NETCARE

Medical Scheme
Administered by Discovery Health

Netcare
Medical Scheme

Member Brochure
Savings Option

2023

CARE | DIGNITY | PARTICIPATION | TRUTH | COMPASSION

Contents

Introduction

Netcare Medical Scheme is pleased to present you with your Membership Brochure. The Scheme trusts that you will find this document informative and helpful over the coming year, during which the Scheme remains as committed as ever to meeting your healthcare needs and those of your loved ones.

About this Benefit Brochure

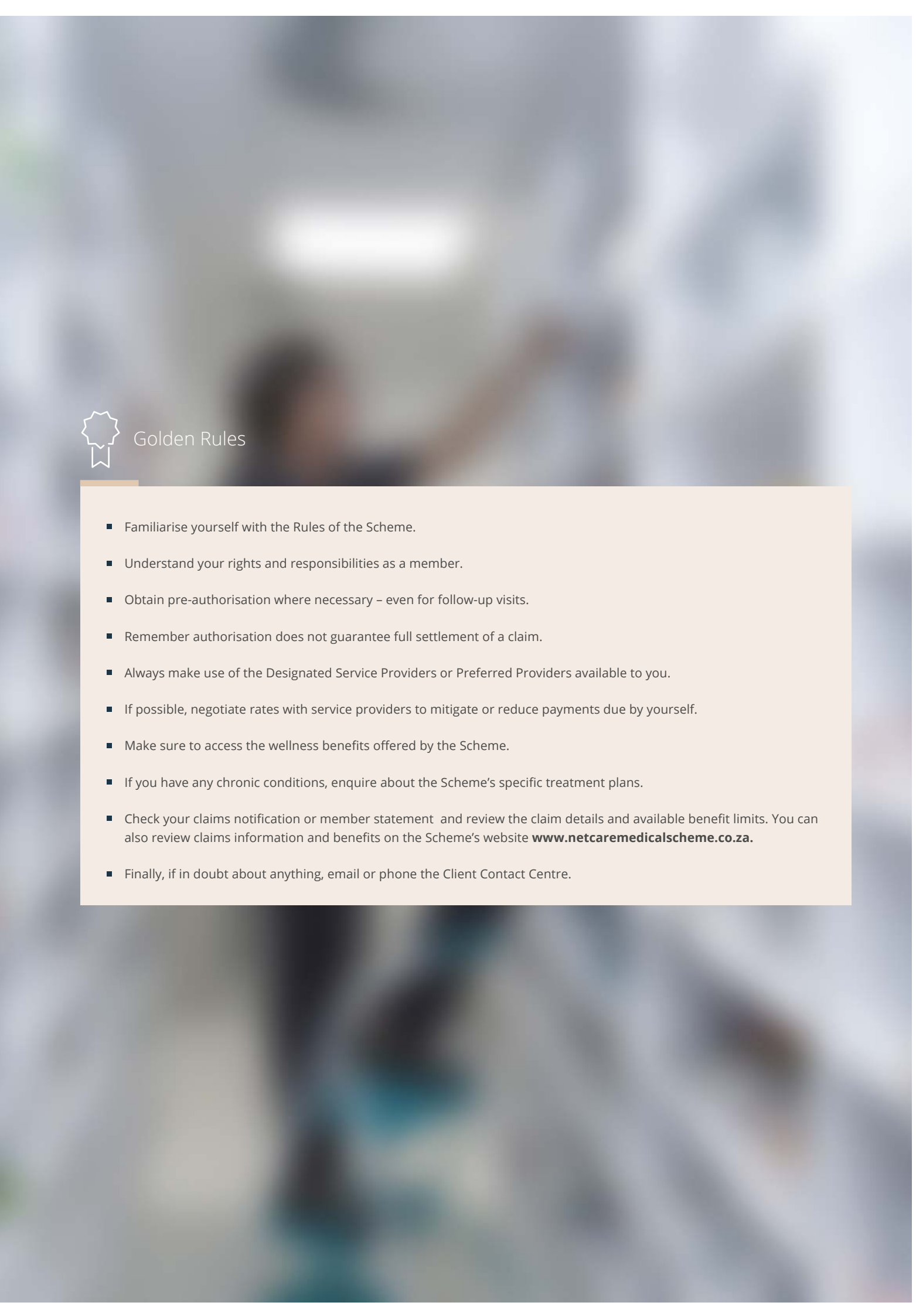
This brochure serves as a guide to the Netcare Medical Scheme. It consists of information about your membership and benefits. This Benefit Brochure provides you with a summary of the benefits and features of the Netcare Medical Scheme, pending approval from the Council for Medical Schemes and is subject to the Rules of the Netcare Medical Scheme. The registered Scheme Rules are legally binding and always take precedence. Members who require further information should contact the Client Contact Centre on 0861 638 633.

Scheme Overview

The Netcare Medical Scheme was established in 1999 to provide excellent healthcare benefits that would truly make a difference in the lives of Netcare employees and their families.

The Netcare Medical Scheme is managed by a Board of twelve Trustees.

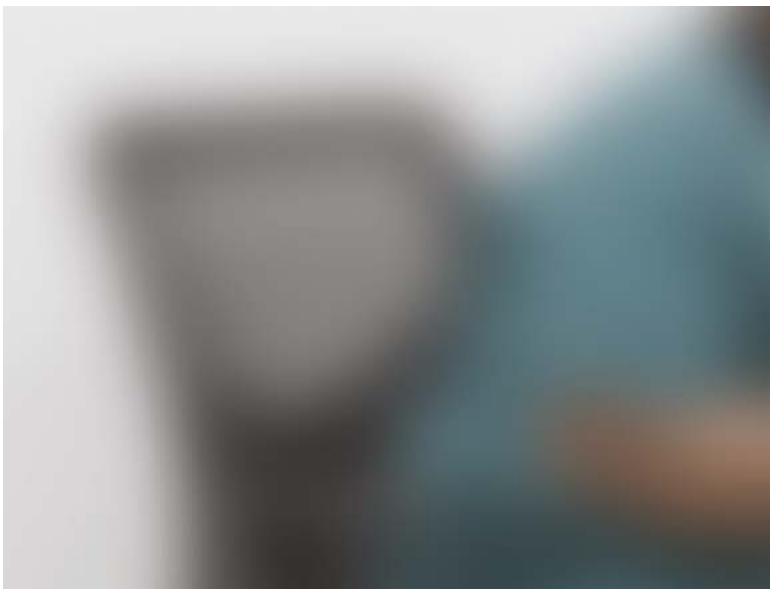
The Board of Trustees is responsible for the setting of the rules that govern the Scheme, for determining the benefits available to members and the contributions charges, and whilst ensuring the financial stability of the Scheme and equitable access to benefits for all members.

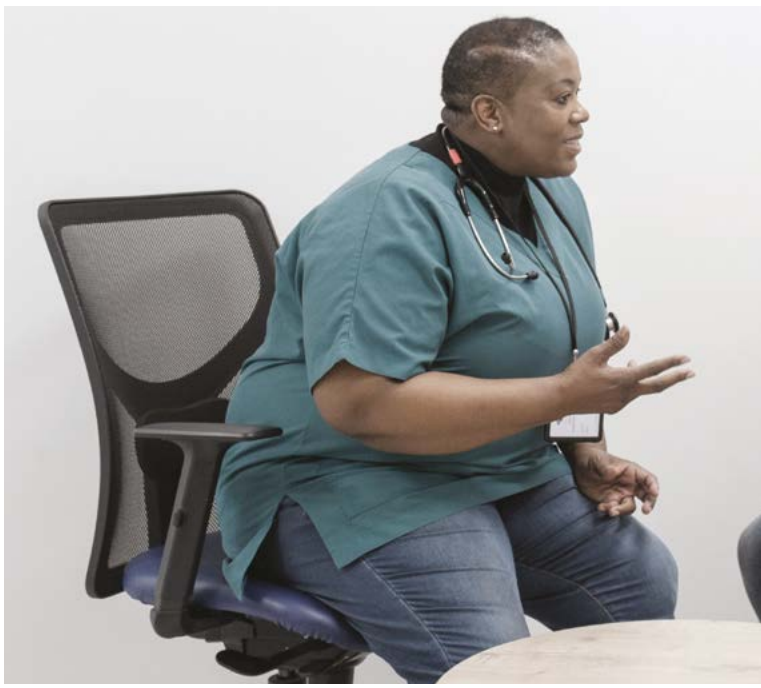


Golden Rules

- Familiarise yourself with the Rules of the Scheme.
- Understand your rights and responsibilities as a member.
- Obtain pre-authorisation where necessary – even for follow-up visits.
- Remember authorisation does not guarantee full settlement of a claim.
- Always make use of the Designated Service Providers or Preferred Providers available to you.
- If possible, negotiate rates with service providers to mitigate or reduce payments due by yourself.
- Make sure to access the wellness benefits offered by the Scheme.
- If you have any chronic conditions, enquire about the Scheme's specific treatment plans.
- Check your claims notification or member statement and review the claim details and available benefit limits. You can also review claims information and benefits on the Scheme's website **www.netcaremedicalscheme.co.za.**
- Finally, if in doubt about anything, email or phone the Client Contact Centre.

Membership





Who is eligible for membership to the Netcare Medical Scheme?

- The Netcare Medical Scheme is a closed medical scheme and membership is restricted to permanent employees, pensioners, disability and continuation members of Netcare Limited as defined in the Rules of the Scheme.
- At the time of their application or at any time thereafter, employees who join the Scheme may apply to have children and/or adults added to their membership as dependants. Dependants have to qualify for Scheme membership in terms of the Rules of the Scheme.

Who is not eligible for membership to the Netcare Medical Scheme?

- Members of the Scheme who resign from the employment of Netcare Limited or a subsidiary of the Group, together with their dependants.
- Employees who were not members of the Scheme before retirement or the termination of their services on account of ill-health or other disability are not eligible to become members of the Scheme.
- A Continuation member who voluntarily resigns from the Scheme for any reason whatsoever, with their dependants, are not allowed to re-join as members once they have resigned.
- The dependants of a deceased member who initially retain membership after the death of the main member, but who later resign from the Scheme for any reason whatsoever, are not allowed to re-join as members once they have resigned.
- Those dependants of deceased members, or members who are retirees or who suffer from ill-health and disability, lose their membership to the Scheme if the Scheme terminates their membership as a result of non-payment of contributions. Kindly note, that you will not be able to pay up the premiums and re-join the scheme as unpaid contributions result in a loss of continuation status.

Retention of membership in the event of retirement, ill-health or death

- Members may retain their membership of the Scheme in the event of retirement or when their employment is terminated by Netcare Limited or a subsidiary of the Group on account of ill-health or other disability.
- Registered dependants may continue membership in the unfortunate event of the death of the main member as long as they continue to pay all contributions that become due and are **specifically required to advise the scheme of their intention to exercise this right to remain.**

How to apply for membership

01

Obtain

An application form can be obtained from your HR department.

02

Complete

Complete your application and attach the required supporting documentation.

03

Submit

Submit the completed application and supporting documentation to your HR Department.

Incomplete and outstanding supporting documentation

All new applicants who join after sixty (60) days from the date of employment are required to complete the medical questionnaire. Applicants must disclose to the Medical Scheme information regarding any medical condition for which medical advice, diagnosis, care or treatment was recommended or received over the twelve (12) months prior to their date of application. This requirement applies to the applicant and his/her dependants and includes but is not limited to medical conditions and/or diseases that:

- A member or dependant suffers from as at the date of application.
- A member or dependant was diagnosed with sometime over the past twelve (12) months, including conditions that were diagnosed but managed with lifestyle changes e.g. high cholesterol.
- A member or dependant was treated for over the previous twelve (12) months including treatment received and treatment that was recommended, but not necessarily taken.
- A member or dependant obtained medical advice not from a doctor but from another healthcare provider such as a pharmacist.
- The member or dependant had any symptoms of illnesses that were not specifically diagnosed by a doctor, or for which no specific treatment was provided.

The Scheme may terminate membership if the member does not disclose any and all relevant medical information.

Waiting periods

Where an employee joins the Scheme sixty (60) days after commencing employment, the Scheme may impose the following waiting periods as provided for in terms of the Medical Schemes Act (No. 131 of 1998):

CATEGORY	THREE (3) MONTH GENERAL WAITING PERIOD	12 MONTH CONDITION-SPECIFIC WAITING PERIOD	APPLICATION TO PRESCRIBED MINIMUM BENEFITS (PMBS)
New applicants, or persons who have not been a member of a medical scheme for the preceding 90 days	Yes	Yes	Yes
Applicants who were members of another medical scheme for less than two years	No	Yes	No
Applicants who were members of another medical scheme for more than two years and who did not join within 30 days of employment	Yes	No	No
Child-dependants born during a period of membership and registered within 30 days of birth/adoption	No	No	No
Addition of a spouse/life-partner within 30 days of marriage/proof of common household	No	No	No

Membership cards

The Scheme provides members with a Welcome Pack, which includes a membership card for the main member and all of the adult dependants on his/her membership.

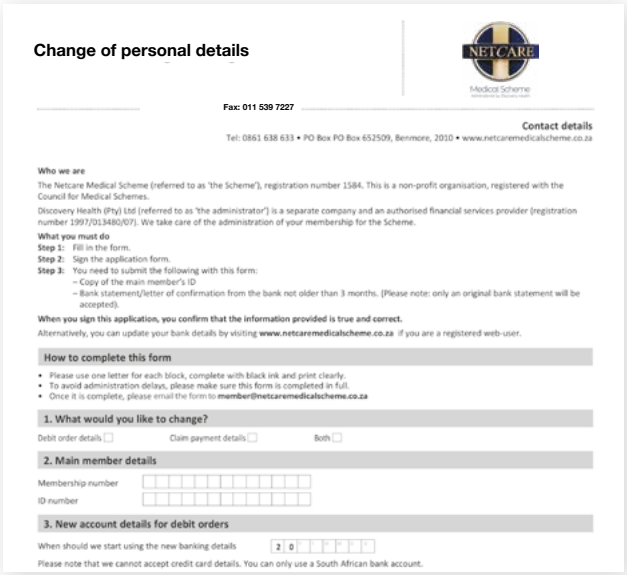
Membership cards may only be used by the registered member and registered dependants. **It is fraudulent to permit someone else to use your medical scheme card and benefits. Please note that the scheme will proceed with civil and criminal action should you be found doing so.**

Welcome Packs and membership card(s) are couriered to the relevant Human Resources (HR) Departments. It is therefore essential that the correct workplace or work site is clearly indicated on all application forms.

Change of personal details

In order for the Scheme to communicate with you effectively it is important for you to notify us of changes to your contact details.

In compliance with the Protection of Personal Information Act (POPIA), HR departments do not inform the Scheme of any changes made to personal details. Therefore any changes to personal details should be separately directed to the Scheme.



Change of personal details

NETCARE Medical Scheme

Fax: 011 539 7227

Contact details

Tel: 0861 638 633 • PO Box PO Box 652509, Benmore, 2010 • www.netcaremedicalscheme.co.za

Who we are

The Netcare Medical Scheme (referred to as "the Scheme"), registration number 1584. This is a non-profit organisation, registered with the Council for Medical Schemes.

Discovery Health (Pty) Ltd (referred to as "the administrator") is a separate company and an authorised financial services provider (registration number 1997/013480/07). We take care of the administration of your membership for the Scheme.

What you must do

Step 1: Fill in the form.
Step 2: Sign the application form.
Step 3: You need to submit the following with this form:
– Copy of the main member's ID
– Bank statement/letter of confirmation from the bank not older than 3 months. (Please note: only an original bank statement will be accepted).

When you sign this application, you confirm that the information provided is true and correct.

Alternatively, you can update your bank details by visiting **www.netcaremedicalscheme.co.za** if you are a registered web-user.

How to complete this form

- Please use one letter for each block, complete with black ink and print clearly.
- To avoid administration delays, please make sure this form is completed in full.
- Once it is complete, please email the form to **member@netcaremedicalscheme.co.za**

1. What would you like to change?

Debit order details ☐ Claim payment details ☐ Both ☐

2. Main member details

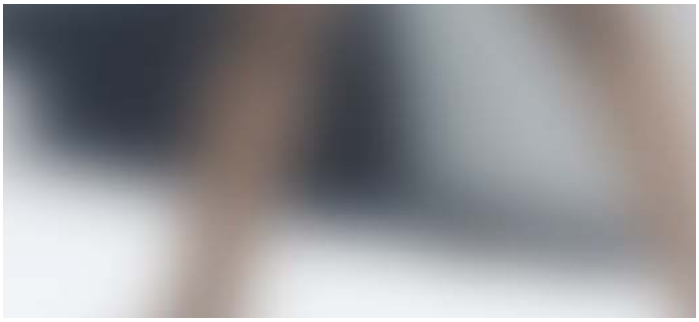
Membership number

ID number

3. New account details for debit orders

When should we start using the new banking details 2 0

Please note that we cannot accept credit card details. You can only use a South African bank account.



Update your information – it is as easy as 1…2…3…

01

To update your personal information, log on to the Scheme's website **www.netcaremedicalscheme.co.za** and go to the **'YOUR DETAILS'** section. You can also obtain the Change of Personal Details form from the Scheme's website under the tab **'Find a document'**, or phone our Client Contact Centre at **0861 638 633** for assistance. You may also request a copy from your Human Resources (HR) Department.

02

Complete the form and ensure it is signed and that a copy of your Identity Document (ID) is attached.

03

Your completed form may be returned to the Scheme in one of the following ways:

- **Email:**
  member@netcaremedicalscheme.co.za
- **Registered post:**
  The Netcare Medical Scheme
  Membership Department
  PO Box 652509
  Benmore 2010

The Scheme shall not be liable if a member's rights are prejudiced or forfeited as a result of neglect or failure to comply with these requirements.

Monthly contributions

Membership contributions are deducted by the employer from the employee's monthly remuneration. This is paid to the Scheme every month in arrears on behalf of the member.

Pensioners, dependants of deceased members and disability claimants must make payment directly to the Scheme and may be liable for the full contribution if they do not qualify for the Netcare post-retirement employer subsidy. The employer subsidy is determined by Netcare Limited.

Late payments can result in suspended benefits or cancellation of membership.

The Scheme calculates your contribution using the Contribution Table based on:

- The income (rate-of-pay/ROP) of the principal member.
- The number of adult dependants defined as spouses, life-partners and any immediate family for whom the principal member is liable, including children from the age of twenty-one (21) years. Additional adult dependants must be financially dependent on the member and evidence to this effect is required for acceptance on to the Scheme. Spouses, life-partners and any immediate family for whom the principal member is financially responsible may apply to become a dependant including children from the age of twenty-one (21) years.
- The number of child dependants. All dependants younger than twenty-one (21) years are considered to be child dependants. Children from the age of twenty-one (21) years, registered as bona fide students at an educational institution up to the age of twenty five (25) years, subject to providing proof of current registration at a tertiary institution to the Scheme annually, are also considered to be child dependants.
- The contribution table applies from 1 April 2023 and is included as Annexure A.

Late joiner penalties

Late joiner contribution penalties in respect of persons over the age of 35 years will be imposed as per the Medical Schemes Act and the membership rules noted in this guide.

Termination of a dependant or membership

You may terminate the membership of any of your dependants by notifying your Human Resources (HR) Department using the documentation provided by the Scheme, giving one (1) calendar month's written notice to the Scheme.

Principal members may only terminate membership if they resign from employment with Netcare Limited or provide proof of alternative medical scheme cover (as a dependant). One (1) calendar month's notice is required using the necessary Scheme documentation.

Structure of Benefits

The benefit structure of the Netcare Medical Scheme includes a 15% Member Savings Account (MSA) component for day-to-day expenses. Preventative benefits and high cost items are paid by the Scheme from the insured or risk portion.

Expenses payable from the Scheme's insured or risk portion

The Scheme will cover expenses such as those noted below from the insured or risk portion of benefits. Note that payment may be subject to:

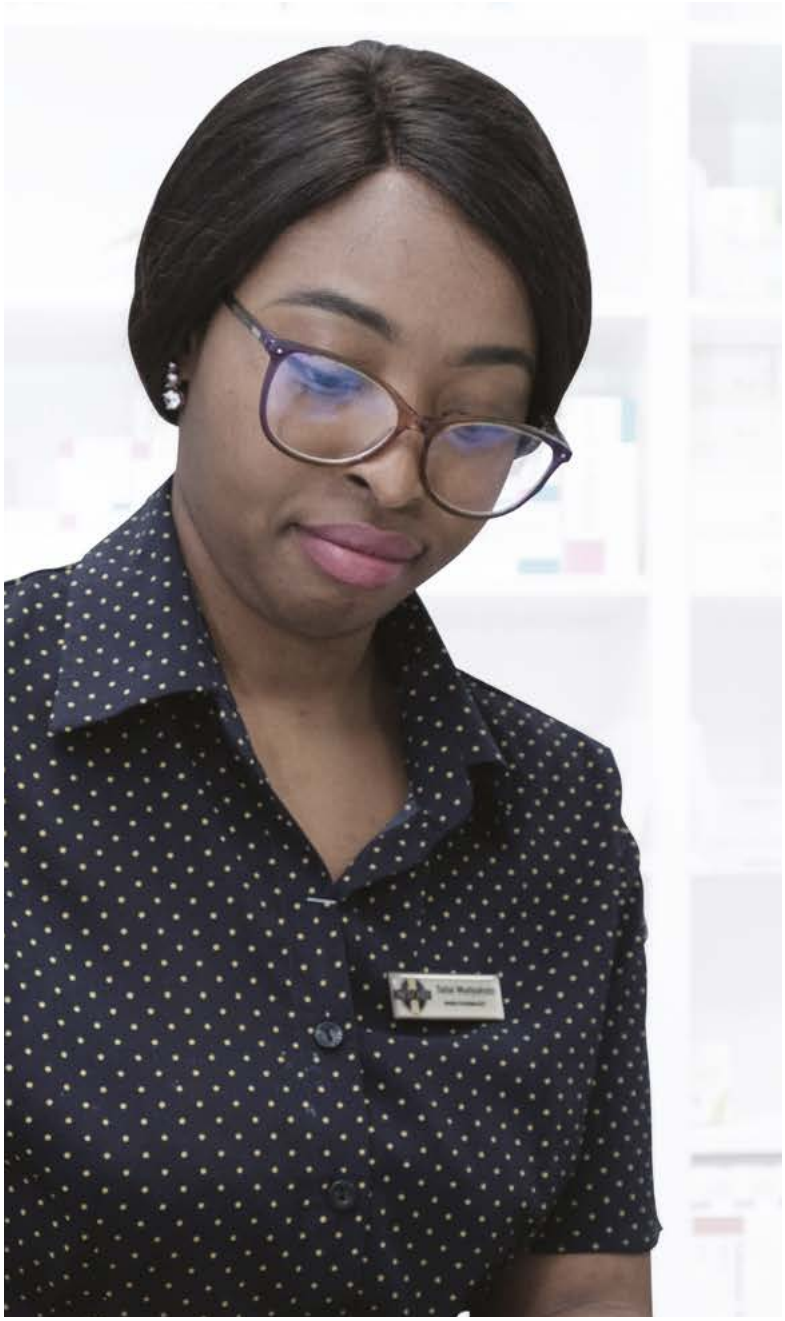
- Pre-authorisation
- Managed Care Protocols and Clinical Guidelines generally accepted in the industry as best practice principles
- Co-payments
- Sub-limits.

Expenses payable from your Member Savings Account (MSA)

The following day-to-day expenses are covered from your MSA:

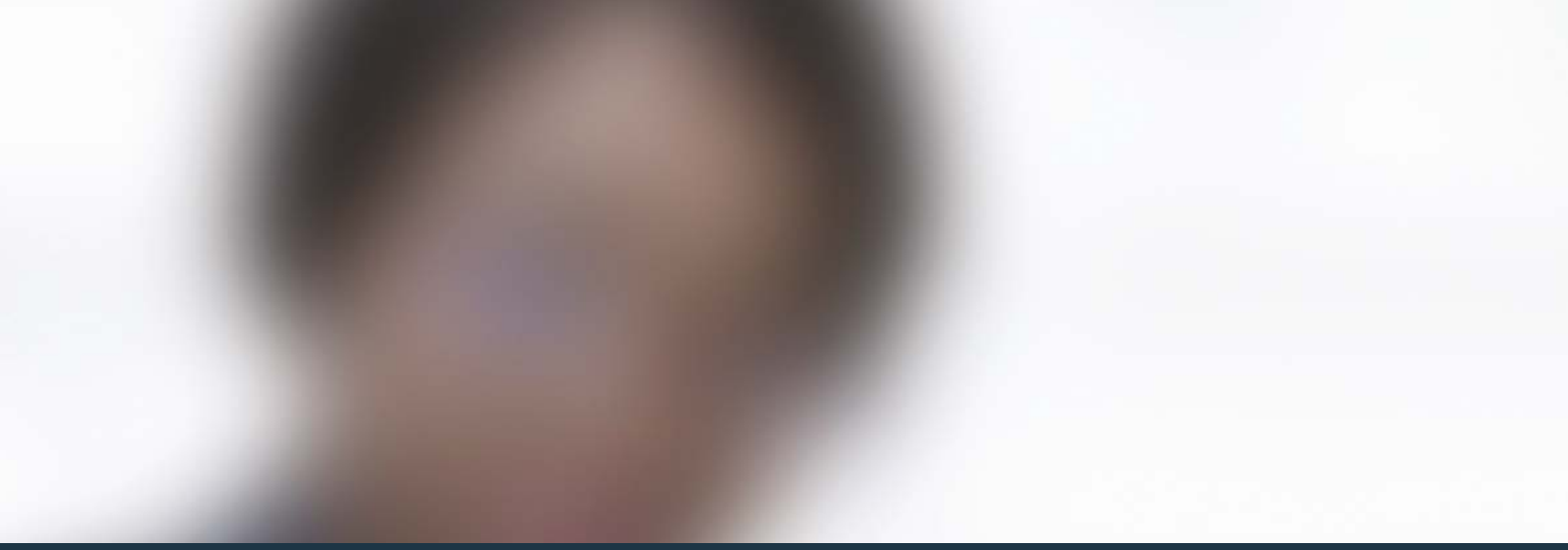
- General Practitioner services out-of-hospital
- Non-emergency consultations at any Netcare emergency department
- All optical services (note: one optometric consultation per beneficiary per annum is payable from the insured risk portion of your benefits and is deducted from your specialist consultation limit)
- Prescribed acute medication
- Self-medication or over-the-counter (OTC) medication
- Vitamins
- Homeopathic formulations
- Physiotherapy and bio-kinetics out-of-hospital
- Psychology and social services.

Treatment for the services above will be paid from your MSA only if there is an available balance.



The following are covered from the insured or risk portion of your benefits:

- Hospitalisation (including ward fees, theatre fees, ward medicine and treatment, surgery and anaesthesia etc.)
- A seven (7) day supply of medication on discharge from hospital (To-take-out (TTO))
- General Practitioners, specialist and technician consultations and treatment while in hospital
- Physiotherapy and occupational therapy while in hospital
- Organ transplants including donor costs, surgery and immuno-suppressant drugs
- Unlimited chemotherapy, radiation and dialysis treatment
- Injuries sustained in motor vehicle accidents subject to a legal undertaking in favour of the Scheme
- Routine diagnostic endoscopic procedures
- Outpatient or emergency department visits with a final diagnosis of a Prescribed Minimum Benefit (PMB) or Priority Emergency or leading to an immediate admission
- Specialist consultations out-of-hospital (full cover for Preferred Provider specialists)
- Pathology (using a Preferred Provider will ensure full cover)
- Prescribed Minimum Benefits in and out of hospital
- In-hospital dentistry – theatre and anesthetist accounts for children under the age of 8 years
- Unlimited specialised radiology such as CT, PET and MRI scans and radio isotope studies
- Basic radiology, subject to annual limits out-of-hospital
- Maternity benefits (including home births), subject to registration on the Maternity Care Programme
- PMB Chronic Disease List chronic medication, subject to registration on the Chronic Illness Benefit
- Prostheses
- Hearing aids (including repairs)
- Appliances i.e. nebulisers, glucometers and blood pressure monitors with motivation
- Ambulance and emergency services through Netcare 911
- Home-nursing, step-down facilities, physical rehabilitation and hospice services as an alternative to hospitalisation immediately following an event (excluding day-to-day care)
- HIV management
- Infertility interventions and investigations in line with PMBs
- Conservative and specialised dentistry including orthodontics. Subject to annual limits where applicable.
- Maxillo-facial and oral surgery
- Some preventative care benefits. Subject to annual limits where applicable.
- World Health Organisation recognised disease outbreaks, subject to Prescribed Minimum Benefit guidelines or as otherwise legislated.



Important things you should know before utilising your benefits

Network arrangements

The Scheme has Designated Service Provider (DSP) and Preferred Provider arrangements in place. You should make sure that you use these appointed DSPs and Preferred Providers in order to minimise your co-payments in- and out-of-hospital and/or to prevent claims from being rejected. Visit the Scheme's website at **www.netcaremedicalscheme.co.za** and log on to the MaPS tool through the 'Doctor visits' tab, for a complete list.

Scheme appointed DSPs

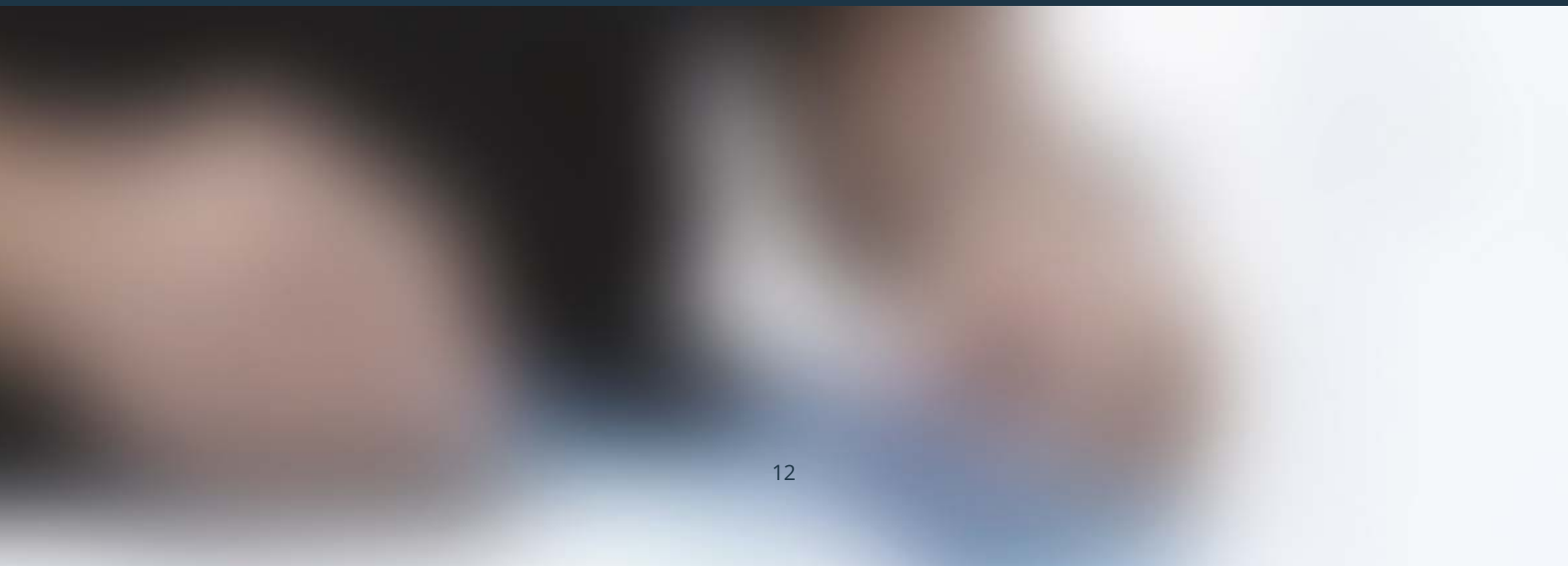
- For all Hospital admissions:
  - Any Netcare Hospital or Akeso Clinic
- Chronic medication – register first:
  - Any Netcare Retail Pharmacy or pharmacies located inside a Medicross facility
- For Ambulance services:
  - Netcare 911.

Note

- Exceptions are only allowed in an emergency as defined in the Medical Schemes Act, No. 131 of 1998.
- Voluntary use of a non-DSP hospital or failure to pre-authorise any hospital admission will result in a 25% co-payment (including PMBs), unless it is a defined emergency.

Preferred Provider arrangements

- Specialist Network
- Pathology laboratories: Ampath, Lancet and Pathcare
- Radiology Network
- National Renal Care facilities
- Netcare Oncology Units
- Medicross Dentists
- Medicross and Netcare Day Theatres
- Baby clinics located within Netcare Hospitals.



Pre-authorisation is required to access the following benefits

- Hospital admissions/home nursing/step down/sub-acute/rehabilitation and hospice
- Specialist visits (including follow up visits) out-of-hospital
- Some radiology scans: IVP tomography, contrast studies, bone densitometry, MRI, PET and CT scans and mammograms
- All appliances and prosthesis
- All chronic medication
- Outpatient procedures.

Please obtain pre-authorisation at least 72 hours prior to a planned event and within 72 hours after an emergency.

Some benefits have limits

ANNUAL LIMITS APPLICABLE PER BENEFICIARY	
Out-of-hospital pathology including consumables and materials	
Psychiatric hospitalisation	21 days per beneficiary
Specialist consultations	Nine (9) visits per beneficiary
Alcohol and drug rehabilitation	21 days per beneficiary
External and Internal prostheses Hearing aids and hearing aid repairs Other appliances	
ANNUAL FAMILY LIMITS	
Dentistry (overall limit applicable to basic and specialised, in-and out-of-hospital) Includes orthodontic (braces) treatment	
Basic Radiology (black and white x-rays and ultrasonography)	
MATERNITY LIMITS (SUBJECT TO REGISTRATION ON THE MATERNITY PROGRAMME)	
Ultrasound scans	Two (2) ultrasound scans per pregnancy
Antenatal consultations at a Gynaecologist, General Practitioner or Midwife units	13 consultations per pregnancy
Antenatal classes	R1 000 per pregnancy at baby clinics located within Netcare Hospitals

Benefits

The benefit table shows the expenses that are covered by the Scheme and limits, co-payments, authorisation requirements and DSP or Preferred Provider arrangements that may apply.

Hospital admission and treatment whilst in hospital

A copy of the authorisation, including possible exclusions, will be emailed to you (if we have your email address) your treating doctor and the hospital. Make sure to clarify any uncertainty you may have with your treating practitioner or the Scheme prior to your admission as some procedures, items and medication may not be covered. Should the treating practitioner disregard the terms and conditions of the authorisation you will remain responsible.

- Members are advised to, where possible, make use of specialists and other medical service providers on the Preferred Provider lists to optimise benefits and minimise co-payments for treatment while in hospital. Please visit the Scheme's website at **www.netcaremedicalscheme.co.za** for a list of DSPs and Preferred Providers of the Scheme.
- Accommodation in a private ward is subject to a motivation from the attending practitioner.
- CT, MRI and PET scans in-hospital require a separate authorisation but have no co-payment.

Authorisation – a clinical confirmation, not a guarantee of payment

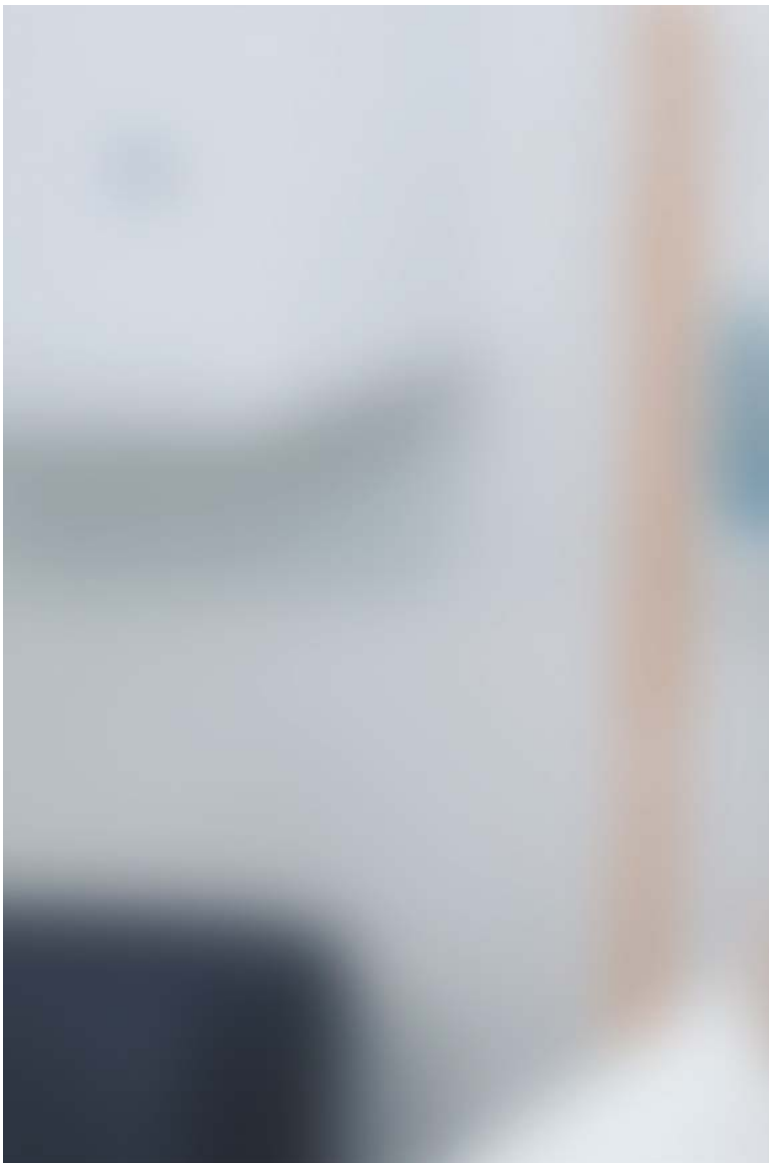
Pre-authorisation is provided based on a clinical decision and enables the Scheme to ensure that the treatment that is provided to you is clinically appropriate and cost-effective. It should be noted that pre-authorisation is not a guarantee of payment. Failing to obtain an authorisation may, in terms of the rules of the Scheme, lead to claims not being paid or substantial co-payments even if the medical condition is a PMB.

In-theatre dentistry

- It is important to note that dentist and dental surgeon accounts in-theatre are not paid from the unlimited hospital benefit but from the annual family dentistry limit. The theatre and anaesthetist accounts will be paid from the unlimited hospital benefit and a co-payment will apply. All in-hospital dentistry requires pre-authorisation.
- When a maxillo-facial surgeon performs a standard dental procedure in theatre, the event is still payable from your annual family dentistry limit. Only when a maxillo-facial surgeon performs surgery pertaining to the jaw and face that is specialised and pre-authorised, will services be paid from the unlimited risk portion of the Scheme's benefits.

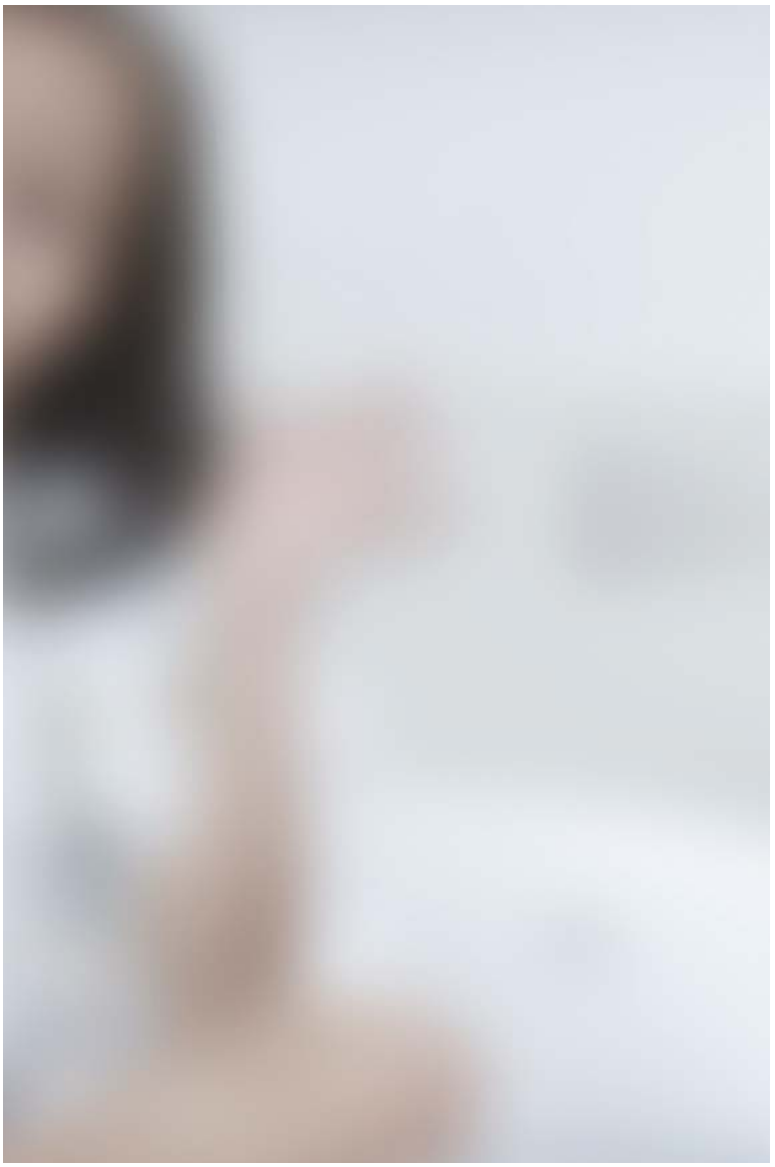
Dentistry

It is important to note that all dental work in- and out-of-hospital, as well as orthodontic work, forms part of the dental benefit and is covered by the annual family dentistry limit except for theatre and anaesthetist costs for children under the age of 8 years which will be paid from the unlimited hospital benefit.



Cover for chronic conditions

- The Scheme covers approved chronic medicine for the 26 Prescribed Minimum Benefit (PMB) Chronic Disease List (CDL) conditions.
- A medicine list (formulary) applies to the Chronic Disease List (CDL) conditions. Approved medicine on the medicine list for CDL conditions will be funded in full up to the Scheme rate. Approved medicine not on the medicine list will fund up to the Chronic Drug Amount (CDA). The CDA is a set monthly amount of money the Scheme will fund up to for each medicine category.
- You also have cover for two this is usually referred to as ADL (Additional Disease List) namely Depression and Attention Deficit Hyperactivity Disorder (ADHD).
- For Depression we pay approved medicine in full up to the Scheme Rate if it is on the Scheme's medicine list (formulary). If your approved medicine is not on the medicine list we will pay your medicine up to the monthly Chronic Drug Amount (CDA). For ADHD we pay approved medicine up to 80% of the Scheme rate.
- You must apply for cover by completing a Chronic Illness Benefit application form with your doctor and submitting it for review. For a condition to be covered from the Chronic Illness Benefit, there are certain benefit entry criteria that need to be met.
- There is a DSP arrangement with Netcare Retail pharmacies and pharmacies located in Medicross facilities.
- Use of a non-DSP pharmacy will require upfront payment from the member and the claim needs to be submitted to the Scheme in order for the member to be reimbursed. The Scheme will refund the member at the fee that would have been payable if the medication was obtained from a DSP. In other words, you may be liable for a co-payment if you do not use a DSP.
- If your Chronic Disease List (CDL) condition is approved, the Chronic Illness Benefit will cover certain procedures, tests and consultations for the diagnosis and ongoing management of the condition in line with Prescribed Minimum Benefits.



Out-of-pocket expenses can be avoided by using alternative products which have been shown to be clinically effective and cost less. Discuss your options with your treating provider or pharmacist.

PRESCRIBED MINIMUM BENEFIT (PMB) CHRONIC DISEASE LIST (CDL) CONDITIONS:	
Addison's disease	Epilepsy
Asthma	Glaucoma
Bipolar mood disorder	Haemophilia
Bronchiectasis	HIV/AIDS*
Cardiac failure	Hyperlipidaemia#
Cardiomyopathy	Hypertension#
Chronic obstructive pulmonary disease	Hypothyroidism
Chronic renal failure	Multiple sclerosis
Coronary artery disease#	Parkinson's disease
Crohn's disease	Rheumatoid arthritis
Diabetes insipidus#	Schizophrenia
Diabetes mellitus type 1#	Systemic lupus erythematosus
Diabetes mellitus type 2	Ulcerative colitis
Dysrhythmia	

NON-CHRONIC DISEASE LIST CONDITIONS	
Attention Deficit Hyperactivity Disorder (ADHD)	Depression

** Managed through the HIV Programme*

 # We cover condition-specific care programmes that help you to manage your diabetes or heart-related medical conditions. You have to be registered on these condition-specific care programmes to access additional benefits and services. You can read more about these programmes in the Care Programme section of this brochure.

01 Confirm that we have your latest email and cell phone details as authorisation confirmation will be sent to the contact details that we have on system in the event of a hospital admission.

02 Read the authorisation letter/SMS and familiarise yourself with the terms and conditions i.e. scheme exclusions and limits associated with the procedure. If you have any questions or are not sure about anything, please speak to your treating healthcare practitioner and/or one of our Case Managers before you are admitted to hospital.

03 Make use of a Netcare hospital. If you choose to use any other hospital in a non-emergency situation, it will result in a 25% co-payment on the Hospital account associated with the event.

04 Make use of a Preferred Provider (a contracted doctor) as the Scheme has negotiated fees with them and they are not allowed to charge more than has been agreed with them by the Scheme. If they do charge more than the agreed upon rate please **notify us without delay** so that we can assist you in resolving the matter.

05 Obtain a pre-authorisation for any specialist follow-up consultations that may be related to your hospital admission, as follow-up consultations do not form part of the hospital authorisation process.

06 Few anaesthetists charge scheme rates. It is therefore a good idea to ask your doctor which anaesthetist he/she makes use of and negotiate fees with them upfront.

Preventative healthcare

Preventative care is an important part of maintaining good health. We encourage our members to make use of this special benefit as it can assist you in ensuring that you maintain your good health. These benefits are paid from the insured risk portion subject to the terms and conditions of the rules of the Scheme.

The Scheme provides cover for the following:

Flu immunisations*

- Flu vaccination – one (1) per beneficiary per year.

Baby and child immunisations

- Standard immunisations for beneficiaries up to the age of twelve (12) years in accordance with the Department of Healthprotocols (excluding the HPV vaccine).
- MMR vaccine for measles, mumps, and rubella (also called German measles).

Health tests*

- Blood sugar test
- Cholesterol test
- HIV test
- Pap smear
- Prostate test

Scans*

- Bone densitometry scan (males and females 50 years and older)
- Mammogram

For the expecting mother

- Thirteen (13) antenatal consultations at a Gynaecologist or General Practitione
- Two (2) ultrasound scans per pregnancy

Netcare Medical Scheme Savings Option Benefit Summary

A list of the Designated Service Providers (DSPs) and Preferred Providers is available at **www.netcaremedicalscheme.co.za** or by calling the Client Contact Centre on **0861 638 633**

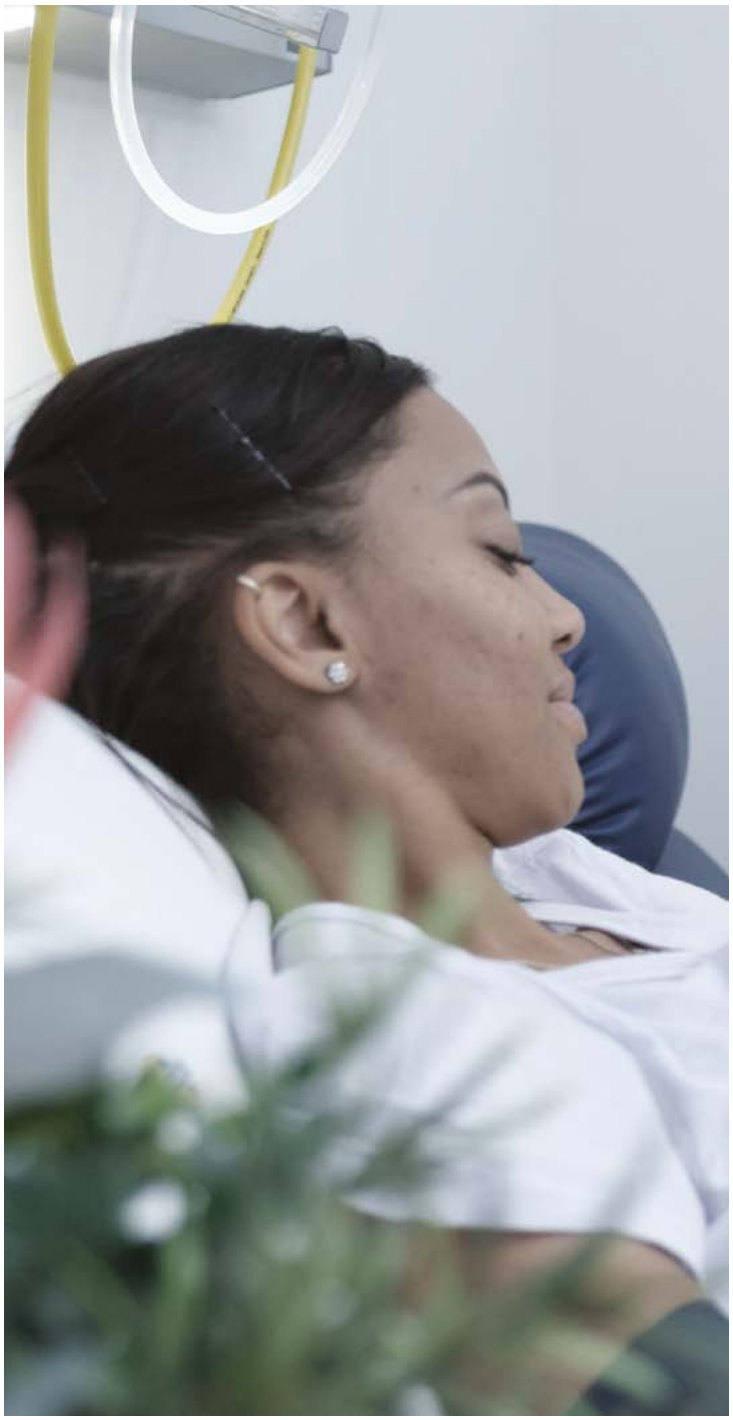
SERVICE	BENEFIT	LIMITS (SUBJECT TO MANAGED CARE RULES AND PROTOCOLS)	AUTHORISATION REQUIREMENTS	DESIGNATED SERVICE PROVIDER (DSP)/ PREFERRED PROVIDER
IN-HOSPITAL COVER				
Limits do not apply to Prescribed Minimum Benefits (PMBs). PMBs are paid in full when making use of a Designated Service Provider (DSP). Admission to Netcare hospital (DSP) – Failure to make use of a DSP or failure to pre-authorise any hospital admission will result in a 25% co-payment (including PMBs)				
Hospital stay	100% of NMS tariff	Unlimited cover	Yes, at least 72 hours prior to admission or within 72 hours of an emergency admission	At DSP
Psychiatric hospitalisation	100% of NMS tariff	21 days per beneficiary per annum or 15 outpatient psychotherapy sessions	Yes, at least 72 hours prior to admission or within 72 hours of an emergency admission	At DSP
Gender Affirming Surgery Clinical and benefit entry criteria and treatment guidelines apply	100% of NMS tariff	Up to R200,000	Yes, email clinicalhelp@netcaremedicalscheme.co.za	Preferred Provider
Day clinic or day theatre admission	100% of NMS tariff	Unlimited cover	Yes, at least 72 hours prior to admission or within 72 hours of an emergency admission	At DSP
To Take Out (TTO) drugs	100% of NMS tariff	Seven (7) day supply No levy applicable	Forms part of the related hospitalisation	At DSP
Treatment whilst in hospital				
Consultations, surgical procedures, physiotherapy, medication and blood transfusions	100% of NMS tariff	Unlimited cover	Forms part of the related hospitalisation	At DSP
Anaesthetics	100% of NMS tariff	Unlimited cover	Forms part of the related hospitalisation	At DSP
Pathology	100% of NMS tariff	Unlimited cover	Forms part of the related hospitalisation	At DSP
Organ transplants (including donor cost and immunosuppressant medication)	100% of NMS tariff	Unlimited cover	Yes, at least 72 hours prior to admission or within 72 hours of an emergency admission	At DSP
Peritoneal dialysis and haemodialysis (kidney dialysis) including renal unit and technicians	100% of NMS tariff	Unlimited cover	Yes, registration on the renal treatment plan required	At DSP
Dentistry hospitalisation for children under the age of 8 years	100% of NMS tariff	Unlimited cover for theatre and anaesthetist Combined in- and out-of-hospital dentistry limit applies for dentist/dental surgeon M - R5,690 M+1 - R8,865 M+2 - R11,395 M+3+ - R13,925	Yes, at least 72 hours prior to admission or within 72 hours of an emergency admission	Preferred Provider use recommended to minimize co-payments
Dentistry hospitalisation 8 years and older - hospitalisation and all related accounts for dental treatment including theatre and anaesthetics	100% of NMS tariff	Combined in- and out-of-hospital dentistry limit M - R5,690 M+1 - R8,865 M+2 - R11,395 M+3+ - R13,925	Yes, at least 72 hours prior to admission or within 72 hours of an emergency admission	Preferred Provider use recommended to minimize co-payments
Dentistry: maxillo-facial surgery	100% of NMS tariff	Related to certain treatment	Yes, at least 72 hours prior to admission or within 72 hours of an emergency admission	Preferred Provider use recommended to avoid co-payments
Admission to a NON-DSP hospital (a non-DSP hospital is defined as a provincial or private hospital other than a Netcare Hospital or an Akeso Clinic)				
Hospital (voluntary admission) stay and all related services including consultations, surgical procedures, treatment, medication, physiotherapy, anaesthetics, etc.	75% of NMS tariff	25% co-payment will apply on the entire admission	Yes, at least 72 hours prior to admission or within 72 hours of an emergency admission	–
Hospital (#emergency/involuntary non-DSP admission) will qualify for the same benefits as for a DSP hospital admission #emergency as defined in the Medical Schemes Act, No. 131 of 1998	100% of NMS tariff	Unlimited cover	Yes, at least 72 hours prior to admission or within 72 hours of an emergency admission	–
Motor vehicle accidents and third party claims				
Payment is subject to a legal undertaking and completion of an accident injury form and report by the member	100% of NMS tariff	Unlimited cover	Yes, at least 72 hours prior to admission or within 72 hours of an emergency admission	At DSP

SERVICE	BENEFIT	LIMITS (SUBJECT TO MANAGED CARE RULES AND PROTOCOLS)	AUTHORISATION REQUIREMENTS	DESIGNATED SERVICE PROVIDER (DSP)/ PREFERRED PROVIDER
World Health Organisations (WHO) Global Outbreak Benefit				
Benefits will be subject to PMBs. Includes a basket of care to manage the disease and provide supportive treatment of Global WHO recognized disease outbreaks				At DSP
OUT-OF-HOSPITAL COVER				
Chronic medication				
Chronic medication benefit is applicable to members and/or dependants registred on the Chronic Illness Benefit Medicine for the Chronic Disease List (CDL) conditions Medicine for additional chronic conditions listed by the Scheme (ADLs): Depression	100% of NMS tariff	Approved medicine on the medicine list (formulary) will be funded in full up to the Scheme Rate. Approved medicine not on the medicine list (formulary) will be funded up to the monthly Chronic Drug Amount (CDA).	Yes, once diagnosed	At DSP (failure to utilise the services of a DSP will require upfront payment by the member and the submission of a claim to the Scheme for reimbursement)
Attention Deficit Hyperactivity Disorder (ADHD)		20% co-payment will apply		
Outpatient procedures and emergency visits				
Gastroscopies and colonoscopies	100% of NMS tariff	Unlimited cover At DSP R500 co-payment at non-DSP	Yes, at least 72 hours prior to procedure	At DSP
Sigmoidoscopy, direct laryngoscopy, biopsy of breast lumps, excision of nail bed, surgical removal of plantar warts, non-cosmetic varicose vein injections or drainage and wound care	100% of NMS tariff	Unlimited cover	Yes, at least 72 hours prior to procedure	At DSP
Removal of wisdom or impacted teeth, removal of retained dental roots in lieu of hospitalisation	100% of NMS tariff	Combined in- and out-of-hospital dentistry limit M - R5,690 M+1 - R8,865 M+2 - R11,395 M+3+ - R13,925	Yes, at least 72 hours prior to procedure	At DSP
Outpatient or casualty procedure that results from a procedure previously requiring hospital admission (within 72 hours post-event)	100% of NMS tariff	Unlimited cover	Yes, at least 72 hours prior to procedure or within 72 hours of an emergency admission	At DSP
Outpatient or casualty consultations, procedures, medication and treatment defined as an emergency or a priority emergency	100% of NMS tariff	Unlimited cover	None	At DSP
Specialist consultations and treatment out-of-hospital – failure to pre-authorise will result in payment being made from savings for non-PMB conditions or a co-payment on PMB conditions				
Consultations, procedures in room, material and visits (including outpatient visits)	NMS negotiated tariff at contracted Preferred Provider	Nine (9) consultations per beneficiary per annum	Yes, at least 72 hours prior to consultation or procedure or within 72 hours of an emergency	Preferred Provider use recommended to avoid co-payments
	100% of NMS tariff at non-contracted provider			Use of a non-Preferred Provider may lead to co-payments
One specialist consultation per beneficiary per annum may be utilised for an optometric consultation			None	–
Oncology				
Any oncology treatment including chemotherapy and radiation in- and out-of-hospital	100% of NMS tariff At DSP	Unlimited cover	Yes, registration on oncology programme required and submission of a treatment plan	At DSP
Pathology				
Pathology including consumables and materials Point of care pathology testing is subject to meeting the Scheme's Treatment guidelines and Managed Health Care criteria	100% of NMS tariff	R3,990 per beneficiary per annum	None	Preferred Provider use recommended to avoid co-payments: Ampath, Lancet and Pathcare
Specialised radiology				
IVP tomography, contrast studies, MRI, bone densitometry for males and females younger than 50, CT scans, PET scans and related consumables	100% of NMS tariff	Unlimited cover R500 co-payment applicable to out- of-hospital non-PMB conditions and not applicable to PET scans	Yes, at least 72 hours prior to procedure	–

SERVICE	BENEFIT	LIMITS (SUBJECT TO MANAGED CARE RULES AND PROTOCOLS)	AUTHORISATION REQUIREMENTS	DESIGNATED SERVICE PROVIDER (DSP)/ PREFERRED PROVIDER
Bone densitometry for males and females older than 50	100% of NMS tariff	One per beneficiary per annum No co-payment for out- of-hospital non-PMB conditions	Yes, at least 72 hours prior to procedure	–
Mammogram	100% of NMS tariff	One per beneficiary per annum	Yes, at least 72 hours prior to procedure	–
Any other specialised radiology	100% of NMS tariff	Unlimited cover	None	–
Basic radiology				
Black and white X-rays and ultrasonography	100% of NMS tariff	Combined in- and out-of-hospital limit applies for basic radiology M - R3,600 M+1 - R5,390 M+2 - R6,290 M+3+ - R6,745	None (maternity ultrasounds require registration on the Maternity Care Programme)	–
Maternity benefit				
Hospital and home confinements	100% of NMS tariff	Unlimited cover	Yes, registration on Maternity Care Programme	At DSP
Ultrasound scans	100% of NMS tariff	Two (2) ultrasounds	Yes, registration on Maternity Care Programme	–
Antenatal consultations at a Gynaecologist or General Practitioner	100% of NMS tariff	13 consultations	Yes, registration on Maternity Care Programme	Preferred Provider use recommended to avoid co-payments
Antenatal classes	R1,000 per pregnancy at any baby clinic located within a Netare Hospital		Yes, registration on Maternity Care Programme	At baby clinic located within a Netcare Hospital
Immunisations – Failure to make use of a DSP will result in payment from MSA				
Baby and child immunisations (up to 12 years)	100% of NMS tariff	Unlimited cover. According to Department of Health protocol including MMR vaccine but excluding HPV vaccine	None	Vaccine – At DSP Pharmacy Administered at a baby clinic located within a Netcare Hospital
Dentistry				
Basic dentistry (fillings, extractions, X-rays and prophylaxis) and specialised dentistry (periodontics, bridgework, crowns, dentures and dental implants)	100% of NMS tariff	Combined in- and out-of-hospital dentistry limit, subject to Dental Managed Care Protocols. M - R5,690 M+1 - R8,865 M+2 - R11,395 M+3+ - R13,295	None	Preferred Provider use recommended to minimise co-payments
Orthodontics (under 21 years of age)	100% of NMS tariff		None	Preferred Provider use recommended to minimise co-payments
Maxillo-facial and oral surgeons performing specialised dental procedures	100% of NMS tariff	Subject to Managed Care Rules and Protocols	Yes	Preferred Provider use recommended to minimise co-payments
In-hospital dentistry and maxillo-facial surgery: refer to in-hospital cover above				
Prostheses				
External and internal prostheses	100% of approved benefit	R97,110 per beneficiary per annum, and the following sub-limits: Hip & knee replacements – R34,340 Shoulder replacements – R47,730 Prosthetic devices used in spinal surgery – R29,170 for the first level and R58,340 for two or more levels. Sub-limits will not apply if a preferred provider is used	Yes	Unlimited where preferred provider is used
Appliances				
Hearing aids and hearing aid repairs	100% of approved benefit	R21,350 per beneficiary per ear every two (2) years	Yes	–
Other appliances	100% of approved benefit	R4,720 per beneficiary per annum	Yes	–
Ambulance services				
Air and road emergency services	100% of cost At DSP	None	No authorisation required if DSP is utilised	Through DSP, Netcare 911
A 25% co-payment will apply for voluntary, non-emergency use of any other service provider.				
Home nursing, step down/sub-acute, rehabilitation				
Home nursing, step down, sub-acute (physical) rehabilitation	100% of NMS tariff	Subject to Managed Care Rules and Protocols	Yes	As authorised

SERVICE	BENEFIT	LIMITS (SUBJECT TO MANAGED CARE RULES AND PROTOCOLS)	AUTHORISATION REQUIREMENTS	DESIGNATED SERVICE PROVIDER (DSP)/ PREFERRED PROVIDER
Home-based acute Care - in lieu of hospitilisation - after early discharge, or - as a continuation of care after discharge from hospital, or - home-based readmission prevention	Unlimited cover 100% of NMS tariff at approved provider	Subject to clinical criteria and the Scheme's Basket of Care (BOC) Incudes devices for home-monitoring (based on clinical need) for qualifying members	Yes	As authorised
Home nursing, hospice, end of life care				
Advanced Illness Benefit for members with terminal illnesses	100% of NMS tariff at approved provider	Subject to Managed Care Rules and Protocols	Yes	As authorised
HIV management				
HIV Treatment - Prescribed antiretroviral medication for HIV/AIDS and medication to treat opportunistic infections such as tuberculosis and pneumonia	100% of NMS tariff	Approved medicine on the medicine list (formulary) will be funded in full up to the Scheme Rate. Approved medicine not on the medicine list (formulary) will be funded up to the monthly Chronic Drug Amount (CDA).	Yes	–
Post-exposure prophylaxis				
Post-exposure HIV prophylaxis following occupational exposure, traumatic exposure or sexual assault	100% of NMS tariff	1 claim within 182 days. Should additional medication be needed this is to be authorised	2nd or second request within 182 days	–
HIV prophylaxis to prevent mother-to-child transmission	100% of NMS tariff	Maximum of R315 per month and a maximum of R1,900 per 6 month subject to formulary. Maximum quantity of 1.8kg of infant formula per infant, per month for a maximum duration of 6 months is allowed. We approve the first month upfront however the infant needs to be registered on your health plan in order to qualify for the remaining five months.	Yes	–
MEMBER SAVINGS ACCOUNT (MSA)				
General practitioners				
Consultations and all visits and procedures performed out-of-hospital or in the emergency department	100% of NMS tariff	Subject to MSA balance	–	–
Prescribed acute medication				
Acute medicine prescribed and or dispensed by medical practitioners or specialists	100% of NMS tariff	Subject to MSA balance	–	–
Self-medication or over-the-counter (OTC) medication	100% of NMS tariff	Subject to MSA balance	–	–
Homeopathic medicines, multi-vitamins, calcium, magnesium, tonics, stimulant laxatives, contact lens preparations	100% of NMS tariff	Subject to MSA balance	–	–
Optical				
First optometric consultation will automatically be paid from specialist benefit	100% of NMS tariff	One consultation per beneficiary per annum	None	Preferred Provider use recommended to minimise co-payments
Subsequent optometric consultations	100% of NMS tariff	Subject to MSA balance	–	Preferred Provider use recommended to minimise co-payments
Spectacle lenses and frames, readers and contact lenses	100% of NMS tariff	Subject to MSA balance	–	Preferred Provider use recommended to minimise co-payments
Hospital out patient visits				
Out patient visits to the emergency department with non-PMB and non-priority emergency diagnoses	100% of NMS tariff	Subject to MSA balance	–	–
Auxiliary services				
Psychology and social services: consultations, therapy, treatment and social workers	100% of NMS tariff	Subject to MSA balance	–	–
Physiotherapy out-of-hospital and biokinetics	100% of NMS tariff	Subject to MSA balance	–	–
Homeopathy, naturopathy, chiropractic, speech therapy, audiology, occupational therapy, acupuncture, podiatry and dietetics (excluding X-rays and appliances)	100% of NMS tariff	Subject to MSA balance	–	–
Educational, remedial and marriage counselling	No benefit	No benefit	–	

Care Programmes



Advanced Illness Benefit (AIB)

Through the Advanced Illness Benefit (AIB), Netcare Medical Scheme provides comprehensive out-of-hospital palliative care for members who are terminally ill. This is a unique home-based service that offers you quality care in the comfort of your own home, with minimum disruption to your normal routine and family life. Supportive care is provided by nurses or care workers in partnership with the Hospice Palliative Care Association of South Africa. Registration is required to access this benefit.

Oncology management

If you are diagnosed with cancer and need treatment, it is important that you register your treatment plan with the Scheme. All oncology treatment is subject to case management review. Netcare Medical Scheme Oncology Programme follows the SAOC protocols and guidelines.

Please make sure your doctor advises you of any change to your treatment, as your authorisation will need to be evaluated and updated. If this is not done, claims could be rejected for payment or paid from the incorrect benefit.

Maternity Care benefit

The Maternity Care benefit has been specially designed to enhance the Scheme's maternity benefit for expectant mothers, helping to ensure a healthy, happy pregnancy. Expectant mothers are required to register on this programme from the 12th week of their pregnancy. At registration, we will provide you with a list of benefits available as well as any other information you may require.

Substance abuse focus

All Netcare Medical Scheme members have access to South African National Council on Alcoholism and Drug Dependence (SANCA) approved facilities as in-patients for drug and alcohol addiction. Please contact the Client Contact Centre for confidential support and a referral to an appropriate treatment facility should you be in need of assistance. Daily limits and annual limits apply and pre-authorisation is required.

HIV/AIDS programme

It has been demonstrated that by proactively managing HIV, those who have been diagnosed as HIV positive can live a healthy and fulfilling life. When you register for our HIVCare Programme you are covered for the care that you need. You can be assured of confidentiality at all times. Call us on **0861 638 633** or email **hiv@netcaremedicalscheme.co.za** to register.

Cover for HIV Prophylactics

If you, as a Netcare member, need HIV prophylactics to prevent HIV infection from mother-to-child transmission, occupational and traumatic exposure to HIV or sexual assault, please call Netcare Medical Scheme immediately on **0861 638 633** as treatment must start as soon as possible.

This treatment is paid for by the Netcare Medical Scheme at 100% NMS tariff.

Diabetes Care programme

The Diabetes Care programme, together with your Premier Plus GP, will help you, and your dependants, actively manage diabetes. A Premier Plus GP is a network GP who has contracted with us on a set of diabetes focused quality-based metrics.

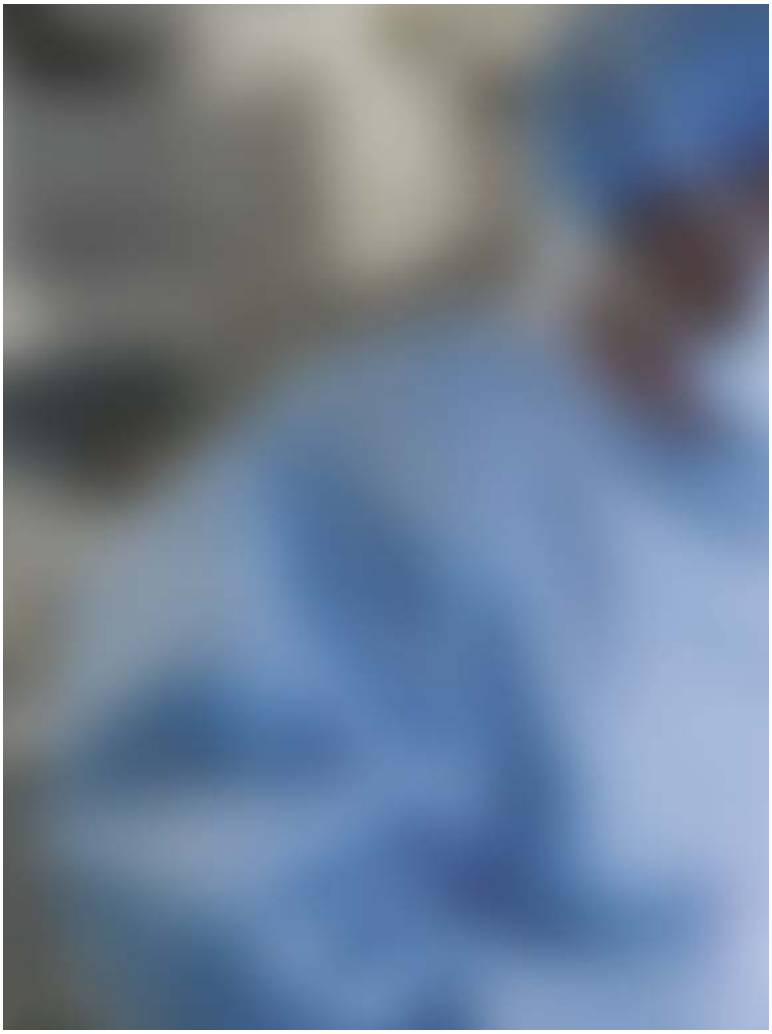
You and your GP can track progress on a personalised dashboard displaying your unique Diabetes Management Score.

This programme also unlocks cover for valuable healthcare services from healthcare providers like dietitians and biokineticists. Members with diabetes who have registered on the Chronic Illness Benefit (CIB) will be eligible to enrol on the Diabetes Care programme but you must make use of a Premier Plus GP so please check if your GP is listed.

Cardio Care programme

The Cardio Care Programme is designed to offer members with certain heart-related conditions who have registered on the Chronic Illnesss Benefit (CIB) optimal care from the best service providers in a coordinated network thereby ensuring the best outcomes and quality of life for our members.

To access the programme, you need to be 18 years or older and registered on the Chronic Illness Benefit (CIB) with hypertension, hyperlipidaemia and/or ischaemic heart disease. A GP in the Premier Plus GP network can enroll you onto the programme.



Health at Home Benefit

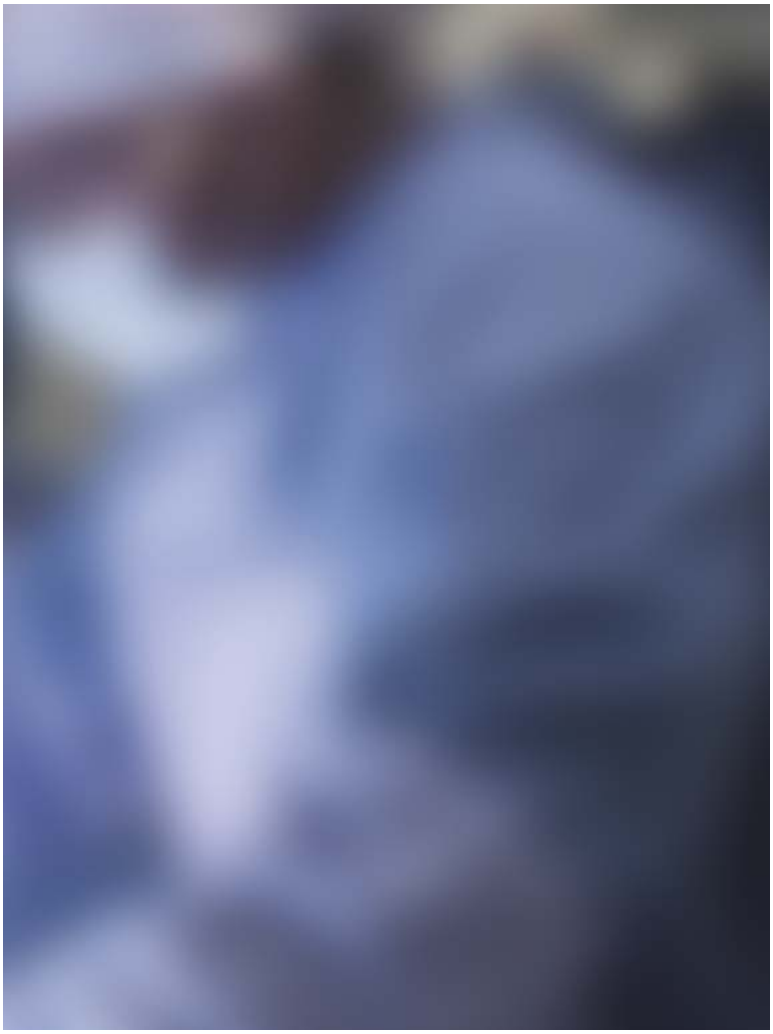
Health at Home comprise of several sub-programmes providing members access to a full spectrum of quality healthcare across all levels of acuity, from home. Health at Home brings together both new and existing benefits and service offerings thereby offering our members an end-to-end, integrated at-home care experience.

Hospital at Home

Hospital at Home provides qualifying members with the option to receive hospital level home-based care instead of being admitted to a traditional hospital or after an early discharge from hospital for continuation of care in the home. Scheme members admitted to Hospital at Home have access to enhanced benefits and services, delivered through their personalised care team. Together, these benefits and services ensure a seamless healthcare experience for patients, making them healthier, and enhancing and protecting their lives.

Members may qualify for Hospital at Home if their treating doctor deems home-based care appropriate for their medical condition. The medical conditions include but are not limited to, chronic obstructive pulmonary disease (COPD), congestive cardiac failure (CCF), community acquired pneumonia, complicated urinary tract infection (UTI), deep vein thrombosis (DVT), cellulitis, diabetesCOVID-19 pneumonia etc. Where approved, cover will be from your Hospital Benefit if you have a valid pre-authorisation for hospital level home-based care and will not affect your day-to-day benefits.

Care delivery within a home setting will be facilitated by a dedicated care team who will provide clinical support and monitoring of your condition using remote monitoring devices. While receiving care at home, members have 24/7 access to an in person and a virtual care team. This real-time connection ensures that patients can always reach a clinician if they have questions or concerns. Depending on a patient's specific needs, consultations with allied healthcare professionals may be incorporated into their personalised care plan.



Clinical oversight

While receiving care at home, you will have access to in-person and virtual care from a dedicated care team including doctors, nurses, and allied healthcare professionals. The care team will provide you with 24-hour clinical oversight and qualifying members will have access to additional Hospital at Home services to support a seamless home care delivery experience, such as

- Discharge planning and care coordination
  - A personalised plan which includes delivery of discharge medications, collection of oxygen concentrators, scheduling follow up diagnostic tests and doctor appointments, navigation of Scheme benefits, and enrolment on any relevant programmes.
- 24-hour carer*
  - If additional support is required, access to a full-time carer may be provided to assist with activities of daily living

*Individual member qualification criteria apply

Remote monitoring

Enabled by the Home Monitoring Device Benefit, you will get access to a remote monitoring device that will automatically transmit your physiological information to the hospital-based care team, 24 hours a day, 7 days a week. A member companion app will be available to you which will not only allow for the transferring of information from your remote monitoring device but also enable you to receive reminders of upcoming visits with the care team, conduct virtual consultations, and view your treatment plan. This companion device allows your care team to directly communicate with you throughout your admissions as well as send you prompts when it is time to take your medications or perform certain tasks that will contribute towards optimising your health and aid in faster recovery.

It is important that you have constant active connection to the Internet to enable the transmission of both your physiological parameters as well as check-up responses sent via your companion app. Medical providers will be able to continually assess your health status, monitor your medical stability and recommend interventions when necessary by accessing the provider dashboard. It is important that you are in your home until you are discharged.

Hospital care

An enhanced range of clinical diagnostic procedures and interventions will be available to manage your medical or postsurgical hospital-level care requirements in the home, supported by additional risk-funded benefits to enhance your experience while receiving care in the home.

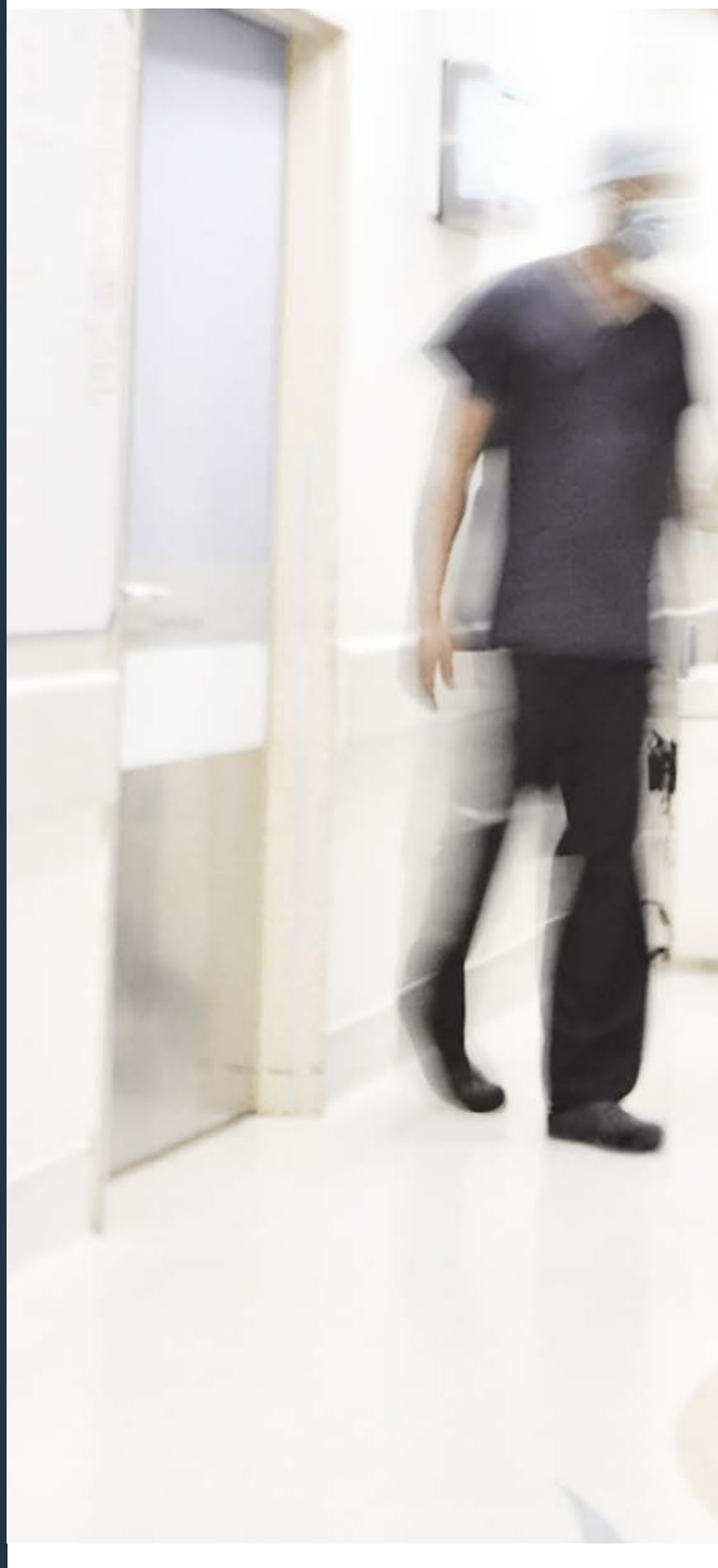
- **Interventions**
  - Medicine
  - Home oxygen
  - Phlebotomy
  - Emergency services
  - Intravenous therapy
  - Wound care
  - Suture and staple removals post-surgery
  - Stoma care
  - Urinary catheter care
  - Tracheostomy care
  - Total Parenteral Nutrition (TPN)
- **Diagnostics**
  - ECG in the home
  - Ultrasound in the home
- **Value-added benefits and services**
  - Vaccinations
  - Spirometry
  - Urinalysis POC
  - Urine culture sample
  - COVID-19 testing
  - Pap smear
  - Clinically appropriate screening service

How you are covered

You can receive home-based care when recommended by your treating doctor. The programme is available on all plans, with a defined basket of care for clinically appropriate conditions that require treatment.

Where approved by the Scheme, cover includes:

- **Assessment**
  - Initial assessment by your treating doctor to determine eligibility for treatment at home
- **Supportive care at home**
  - physical nurse visits for the duration of treatment
  - online virtual consultations with your treating doctor
  - 24-hour virtual monitoring and oversight from a network of experienced healthcare providers
  - 24-hour caregiver (for qualifying members)



- **Devices**
  - Access to condition-specific remote-monitoring biosensor devices to measure key physiological parameters
- **Pathology services**, if required
- **Three meals a day** (for qualifying members)
- **In-person visits by allied healthcare professionals**
- **Discharge planning and care coordination**
- **Access to any other clinically appropriate at-home treatment required**, as prescribed by your treating doctor

Continuation of care after discharge (Readmission prevention)

Hospital readmissions are increasing worldwide and equally noticeable within our Scheme. Internationally up to 20% of patients admitted have a readmission within 30 days and mainly occurs within the 1st week of being discharged.

Whilst efforts have been concentrated on preparing patients for good discharge during their admission, there is still gains to be made from focusing on managing patients considered high risk for a readmission within the immediate acute stages following a discharge. This benefit is aimed to achieve improvements in readmission rates based on international literature showing that a 27% reduction in readmissions can occur with a home health initiative. When integrated into the continuum of care, home health ensures that patients discharged from acute care, do not suffer a relapse or deterioration that may require readmission to hospital.

This benefit has 3 components:

- Homecare (1 physical visit, 3 virtual consults, and a care coordination aspect)
- A doctor follow-up consultation
- A medicine reconciliation done at the point of discharge by the treating doctor

These components will occur intensely within the first 10-14 days of the patient leaving the hospital.

The benefit is targeted at only those considered high risk for a readmission, as such a predictive model, built for this purpose, will identify those considered highest risks for a readmission for benefit eligibility.

Special Features

Emergency medical evacuations

If you ever find yourself in a situation where you require emergency transport for medical reasons, you are in safe hands. The Netcare Medical Scheme ambulance benefits, which are covered under insured benefits, include medically appropriate air and road response services provided by Netcare 911. This benefit is available by contacting **082 911**.

International travel cover

Only minor incidentals will be covered by the Scheme and we recommend that members purchase international travel insurance with a reputable insurer in order to ensure comprehensive medical cover when travelling to another country.

The Scheme will however reimburse members for treatment based on the equivalent Netcare Medical Scheme tariff (in South African Rands) for a medical service rendered as if the service had been rendered within the Republic of South Africa. There may be a substantial difference between South African and international tariffs which may result in the member being responsible for a significant shortfall.

Members are required to settle all healthcare accounts in the country of travel and to submit such claims to the Scheme upon return. It is important to understand that the Netcare Medical Scheme membership card is not recognised by healthcare providers outside of the borders of the Republic of South Africa and it will not be accepted by international agents and service providers.

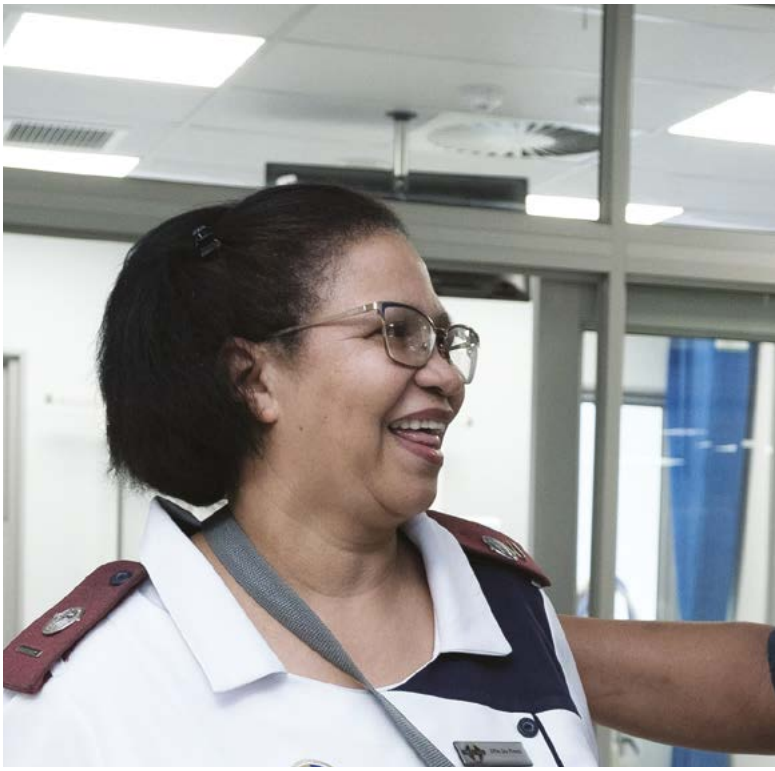
The Scheme will permit members and beneficiaries on chronic medication to have an extra month's supply of chronic medication dispensed to them prior to departure, in cases where the journey is for a prolonged period. However, this must be arranged with the Scheme by contacting the Client Contact Centre before the medication can be dispensed.

International travel cover **does not** include any form of repatriation that may be required.

Self service facilities

The Netcare Medical Scheme website has been specifically developed for the benefit of members, and by registering on the site, you are able to review your monthly statements, claims and personal information on-line.

To register, simply visit **www.netcaremedicalscheme.co.za** and register by entering your membership number and identification or passport number.



Administrative Requirements

Claims administration

In order to qualify for benefits a claim must be submitted to the Scheme not later than the last day of the fourth month following the month in which the service was rendered. If you believe a claim has been rejected in error, you have 60 days to report the error and resubmit the claim failing which the claim will be classified as stale.

As the member of the Scheme you are responsible for monitoring and reviewing your monthly statement and for acting promptly where a claim is not reflecting, or has not been paid. This will ensure that such claims do not become stale. Claims submitted after they have become stale will not be paid by the Scheme (in line with Regulation 6 of the Medical Schemes Act No. 131 of 1998).

Members who pay cash for any services received should remember to submit the claim with the receipt as proof of payment using the appropriate contact details of the Scheme as provided in this Membership Brochure or communicated by the Scheme from time-to-time.

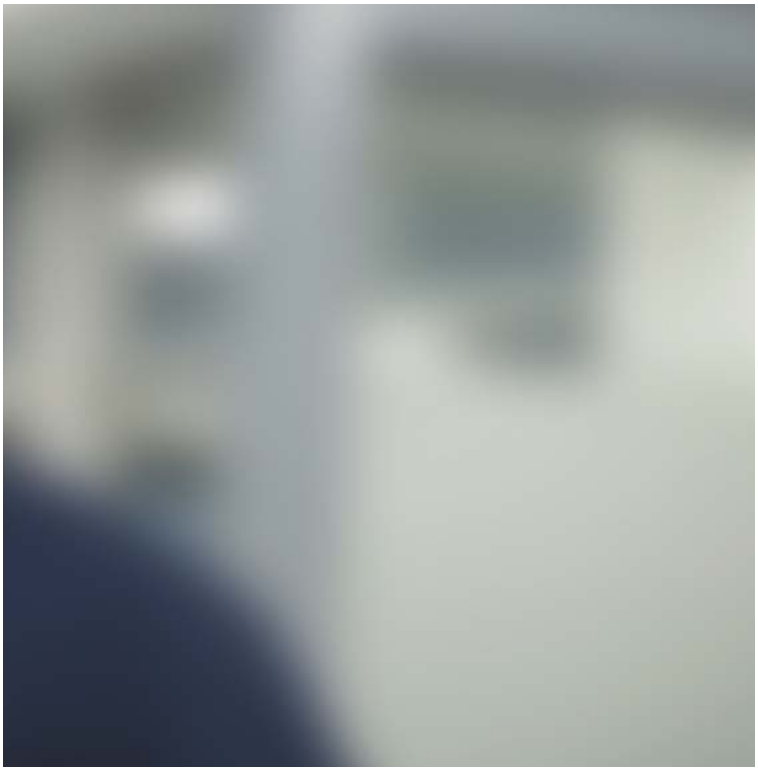
Members will be reimbursed at the relevant Scheme Rate and you may request the Scheme in writing for differences between claimed amounts and benefit amounts to be settled from your Member Savings Account (MSA).

This can only be done if your MSA reflects a positive balance.

Members are responsible for ensuring that the Scheme is informed of any changes to their banking details. Please note that changing your banking details with your Human Resources (HR) Department does not update your banking details with the Scheme.

Payment of claims is always subject to Scheme rules, tariffs, limits and Managed Care Protocols and Guidelines may apply.

Remember to obtain pre-authorisation at least 72 hours prior to a planned event or within 72 hours following an emergency.



Membership statements

Claims notification will be sent electronically where email details are available. Member statements will also be available on the Scheme's website **www.netcaremedicalscheme.co.za**.

Member Savings Account (MSA)

- All members contribute 15% of their total monthly contribution into their Member Savings Account. For example, if your total Scheme contribution is R1,000, an amount of R150 (15% of R1,000) will be allocated to your savings and R850 towards the risk pool.
- If you have a positive savings balance in your MSA at month-end you will receive interest on that amount.
- If you resign from the Scheme your savings balance will be kept for a four (4) month period in order to settle any claims that were incurred before resignation. After the four (4) months, in compliance with the Medical Schemes Act 131 of 1998, the balance will be paid out to you or transferred to your new medical scheme. If this pay-out occurs before month-end, you will not receive interest on the part-month.
- On termination of membership, the Scheme may use your savings to offset any debt owed by the member which may include outstanding contributions.
- The Scheme advances six (6) months of savings to members effective 1 January and 1 July of each year. Overdrawn savings (i.e. if you have used an amount from your advanced savings that exceeds the amount you have contributed at the time of your resignation) will have to be repaid if you resign from the Scheme.
- Payments from your MSA will be done at 100% of the NMS rate subject to funds being available at the date on which a claim is processed.
- You may give written instruction to the Scheme to fund any co-payments or shortfalls you may be responsible for from your MSA.
- If you have savings available at the end of the financial year (31 December) your savings will be carried over to the next year.
- In the unfortunate event of your death, the savings balance due to you will be transferred to your dependants in the event that they decide to continue membership of the Scheme or, in the absence of such dependants, paid into your estate.

Exclusions

Unless prescribed as a minimum benefit or otherwise provided for or decided by the Netcare Medical Scheme Board of Trustees, expenses incurred in connection with any of the following will not be paid by the Scheme:

- Wilful self-inflicted injury except for PMBs.
- Holidays for recuperative purposes.
- Accommodation and services provided in a geriatric hospital, old age home, frail care facility, or the like.
- 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.
- Treatment consequential to medical procedures for which the Scheme does not pay.
- Expenses relating to, or incurred in a research environment.
- Medical examinations and tests for insurance or fitness purposes and overseas visits.
- Treatment of injuries arising from members and beneficiaries professionally participating in any sport or speed contests.
- Treatment required as a result of members' or dependants' use of any dependence-producing drugs or intoxicating liquor or the member being under the influence of any dependence-producing drugs except for PMBs.
- Treatment of obesity and slimming preparations.
- The treatment of infertility and artificial insemination, including all costs relating to sperm count tests, in-vitro fertilisation, gamete intrafallopian transfer, GIFT procedures, zygote intrafallopian transfer (ZIFT) procedures, embryo transport, surrogate parenting, donor semen (and related costs including collection and preparation), and non-medically necessary amniocentesis other than PMBs stipulated in the Regulations to the Medical Schemes Act, No. 131 of 1998.
- Interest and/or legal fees relating to overdue medical accounts.
- Domestic and biochemical remedies.
- Exceeded annual or pro-rated limits.
- Patent foods or baby food, bandages, cotton wool or similar aids, sunscreen, shampoos and skin-cleansing remedies.
- Sterility and impotence examinations.
- Cosmetic procedures including but not limited to gastroplasty, bat ears, blepharoplasty, dermabrasion, lipectomy, breast augmentation and reduction, liposuction, nasal reconstruction, revision of scars and face lifts.
- Vitamins, tonics and mineral supplements not prescribed in conjunction with an antibiotic or forming part of the maternity and HIV programmes. Some vitamins that have a NAPPI code may be procured from positive savings at a member's discretion.
- Illness, injury or disease arising from war, unrest or riots except for PMBs.
- Appointments not kept.
- Injury or sickness caused by/or treatment of alcohol or drug abuse, unless registered with a SANCA approved programme or a PMB.
- Antenatal and post-natal classes or post natal care at home unless registered on the maternity programme.
- Sunglasses and tinted lenses, unless the member requests this to be paid from positive savings account balances.
- Charges for services relating to preventative healthcare not explicitly listed under the Preventative Care benefit.
- Boarders in respect of patient's stay in hospital.
- Fees charged by persons not legally registered with the relevant authority.
- Any sexually transmitted diseases except for PMBs.
- Travel expenses (other than ambulance costs, where the use of an ambulance is certified as necessary by a medical practitioner and transport is provided by Netcare 911).
- Accommodation in retirement villages.
- Treatment not set out in the benefit structures and rules except for PMBs.
- Treatment relating to pre-existing sickness conditions subject to waiting periods when the member joined the Scheme.
- Limitation of Benefits
  - The maximum benefits to which a member and his dependants are entitled in any financial year are limited as set out in Annexure B of the official Scheme rules.
  - Members admitted during the course of a financial year are entitled to the benefits set out in Annexure B of the official Scheme rules, with the maximum benefits being adjusted in proportion to the period of membership calculated from the date of admission to the end of the particular financial year.
- Unless otherwise decided by the Board, benefits in respect of medicines obtained on a prescription are limited to one (1)month's supply for each such prescription or repeat thereof.
- Laparoscopic approach procedures except if specifically authorised.
- Any services which are not mentioned in the rules that are not rendered in terms of accepted protocols or that are not aimed at the treatment of an actual or supposed condition or deficiency, disadvantaging or endangering essential bodily functions.

Important Terminology

Co-payment

A co-payment is a fee that members are required to pay directly to the service provider if there is a difference between the cover provided by the Scheme and the cost charged by the service provider. Co-payments will also apply if you do not make use of appointed DSPs.

Emergency medical condition

An emergency medical condition means any sudden and unexpected onset of a health condition that requires immediate medical or surgical treatment, where failure to provide such 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.

Chronic Drug Amount (CDA)

If you are registered for a chronic condition NMS will fund your chronic medicine on the Scheme's medicine list (formulary) in full. If your approved medication is not on the Scheme's medicine list, your chronic medicine will be funded up to a set monthly amount (Chronic Drug Amount).

Netcare Medical Scheme Tariff (NMS Tariff)

The NMS Tariff is the tariff for medical services as approved by the Board of Trustees on an annual basis.

Priority emergencies

There are instances where treatment at a DSP out-patient or emergency department is classified as an emergency although it may not be a PMB. The Scheme will pay for such emergencies from the insured (risk) benefit and not from your MSA.

Preferred Provider

Preferred Providers are those healthcare providers with whom the Scheme has made special arrangements to provide members with effective and cost-efficient services. These providers will not request upfront payment from members. Unlike in the case of DSP arrangements, the Scheme does not restrict members to utilise the services of Preferred Providers.

Rather, we recommend their use where they are available in order to optimise benefits and minimise co-payments.

Prescribed Minimum Benefits (PMBs)

Prescribed Minimum Benefits are defined in the regulations of the Medical Schemes Act, No. 131 of 1998, as being the minimum level of benefits that are available to all medical scheme members and their dependants. The diagnosis, medical management and treatment for these benefits are not limited and are paid according to specific treatment plans and conditions. Members are required to utilise Designated Service Providers for PMBs. A total of 271 diagnoses and 26 chronic conditions are listed as PMBs.

Ex-gratia Policy

Ex-gratia is defined by the Council for Medical Schemes (CMS) as 'a discretionary benefit which a medical scheme may consider to fund in addition to the benefits as per the registered Rules of a medical scheme. Schemes are not obliged to make provision there for in the rules and members have no statutory rights thereto'.

The Board of Trustees may, in its absolute discretion, increase the amount payable in terms of the Rules of the Scheme as an ex-gratia award. As ex-gratia awards are not registered benefits, but are awarded at the discretion of the Board of Trustees. The Board has appointed an ex-gratia committee who review the applications received and this committee is mandated to act on behalf of the Board in making decisions on behalf of the Trustees and the Scheme in this regard. Ex-gratia requests are considered on an individual basis and any decision made will in no way set a precedent or determine future policy. Decisions taken by this committee are final and are not subject to appeal or dispute and do not set a preceded.

Complaints and Appeals Process

If you are not satisfied with the manner in which your claims were processed or wish to lodge a complaint, the process you need to follow is:

1. Contact the Scheme's call centre during office hours and try to resolve your query with the call centre.
2. If the result is not considered to be satisfactory by you, you can contact the Principal Officer, the contact details are available in the Contact Detail section of this brochure.
3. Lodge your complaint in writing, for the attention of the Disputes Committee, c/o The Principal Officer, (the details are available on the website). The Disputes Committee will meet to decide on your complaint or dispute, and determine the procedure to be followed. You have the right to be heard at these proceedings, either in person or through a representative.
4. If you are still dissatisfied after the decision made by the Disputes Committee, you may take your appeal further by approaching the Council for Medical Schemes (CMS) for resolution:

   Council for Medical Schemes
   Block A Eco Glades 2 Office Park
   420 Witch-Hazel Street
   Ecopark, Centurion, 0157

   Telephone: **012 431 0500**

   Fax: **012 431 7544**

   Customer care call number: **0861 123 267**

   E-mail address: **complaints@medicalschemes.co.za**

Contact Details

Client contact centre

For all your general enquiries
(claims, membership, information, etc.)

Phone: **0861 638 633**

member@netcaremedicalscheme.co.za

Ambulance and emergency services

Phone: **082 911**

Member claim submission

Postal address:

Claims Department
PO Box 652509
Benmore 2010

claims@netcaremedicalscheme.co.za

Fax: **0860 329 252**

Maternity registration

maternity@netcaremedicalscheme.co.za

Appliance and prostheses authorisations

preauthorisations@netcaremedicalscheme.co.za

Oncology registrations and authorisation

oncology@netcaremedicalscheme.co.za

Chronic medication queries and renal dialysis registrations and queries

chronics@netcaremedicalscheme.co.za

Chronic Illness Benefit applications

chronicapplications@netcaremedicalscheme.co.za

Specialist authorisation

member@netcaremedicalscheme.co.za

HIV registration and authorisation

hiv@netcaremedicalscheme.co.za

Hospital authorisation

preauthorisations@netcaremedicalscheme.co.za

Escalated complaints

complaints@netcaremedicalscheme.co.za

Principal Officer

Craig Taylor
craig.taylor@netcare.co.za

Reporting fraud

Report irregular or fraudulent claims.

Email: **forensics@discovery.co.za**

To stay anonymous, call our Fraud Hotline on **0800 004 500** or email: **discovery@tip-offs.com**

When sending through a report, please include your membership number and the details of the claim you are querying. If you have any general inquiries on your claims or policy, kindly mail **member@netcaremedicalscheme.co.za.**

*This Member Brochure is intended to summarise the Rules of Netcare Medical Scheme applicable to the principal member and his or her dependants registered with the Scheme. A copy of the full set of Rules can be obtained from the Scheme's website at **www.netcaremedicalscheme.co.za**. Should a discrepancy arise between this Member Brochure and the rules of the Scheme, the rules of the Scheme will take precedence.*

Annexure A

Contribution Table

The contribution table below applies from 1 April 2023.

	SALARY BANDS		TOTAL PREMIUM		
	FROM	TO	PRINCIPAL	ADULT	CHILD
A	-	2,582	2,843	1,286	553
B	2,583	3,444	2,916	1,325	560
C	3,445	4,302	2,993	1,367	585
D	4,303	6,228	3,120	1,463	621
E	6,229	6,886	3,328	1,568	670
F	6,887	8,610	3,623	1,791	738
G	8,611	10,329	3,863	2,043	848
H	10,330	12,049	3,983	2,230	922
I	12,050	13,771	4,070	2,321	977
J	13,772	15,493	4,182	2,501	1,010
K	15,494	17,215	4,273	2,657	1,102
L	17,216	18,936	4,305	2,684	1,109
M	18,937	20,660	4,327	2,702	1,119
N	20,661	22,380	4,366	2,758	1,133
O	22,381	24,101	4,415	2,853	1,148
P	24,102	25,823	4,537	2,929	1,173
Q	25,824	27,544	4,572	2,955	1,187
R	27,545	29,265	4,609	2,993	1,198
S	29,266	30,986	4,711	3,048	1,226
T	30,987	32,709	4,805	3,108	1,245
U	32,710	34,431	4,805	3,108	1,245
V	34,432	43,037	4,910	3,180	1,271
W	43,038	51,645	5,014	3,252	1,301
X	51,646	99,999	5,124	3,321	1,324

Notes

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