELECT
Chronic medication Subject to authorisation	100% of cost, to a maximum of SEP, plus the agreed Preferred Provider dispensing fee.	100% of cost, to a maximum of SEP, plus the agreed Preferred Provider dispensing fee.	100% of cost, to a maximum of SEP, plus the agreed Preferred Provider dispensing fee.
Which conditions are covered on the chronic medicine benefit?	Access to the chronic medicine benefit is subject to CMP's formularies and protocols. If you are diagnosed with a chronic condition, you will more than likely be required by your doctor to take regular medication. Although all our members receive cover for chronic conditions, it is not automatic: you will need to **obtain pre-authorisation by first registering with our Chronic Disease Management programme.** Once you are registered, you will only need to re-register if your medication changes, or if we request it for administrative purposes. The following conditions are covered, and make up our Chronic Disease List (CDL): • Addison's Disease • Anti-coagulating therapy • Asthma • Bipolar Mood Disorder • Bronchiectasis • Cardiac failure • Cardiomyopathy • Chronic Obstructive Pulmonary Disease • Chronic Renal Disease • Coronary Artery Disease • Crohn's Disease • Cushing's Disease • Diabetes Insipidus • Diabetes Mellitus Type 1 & 2 • Dysrhythmias • Epilepsy • Glaucoma • Haemophilia • HIV • Hyperlipidaemia • Hypertension • Hypothyroidism • Rheumatoid Arthritis/Juvenile Rheumatoid Arthritis • Multiple Sclerosis • Parkinson's Disease • Schizophrenia • Systemic Lupus Erythematosis • Ulcerative Colitis To register with the Chronic Disease Management programme, please contact our MRM division at 021 937 8300, or email chronic@cmp.co.za.		
Acute medication	No cover – except for PMBs.	100% of cost to a maximum of SEP, plus the agreed Preferred Provider dispensing fee. Limited to R751 per family, thereafter payable from MSA – except for PMBs.	100% of cost to a maximum of SEP, plus the agreed Preferred Provider dispensing fee. Payable from MSA, thereafter from day-to-day pool – except for PMBs.
Take-home medication	No cover – except for PMBs.	Payable from MSA – except for PMBs.	Payable from MSA, thereafter from day-to-day pool – except for PMBs.

SPECTACLES, CONTACT LENSES AND SUPPLEMENTARY SERVICES

BENEFIT	HEALTHPACT PREMIUM	HEALTHPACT SILVER	HEALTHPACT SELECT
Spectacles and contact lenses	No cover – except for PMBs.	100% of cost, payable from MSA – except for PMBs. 	100% of cost, payable from MSA, thereafter from day-to-day pool – except for PMBs. 
Supplementary services Refer to additional notes and terminologies	No cover – except for PMBs. 	100% of cost, payable from MSA – except for PMBs. 	100% of cost, payable from MSA, thereafter from day-to-day pool – except for PMBs. 

PREVENTATIVE BENEFITS

This is the care you receive to prevent illnesses or diseases. Providing these services is based on the idea that getting preventative care, such as **screenings via various diagnostics and specific consultations** can help you and your family stay healthy.

Examples of preventative care are **pathology and radiology benefits, including mammograms and bone density scans as well as GP, specialist and various maternity benefits.**

BENEFIT	HEALTHPACT PREMIUM	HEALTHPACT SILVER	HEALTHPACT SELECT
Preventative and screening benefits	• Antenatal visits for pregnant moms – Refer to page 5 • Bone mineral density test for beneficiaries > 50 – Refer to page 6 • COVID-19 vaccinations can be performed at any private or public facility. The scheme covers the cost of the vaccinations that are approved by the Medicine's Control Council of South Africa • Flu vaccine for beneficiaries registered for asthma or chronic obstructive pulmonary disease • Mammograms for females > 49 – Refer to page 5 • Pap smear on request of a medical doctor – Refer to page 6 • Prostate test (PSA level) for males – Refer to page 6 • The only scheme that provides all out-of-hospital pathology requested by a medical doctor, which includes but is not limited to blood glucose, cholesterol and thyroid screening, and COVID-19 testing. • Voluntary HIV testing and counselling – Refer to page 6		

PROSTHETIC AND IMPLANTS PRICE LIST – cover is subject to these limits

DEVICE	SUB-LIMIT
Cardiac stents	R15,980 per stent
Trans-vaginal tape	R10,923
Intra-ocular lenses	R3,208 per lens
Patches used in incisional hernia repairs	R4.369
Patches used in groin hernia repairs	R1,463
Pacemakers, including leads	R51,145
Joint replacements	R51,145

WHAT DOESN'T CMP COVER?

As with any medical scheme, we are unable to cover certain procedures, products and services. These are listed as exclusions across all our products and may never be paid for from insured benefits, subject to PMB rules. They may, however, be **paid for from the MSA (HealthPact Silver and Select) if funds are available.** The following exclusions apply:

- COVID-19 testing for travel or leisure purposes
- COVID-19 testing that is in place of a vaccination
- Blepharoplasties, or any procedure to correct eye refraction errors including, but not limited to an excimer laser/Lasik
- Treatment for sexual dysfunction (male and female)
- Infertility treatment, unless authorised within PMB level of care criteria
- Breast reductions, including scar revision, Botox, breast augmentation and gynaecomastia
- Mammaprint genetic testing and any other type of genetic testing
- Non-diseased breast reconstruction, nipple reconstruction and symmetry, unless authorised within PMB level of care criteria
- Any cosmetic surgery
- Long-term nursing care (such as frail care nursing)
- Non-PMB treatment relating to alcohol or substance abuse, wilful self-injury or attempted suicide
- Non-PMB psychological and psychiatric treatment, including sleep studies
- Treatment and/or surgery for obesity
- Educational and group therapy
- Protective gear
- Treatment relating to or forming part of organ transplants that does not fall within the PMB level of care criteria
- Non-PMB external devices (including crutches, commodes, nebulisers, pronator boots, bed pans, raised toilet seats, wheelchairs, and CPAP machines)
- Non-PMB hearing devices and cochlear implants (or the maintenance thereof)
- Artificial and synthetic blood products
- Dental implants, orthodontic treatment, prosthodontic treatment, orthognathic procedures, periodontic treatment
- General dentistry performed under general anaesthetic or conscious sedation for minor beneficiaries over the age of 7 years
- Experimental or unproven treatments, procedures, devices, unregistered medicines and Section 21 medicines, as per the Medicines Control Council
- Household medicinal remedies, contraceptives, patent medicines, non-ethical and all proprietary preparations (including vitamins, supplements, minerals, medical creams, soaps, shampoos, and laxatives)
- Medical examinations for insurance, school, association, emigration, visa, employment or other applications
- Any treatments or costs not specifically provided for

ADDITIONAL NOTES AND TERMINOLOGIES

Agreed tariffs. CMP has negotiated fixed tariffs with the major hospital groups in South Africa, namely Medi-Clinic, Netcare, Life Healthcare and National Hospital Network. These agreed tariffs, which are not necessarily linked to the CMP tariff, are applicable to all CMP members requiring hospitalisation. There are a few specific hospitals that don't fall into these major groupings and in those instances, claims will only be paid at the CMP tariff, which may result in payment shortfalls.

Claims. All claims must be submitted within 4 months of the date of treatment. In order for members to claim reimbursement from CMP, the service provider must have an active Board of Healthcare Funders (BHF) practice number.

CMP tariff. This tariff represents the maximum amount CMP will pay to service providers on behalf of its members. The 2023 CMP tariff is the 2022 CMP tariff + 6.5%.

Co-payments. In some cases, a specific pre-determined amount of the cost of the procedure or service in question will be for members' own account, as per our benefit rules. **A co-payment is not the same as a payment shortfall.**

Day-to-day benefits. (HealthPact Silver only.) In addition to in-hospital benefits and an MSA, **HealthPact Silver** beneficiaries are allocated **built-in, fixed and specified** annual day-to-day benefits like two GP visits, separate dental cover and an acute medicine benefit. Unlike the MSA, any remaining **built-in day-to-day benefits** are not carried over to the following year.

Day-to-day pool. (HealthPact Select only.) At the beginning of each year, **HealthPact Select** beneficiaries are allocated a **versatile and flexible pool** of benefits to pay for day-to-day expenses. This **day-to-day pool** comes into effect once MSA funds are depleted. Unlike the MSA, any remaining day-to-day benefits are not carried over to the following year.

Dental procedures (in- and out-of-hospital). Dental work is only covered as per the CMP Dental Protocol.

Emergency services. If you need the use of **emergency road transport services,** you must obtain **authorisation within 72 hours of the event** and the service must be provided by a **registered service provider.**

Any **airlifting services** must be **pre-authorised prior to take off, and there must be proof of a life-threatening emergency.**

In-excess tariffs. If a service provider charges in excess of the CMP tariff, CMP will reimburse the member.

Medical emergency. The sudden, unexpected onset of a health condition that requires immediate medical attention. Where treatment is not available, the condition could result in serious harm or even death.

ADDITIONAL NOTES AND TERMINOLOGIES continued

Medical Savings Account (MSA). HealthPact Silver and Select members contribute to a compulsory MSA each month via their monthly contributions. The entire savings amount, which is equivalent to 12 monthly contributions, is pre-funded at the beginning of each year. The MSA will accrue interest.

The MSA may not be used to pay for PMBs or to offset contributions. If a member transfers to or from another medical scheme, the savings will be transferred accordingly. If a member resigns before the end of the year and has used the full pre-funded amount, CMP will claim back the portion of savings owing for the rest of the year. If a member dies, any savings will be transferred to the deceased member's estate.

Payment of benefits. If a member requests that benefits are paid directly to them, we will oblige at our discretion. CMP reserves the right to withhold payment of claims referred to the HPCSA for investigation.

Payment shortfalls. When there are not enough insured benefits or savings to pay for a medical account, the amount owing is called a payment shortfall. This often happens when a service provider charges more than what a member's product provides for. A shortfall may be paid from a member's savings account (MSA). However, if savings are depleted, members become personally liable for the amount. **A payment shortfall is not the same as a co-payment.**

Precribed Minimum Benefits (PMBs). Prescribed Minimum Benefits (PMBs). PMBs are the minimum benefits that all medical schemes are legally required to cover so that members are always covered in life-threatening situations. A set of about 270 medical conditions, 29 chronic conditions, and all genuine emergency medical conditions are classified as PMBs. All PMBs are overseen by our internal PMB committee.

To ensure payment of PMB claims, PMB treatment must conform to CMP's formularies and protocols, and all ICD-10 and PMB codes must be recorded on a claim. Failure to adhere to these rules may result in payment only in accordance with the prescribed levels, and a co-payment and payment shortfall may apply **(PMBs may not be paid for from the MSA)**. CMP reserves the right to investigate all PMB claims, and to request and obtain supporting documentation as we deem necessary.

PMBs will be paid in accordance with current legislation if services are obtained from a Preferred Provider, or involuntarily obtained from any other service provider. This condition is subject to pre-authorisation, as well as rules 17.9 and 17.10 (HealthPact Premium), 18.9 and 18.10 (HealthPact Silver) and 19.9 and 19.10 (HealthPact Select) of the full benefit sets.

Pro-rated benefits. Any member who joins CMP after 1 January will receive out-of-hospital benefits (day-to-day benefits/pool and savings, depending on the HealthPact plan in question) in proportion to the number of contributions they will pay for the remainder of the year.

Referral of accounts. If an account submitted to CMP appears to be invalid for whatever reason, we reserve the right to scrutinise the account and, if necessary, take further action on a member's behalf. If necessary, the account will be referred to the HPCSA for further investigation. Until the grievance is resolved, CMP may withhold payment of that claim.

Referral to a specialist. In the interests of better **co-ordinated care** and the management of costs, members must have a **written motivation** from preferably their general practitioner (GP) or family physician **before seeing a specialist,** should they require any form of hospitalisation or procedure.

Registered practitioner. A registered practitioner is one who is registered with the **Health Professionals Council of South Africa (HPCSA)**. The HPCSA is a statutory body established to serve and protect the public and provide guidance to registered healthcare practitioners and medical schemes. Cover is subject to instruction by a HPCSA-registered medical practitioner (including a paramedic).

Cover is subject to services received from registered **medical specialists,** limited to anaesthetists, dermatologists, gynaecologists, paediatric cardiologists, paediatric surgeons, cardiothoracic surgeons, general surgeons, neurologists, neurosurgeons, otorhinolaryngologist (ear, nose and throat specialists), urologists, clinical haematologists, gastroenterologists, nuclear medicine practitioners, ophthalmologists, orthopaedic surgeons, physicians, plastic & reconstructive surgeons, and pulmonologists.

Single Exit Price (SEP). A SEP is the price charged for drugs by drug manufacturers to service providers (pharmacies, hospitals and practices for example). This price, as well as the dispensing fee charged by service providers, is regulated by government.

Supplementary services. This includes aromatherapists, chiropodists, chiropractors, dieticians, hearing aid acousticians, homeopaths, herbalists, naturopaths, occupational therapists, orthotists, orthoptists, physiotherapists, podiatrists, psychiatrists, psychologists, physical medicine practitioners, reflexologists, social workers, speeth therapists and sexologists. **Separate authorisation is required for these services in-hospital and once you leave hospital, if associated with the hospital event.**

Written referral. This is a referral from a registered General Practitioner or family physician. The referral must be in the form of a **clinically appropriate medical report/referral letter.** This report must indicate why a beneficiary needs to be referred, what conservative treatment has been followed and the beneficiary's recent medical history. This is in accordance with rule 17.11 (HealthPact Premium), 18.11 (HealthPact Silver) and 19.11 (HealthPact Select).

ABOUT CAPE MEDICAL PLAN

Medical aid can be complicated. We can't change that. What we can do, however, is make sure that our members have an effective way of defraying the cost of clinically necessary medical care, and all the information they need to make informed healthcare choices at every stage of their lives.

At Cape Medical Plan, we operate as a mutual society. We have done so since establishing ourselves in 1961. To this day, we are wholly owned and governed by our members, and adamantly promote mutuality and social solidarity among ourselves. We all share in a vision of long-term sustainability, and understand our responsibilities toward the Scheme and fellow members.

We provide a rock-solid financial foundation; keep our products as easy to understand as possible; provide up-to-date information about the healthcare industry, and offer our members a compassionate, human voice when they need it most. In addition, we do not use brokers and third-party administrators – we prefer dealing directly with our members.

CONTACT US

Our operating hours are from 8am to 5pm, Monday to Friday. Phone, mail or visit us, or browse to our website at www.cmp.co.za.

Tel: 021 937 8300
Email: mail@cmp.co.za
Address: P.O. Box 6255
Welgemoed
7538

https://www.facebook.com/pg/CapeMedicalPlan

https://www.linkedin.com/company/cape-medical-plan

https://www.instagram.com/capemedicalplan

Medical benefits emergency advice line – 0860 227 363.

This number is **only to be used after hours to get generic information about your benefits,** such as which ambulance service to use, who our Preferred Providers are for hospitals, or to get advice about whether or not you should go to an emergency room.

This is not a contact number for the administration of your membership. You will not be able to get any information about your personal or specific benefits, such as how many GP visits you have left, how much is in your Medical Savings Account (MSA) and if your contributions have been paid.

You also won't be able to use this number to obtain an authorisation number or check on your chronic medication.

You cannot use this number to call an ambulance.

COMPLAINT AND DISPUTE RESOLUTION

Any claims-related complaints or disputes must be put in writing, and directed to:

P.O. Box 6255
Welgemoed
7538

Alternatively, email your complaint to complaints@cmp.co.za.

CMP will respond within 30 days of receipt of the complaint. If you are still dissatisfied with the outcome, you may inform the Chairman of the Disputes Committee (using the same address) in writing within 60 days. Again, CMP will respond within 30 days of receipt.

If after that, you wish to take the matter further, you may approach the Council for Medical Schemes (CMS).

Members are encouraged to explore the Scheme's dispute resolution process prior to lodging their complaints with the CMS.

In order to approach the CMS, members must send their dispute in writing to the Registrar of Medical Schemes. The Registrar will then have 30 days to provide the member with a written reply.

Complaints and disputes must be directed to the CMS at:

Postal address: Private Bag X34, Hatfield, 0028
Physical address: Block A, Eco Glades 2 Office Park, 420 Witch-Hazel Avenue, Eco Park, Centurion, 0157
Sharecall number: 0861 123 267
Fax number: (086) 673 2466
Email: complaints@medicalschemes.co.za
Website: www.medicalschemes.co.za

ABOUT THIS DOCUMENT

This document contains a summary of CMP's benefits, and an excerpt to our General Rules. While care has been taken to include as much relevant detail as possible, the rules take preference over this and any other document. For clarification of any of the items in this document, please visit our website at www.cmp.co.za. Alternatively, contact us at 021 937 8300 or email mail@cmp.co.za.

DISCLAIMER

This brochure is only a summary of the key benefits and features of the Cape Medical Plan (CMP) product plans. Full details can be found in the Council for Medical Schemes-approved Benefit Set documents. The original, stamped documents and the General Rules of the Scheme remain the final authority and are available to members on the CMP website.

Although care has been taken to ensure the accuracy, completeness and reliability of the information provided, changes in circumstances after the time of publication may impact on the accuracy of the information. The information may change without notice and CMP is not in any way liable for the accuracy of the information once it is subsequently copied, printed, stored or in any way interpreted or used by the user.