NEDGROUP
MEDICAL AID
SCHEME

For additional valuable information, visit
our website at nmas.medscheme.com

2020
MEMBER GUIDE

CONTENTS

1 GET IN TOUCH

If you prefer the 24-hour SELF-HELP facility

1. Call 0860 100 080
2. When the following menu is read out, choose option 2, "If you are an existing member please press 2".
3. You will then be prompted to enter your membership number, "Please enter your membership number followed by the # key".
4. The system will recognise your medical scheme membership number and offer you the appropriate menus.

For enquiries about the BENEFITS available to you, MEMBERSHIP, or other GENERAL QUESTIONS and issues

- Use NedChat
- Email nedgroup.enquiries@medscheme.co.za (benefit and general enquiries) or nedgroupregistry@medscheme.co.za (enquiries about membership only)
- Call 0860 100 080 (or 011 671 6833)
- Fax 0860 111 784/011 758 7041

To submit a CLAIM or follow up on the payment of claims

For new claims:

- Scan your account(s) and send via NedChat, or email to nedgroup.newclaims@medscheme.co.za, or
- Fax your accounts to 0860 111 784

To follow up on claims:

- View your claims online on the logged-in Member Zone
- Call 0860 100 080
- Email nedgroup.enquiries@medscheme.co.za

To get AUTHORISATION for a hospital admission

- Email nedgroup.authorisations@medscheme.co.za
- Call 0860 100 080
- Fax 0860 21 22 23 or 021 466 1913

To check whether your provider is on the GP or Specialist NETWORK, or to find one who is

- Email nedgroup.enquiries@medscheme.co.za
- Call 0860 100 080
- Login to the Member Zone to access the provider look-up tool

HOSPITAL NETWORK PLAN

To check where your closest NETWORK HOSPITAL is (only for members on Hospital Network Plan):

- Email nedgroup.enquiries@medscheme.co.za
- Call 0860 100 080
- Refer to the Network Hospital list on the website: nmas.medscheme.com

In an EMERGENCY, or for the 'Ask a Nurse' HELPLINE: **Call 084 124**

To find out where your nearest Network Pharmacy is for preventative SCREENING TESTS AND VACCINES

- Call 0860 100 080
- Email nedgroup.enquiries@medscheme.co.za

To register for the CHRONIC MEDICINE Benefit, update your chronic medication or resolve any queries related to medicines for the chronic conditions covered by the Scheme, contact ScriptPharm Risk Management

- Call 011 100 7557
- Fax 086 679 1579
- Email nedgroup@scriptpharm.co.za
- Visit www.scriptpharm.co.za

To obtain a copy of your TREATMENT PLAN, or have it updated

- Call 0860 100 080
- Email nedgroupapmb@medscheme.co.za

To confirm whether you qualify for the BACK AND NECK REHABILITATION Programme and to find your closest DBC Centre

- Call 0860 100 080
- Email nedgroup.enquiries@medscheme.co.za
- Visit www.dbcsa.co.za

To contact the ONCOLOGY Management Programme (for CANCER patients)

- Call 0860 100 572
- Fax 021 466 2303
- Email cancerinfo@medscheme.co.za

For the HIV and AIDS Management Programme, contact Aid for AIDS

- Call 0860 100 646 / 021 466 1700
- Fax 0800 600 773
- Email afa@afadm.co.za
- Visit www.aidforaids.co.za (or www.aidforaids.mobi on a smartphone)
- SMS (call me) 083 410 9078

To report suspected FRAUD

- Call 0800 112 811
- Email fraud@medscheme.co.za

To claim for medical services you received OUTSIDE SOUTH AFRICA

Email foreign.hos@medscheme.co.za

If you do not have access to email or a fax machine, you can reach us by post:

Nedgroup Medical Aid Scheme, PO Box 174, Vereeniging, 1930

WALK-IN CENTRES

You are welcome to visit the following walk-in centres of the Scheme's administrator, Medscheme.

Bloemfontein	1st Floor, Medical Suites 4 & 5, Middestad Centre, Cnr Charles & West Burger Street
Cape Town	Ground Floor, Icon Building, Cnr Lower Long Street and Hans Strijdom Avenue
Durban	102 Stephen Dlamini Road, Musgrave
Kathu	6 Rietbok Street
Kimberley	Shop 17, Southey Street
Klerksdorp	Shop 11, Medicover Building, 22 Knowles Street, Witkoppies
Lephalale (Ellisras)	Bosveld Boulevard Park, Shop 6, Cnr Chris Hani and Joe Slovo Street, Onverwacht
Mafikeng	1st Floor, East Gallery, Office 101A, Mega City
Nelspruit	Union Square Unit G2, 44 Mostert Street
Polokwane	Shop 2, Ground Floor, Shoprite Checkers Centre, Cnr Hans van Rensburg & Grobler treets
Port Elizabeth	Block 6, Greenacres Office Park, 2nd Avenue, Newton Park
Pretoria	Nedbank Plaza, Shop 17, Ground Floor, 361 Steve Biko Street, Arcadia
Roodepoort	Flora Centre, Entrance 2, Shop 21 & 22, Cnr Ontdekkers and Conrad Road, Florida North
Secunda	Grand Palace, Unit A2, 2302 Heunis Street
Vereeniging	Ground Floor, 36 Merriman Avenue

ESCALATION PROCESS

We understand that members expect reliable and efficient service from the Scheme at all times. To help you resolve medical scheme issues you may have, or have a complaint about service you received, please contact the Medscheme Call Centre on 0860 100 080 or via e-mail on nedgroup.enquiries@medscheme.co.za and provide the details of your complaint. The advantage of going through the Call Centre is that calls are recorded and trends can be picked up, allowing the Scheme to identify specific communication needs.

If you are not satisfied with the outcome, you are requested to make use of the following process to contact the specific Medscheme managers of the Scheme via e-mail if not specified otherwise:

LEVEL 1	Valecia Moodley (Team Leader) **valeciam@medscheme.co.za** / 011 671 2238 Sunelda Gravett (Team Leader) **sundeldag@medscheme.co.za** / 011 758 8766 Lu Soman (Team Leader) **lucindas@medscheme.co.za** / 011 671 4326	If you are not satisfied, go to level 2.
LEVEL 2	Yasmin Khan (Call Centre Manager) **yasmink@medscheme.co.za** / 011 671 2783	If you are still not satisfied, go to level 3.
LEVEL 3	Trevor Bailey (Fund Manager) **trevorb@medscheme.co.za** / 021 466 1632	If you are still not satisfied, go to level 4.
LEVEL 4	Felecia Oortman (Assistant Principal Officer) **feleciao@nedbank.co.za** / 010 234 5595	If you are still not satisfied, go to level 5.
LEVEL 5	Julia Le Roux (Principal Officer) **julial@nedbank.co.za** / 021 412 3814	

If, after following the procedure detailed above, you are still not satisfied with the outcome of the process, or you have not received a response within seven (7) working days, you may contact the Council for Medical Schemes' Complaints Department: **Telephone** 012 431 0500 / **Fax** 012 431 0608 / Send your complaint via the Council's **website** www.medicalschemes.com (follow the "Consumer Assistance – Complaints link")

2 THE SCHEME – THERE FOR YOU

Anybody who has experienced a health scare can testify that any other problem suddenly becomes small once a health risk becomes apparent. That's why a quality medical scheme is no longer a nice-to-have, but a must have. The Nedgroup Medicial Aid Scheme aims to offer our members the best possible value for money. As a restricted membership medical scheme, we have several factors that count in your favour...

One goal and one goal only: improving the health of our members

As a restricted membership scheme we are not for profit, but simply want to ensure that you and your dependants have great medical cover and the support you need to live a healthy life.

We look for reasons to pay claims

Open schemes usually apply strict conditions around the payment of benefits, as paying more than what is legally required may have a negative impact on their surplus levels and related profitability. Generally they do not pay ex gratia claims. Our objective is breaking even and maintaining our solvency ratio. We therefore pay claims within our rules and also offer ex-gratia assistance to our members through a managed governance process.

Savings are passed on directly to you

Unlike open schemes, we don't have to spend a lot of money on marketing to attract new members. This is just one of the ways in which we save... and thus pass the savings on to you. In fact, independent benchmarking shows that our benefits are comparable with those offered by the top open-membership schemes, but that our contributions are much lower!

Bells and whistles... we've got them, too!

Open schemes are in competition with each other for the same member pool, and often add extra benefits to make their offering more attractive... gym memberships and the like. With our partner Sanlam Reality, we can now also offer you a lifestyle rewards programme where you can pay a minimal monthly fee and enjoy extras such as heavily discounted gym fees, movies, flights and more!

WHAT ARE SOME OF MY RESPONSIBILITIES AS A MEMBER?

- Understand how the Scheme and specific Plans work by reading this Member Guide and all communication sent to you by the Scheme.
- Keep the Scheme up to date on any changes to your membership details.
- Check whether the correct contributions are deducted from your salary/pension or bank account. (Child dependants 23 years or older will pay the adult dependant contribution.)
- Check all accounts from service providers as well as your statements and claims advices from the Scheme to make sure that all your details are correct and that your claims have been processed correctly. This will also help to identify fraud.
- Inform the Scheme before you are admitted to hospital or within 24 hours of an emergency admission to hospital.
- File all your documentation regarding the Scheme so that you can refer to it if necessary.
- Keep your membership card in a safe place so that no-one else can use it fraudulently.
- Choose a Plan that best suits your needs. Although HR and Medscheme as administrator can offer you information, neither of these parties is allowed to offer you financial advice such as which Plan to choose.

3 DIGITAL TOOLS

PERSONAL HEALTH RECORD

Personal Health Record (PHR) is a simple, easy-to-use facility that gives you and your doctor access to your complete health record anywhere, any time... plus great lifestyle tools to live better.

You can use it to find information on your condition, surgical procedures and medication.

YOU CAN ALSO USE IT TO:

- View your medical history including immunisations and allergies.
- Track your health measurements such as blood pressure results and blood sugar levels.
- Earn reward badges for healthy behaviour.
- View your doctor appointments and hospital admissions.
- See how healthy you are with a Health Risk Assessment.
- Connect a wearable device and track your activity and calories burned.

ACTIVATING PHR:

The Nedgroup Personal Health Record can be activated from both PC and smartphone.

- On **PC**, you can access the PHR via the logged-in Member Zone (visit nmas.medscheme.com).
- On **smartphones**, search for **Nedgroup PHR** in your app store.

Please note: Before you can access your PHR details, call 0860 100 080 to give consent to activate your PHR. You can start using your PHR via the logged-in Member Zone as soon as it has been activated (usually within 24 hours of giving consent).

NEDCHAT

NedChat is our all-in-one live chat app that puts you in one-on-one contact with a scheme representative – Mondays to Fridays from 8:30 to 17:00.

WHAT CAN YOU DO WITH NEDCHAT?

- Clarify simple enquiries without having to call the Contact Centre or sending emails.
- Ask benefit and/or claims-related questions.
- Attach documentation (even claims) to a message and forward it directly to the consultant.
- Send a photo of any document as an attachment.
- View an electronic version of your membership card.

HOW TO GET NEDCHAT

- **Smartphones:** The NedChat functionality is currently available on Android and Apple iOS platforms. Simply download NedChat free from http://mobile.cellfind.co.za/MobiApp/dl/nedchat, or search NedChat via your mobile app store and start chatting!
- **Desktop computers and laptops:** This service is also available to registered users in the logged-in zone on the NMAS website by clicking on the NedChat widget/icon.

SCHEME APP

Use our responsive member app to -

- access your latest benefit limits,
- see and update beneficiary details,
- check service provider claims,

- and lots more!

GET THE APP ON YOUR SMARTPHONE!

You can download our free Scheme smartphone app from the Android and iOS App Stores.

4 2020 EMPLOYEE CONTRIBUTIONS

1 January 2020 - 31 March 2020 (same amounts as from April 2019)			
	Member	**Adult**	**Child (max 2)**
PLATINUM			
All income levels – monthly	R5 211	R4 065	R1 248
COMPREHENSIVE (includes 15% allocation to PMSA)			
R0 – R4 500.99	R3 867	R3 016	R851
R4 501 – R6 000.99	R4 210	R3 283	R941
R6 001 +	R4 295	R3 350	R970
TRADITIONAL			
Up to R6 000.99	R3 720	R2 900	R816
R6 001 +	R3 793	R2 959	R880
SAVINGS (includes 21.3% allocation to PMSA)			
Up to R6 000.99	R2 075	R1 786	R 634
R6 001 +	R2 262	R2 220	R 753
HOSPITAL NETWORK			
Up to R6 000.99	R1 278	R1 112	R403
R6 001 +	R1 587	R1 563	R545

1 April 2020 - 31 December 2020			
	Member	**Adult**	**Child (max 2)**
PLATINUM			
All income levels – monthly	R5 680	R4 431	R1 360
COMPREHENSIVE (includes 15% allocation to PMSA)			
Up to R10 000.99	R4 526	R3 529	R1 012
R10 001 +	R4 617	R3 601	R1 043
TRADITIONAL			
Up to R10 000.99	R3 999	R3 118	R877
R10 001 +	R4 077	R3 181	R946
SAVINGS (includes 21.3% allocation to PMSA)			
Up to R10 000.99	R2 231	R1 920	R682
R10 001 +	R2 432	R2 387	R809
HOSPITAL NETWORK			
Up to R10 000.99	R1 318	R1 146	R415
R10 001 – R20 000.99	R1 665	R1 640	R 572
R20 001 +	R1 698	R1 672	R583

VALUE-ADD

- Even if you have more children under age 23, you only pay for two.
- A child over age 23 who is physically or mentally disabled and financially dependent on you, qualifies for child rates.
- A child over age 23 who is financially dependent on you can be registered as an additional adult dependant.

TIP:
Use our handy online calculator to automatically calculate your family's monthly contributions.

Contributions for active employees are based on Total Guaranteed Package (TGP).

5 OVERVIEW OF THE FIVE PLANS

THE SAME ...

ALL OUR PLANS OFFER:

Unlimited **Hospital and trauma cover** (with sub-limits on certain benefits and certain PMB-only benefits on the **Hospital Network** and **Savings** Plans, and a list of hospitals on the **Hospital Network** Plan)

NEW

Emergency transport and telephonic support by ER24

Preventative screening tests and vaccines through our **Health Screening** benefits

Access to various **Managed Care Programmes**

Cover for all Prescribed Minimum Benefits (PMB) **chronic conditions**

HOW TO CHOOSE A PLAN

Weigh up your needs with what you can afford...

- How healthy are you and your loved ones? What were your medical expenses during the previous benefit year, and do you anticipate any medical procedures or any need for high-cost drugs during the next benefit year?
- Do you prefer to pay less for a Plan that does not cover much in the way of day-to-day medical needs, or would you rather pay more and have a Plan that offers more comprehensive cover for day-to-day medical needs?
- Do you or any of your loved ones suffer from a chronic disease that would require chronic medicine or treatment? If so, is it a condition that is covered by all the Plans, or only by the higher-cost Plans (or not at all)?

Use our handy calculator tool to calculate your family's monthly contribution rate for each Plan to make sure that you can afford the Plan you select. Before moving to a lower-cost Plan, make sure that you will still have good enough cover for your medical needs.

Remember that you can only change Plans once a year and that is before the start of the benefit year on 1 January. No Plan changes are allowed during the year, except for a Plan upgrade to access enhanced oncology benefits.

TIP: If you are retiring during the next benefit year, choose a Plan which will take into account your financial circumstances at retirement.

... BUT DIFFERENT

THE PLANS DIFFER MAINLY IN HOW THE FOLLOWING ARE COVERED:

	Everyday services benefits	Non-PMB chronic conditions
PLATINUM Flexibility for a healthy family with a higher income who wants excellent cover for everyday services benefits such as GP consultations.	Offers the highest benefits, paying up to 3 x Medical Scheme Rate (MSR).	Covers PMB and approved non-PMB conditions from a set benefit limit, then from Routine Medical Benefit, then covers PMB unlimited.
COMPREHENSIVE Cover for higher healthcare needs, especially chronic conditions, with a savings allocation allowing more flexibility for everyday services benefits.	Covers certain benefits from a personal medical savings account, allowing more flexibility.	Covers approved non-PMB conditions from a set benefit limit; PMB conditions unlimited.
TRADITIONAL Cover for medium healthcare needs, especially chronic conditions, with sub-limits on everyday services benefits.	Covers listed benefits up to pre-set sub-limits.	Covers approved non-PMB conditions from a set benefit limit; PMB conditions unlimited.
SAVINGS Maximum flexibility for a generally healthy family who is happy to have everyday services covered from an annual savings allocation.	Covers all benefits from funds available in the personal medical savings account.	Covers both PMB and approved non-PMB from a set benefit limit, then covers PMB unlimited.
HOSPITAL NETWORK If you have no immediate healthcare needs, but want the peace of mind of having cover mainly for unforeseen hospital procedures and serious diseases.	Restricted cover for everyday services (1 network GP consultation)	Cover only for PMB conditions and Major Depression.

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BENEFITS: HEALTH SCREENING

Why should I go for screening tests?

Having screening tests done is one of the most important things you can do for your health. Screenings are medical tests that check for diseases before there are any known symptoms. Screenings can help doctors find diseases early, when the diseases may be easier to treat. Do bear in mind, though, that screening tests are only indicative. For a more accurate diagnosis of a chronic condition, your doctor may refer you for more extensive blood tests to determine whether you require chronic medication. For more information please call 0860 100 080.

What is available under the Health Screening Benefits?

The following Health Screening Benefits are available to members on ALL Plans:

HEALTH SCREENING

You have access to the Nedgroup Network Pharmacy Screening Programme, allowing you and your dependants to visit a participating Nedgroup Network pharmacy clinic or attend a Scheme health screening event, so that a qualified nurse can give you advice on how to improve your health. Another advantage of these screening tests is that members with potentially high risks in terms of their health may be identified at an early stage.

You will be covered for the following diagnostic tests (two sets, or you will have the flexibility to choose to have all the tests at one encounter, either at a health screening event or at a Nedgroup Network Pharmacy, or to have multiple individual tests over the benefit year, subject to the benefit limit of R345:

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

TIP:
To book a health screening at a pharmacy clinic, or for more information about the process, visit dischem.co.za/stay-well-clinic for Dis-Chem or clicks.co.za/clinicBooking for Clicks Pharmacies.

If you would like information on where you can access the screening tests, please call 0860 100 080.

All screening tests will be covered at the Medical Scheme Rate (MSR). If the provider charges more than MSR, the difference will be for your account.

HIV SCREENING

You also have the following HIV tests and services available on all Plans:

- Pre-testing counselling,
- Testing and post-test counselling.

Your monthly statement will reflect any claims received and paid once this benefit has been accessed. The claims are paid from your HIV Benefit and not from your Everyday Services Benefits.

CANCER SCREENING TESTS

Pap smear (usually performed by a GP or gynaecologist) – limited to one test per female beneficiary per benefit year.

Prostate Specific Antigen (a blood test to screen for prostate cancer) – limited to one test per male beneficiary over age 45 per benefit year.

Mammogram (performed at a radiology practice) – limited to one test per female beneficiary over age 40 per benefit year.

Colorectal screening (where a sample of your stool is screened by a pathologist) – limited to one test per beneficiary over age 50 per benefit year.

PLEASE NOTE
ONLY the tests are covered under this benefit; whereas any consulting fees will be paid from the Everyday Services Benefits limit (for applicable Plans) or, in the case of **Savings** or **Hospital Network** Plan members with insufficient savings in their PMSA, from the member's own pocket.

VACCINATIONS

NEW

The following vaccinations are covered under the Health Screening Benefits:

- One flu vaccine per beneficiary per benefit year.
- One pneumococcal vaccine per member or beneficiary aged 65 or over every 5 years.
- One HPV vaccine course per beneficiary aged 9-26.

PLEASE NOTE
ONLY the vaccines are covered under this benefit, whereas any consultation fees will be paid from the Everyday Services Benefits limit (for applicable Plans) or, in the case of **Savings** Plan members with insufficient savings or **Hospital Network** Plan members, from the member's own pocket.

OTHER SCREENING TESTS

Glaucoma screening (performed at an optometrist/ophthalmologist) – limited to one test per beneficiary over age 55.

Bone density screening (performed at a radiology practice) – limited to one test per beneficiary over age 65 every two years.

Your monthly statement will reflect any claims received and paid once this benefit has been accessed.

The claims are paid from your Health Screening Benefit and not from your Everyday Services Benefits. Any medical expenses not covered under the Health Screening Benefit will be paid from your Everyday Services Benefits.

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BENEFITS: MANAGED CARE PROGRAMMES

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

- Diabetes Management Programme
- GoSmokeFree Programme
- Back and Neck Rehabilitation Programme
- Mental Health Programme
- HIV and AIDS Management Programme
- Oncology Benefit Management Programme
- Active Disease Risk Management Programme
- Renal Dialysis and Organ Transplant Programme

DIABETES MANAGEMENT PROGRAMME

The Scheme's Diabetes Management programme helps members with diabetes better understand this long-term condition and empowers them to make the right decisions to stay healthy.

As most diabetics have at least one other chronic condition, the programme offers a personalised care plan to ensure that your specific needs are taken into account. The care plan will provide cover for the tests required for the management of diabetes as well as your other chronic conditions. It offers access to specialised diabetes doctors, dieticians, podiatrists and diabetic educators to allow you to effectively manage your diabetes.

In addition, you will have access to a dedicated Health Coach to answer any questions you may have, and you will also enjoy online assistance through the YourHealth Portal.

HOW TO ACCESS THE PROGRAMME

For more information, or to register on this programme:

Call 0860 100 080 or
Email membercare@medscheme.co.za

GOSMOKEFREE PROGRAMME (ALL PLANS EXCEPT HOSPITAL NETWORK PLAN)

The GoSmokeFree programme is aimed at helping members who smoke to kick the habit!

Studies show that 70% of smokers would like to give up smoking and 30% go on to attempt to stop each year … yet fewer than 3% successfully quit cold turkey! It has also become clear that the most effective smoking cessation intervention is a combination of behaviour change techniques, medication and support – that is why the GoSmokeFree Stop Smoking Programme uses all these techniques.

HOW DOES IT BENEFIT YOU?

Stopping smoking is the single most important decision you can make for your health. The benefits of stopping smoking are almost immediate, but stopping smoking is not easy, as nicotine is highly addictive and smoking is associated with social activities such as drinking or eating and psychological factors such as work pressure, anxiety and body weight concerns.

The GoSmokeFree Stop Smoking Programme is available at various pharmacies throughout South Africa using a trained Nursing Sister or Pharmacist, so access to the programme is easy.

HOW WILL THIS BENEFIT BE COVERED?

- **Hospital Network** Plan: No benefit
- **Savings** Plan: Payable from available PMSA
- **Comprehensive**, **Traditional** and **Platinum** Plans: Payable from Everyday Services Benefits

HOW CAN YOU ACCESS THE BENEFIT?

Visit www.gosmokefree.co.za to find out more and to locate your nearest pharmacy.

Call 0860 100 080 for more information

BACK AND NECK REHABILITATION PROGRAMME

The DBC back and neck rehabilitation programme consists of up to 12 sessions over a 6-week period. The treatment takes place at specific DBC centres.

The DBC Treatment System was developed in Finland more than 20 years ago and today the DBC network spans treatment providers in more than 22 countries. The DBC system is completely evidence and outcomes based with a current global success rate in excess of 85% after an average of 3 to 9 weeks' treatment. Every centre in the DBC network provides treatment data to DBC Finland and this data is used for quality control and reporting.

HOW TO ACCESS THE PROGRAMME

You can access the programme in various ways.

The Scheme will refer you to the programme if:

- you request a pre-authorisation for an admission related to back/neck surgery (for example a spinal fusion), pain management (for example a rhizotomy) or specialised radiology (for example an MRI scan), or
- Medscheme's predictive model identifies you as being at risk of a back/neck admission in the next year (if you haven't yet visited one of the accredited centres).

As the list of centres is still limited, the Scheme will only identify and contact members within 30km of a DBC centre as we often find that members who have to travel more than 30km would decline to enrol on the Programme.

- Your specialist or GP may refer you to participate in the Programme.
- You may self-refer by contacting the Scheme on 0860 100 080, should you experience chronic, ongoing back or neck pain.

PROGRAMME VS SURGERY – IMPLICATIONS

See the chapter *Co-Payments, Penalties and Out-of-Pocket Expenses* for more information.

WHERE ARE THE DBC CENTRES?

There are DBC centres throughout South Africa, with additional centres opening on an ongoing basis. Please call 0860 106 155 or visit www.dbcsa.co.za to find the DBC centre closest to you.

MENTAL HEALTH PROGRAMME

The Mental Health Programme is aimed at beneficiaries with certain mental health conditions and substance abuse disorders to improve the quality and integration of mental health care of these beneficiaries. Parallel to health care provider decision support, it uses specialised mental health managed care interventions to promote effective self-care by beneficiaries suffering from moderate to severe mental illness. Enrolment is subject to meeting clinical criteria, which identifies moderate to severe symptoms or discharge from hospital for mental illness or substance abuse disorder. Eligibility for enrolment also includes beneficiary consent to participate as well as sharing of information with relevant health care providers.

Did you know that one in three South Africans will suffer from a mental health disorder in his or her lifetime and that a person's physical, social and financial wellbeing is closely tied to their mental health?

HOW DOES IT BENEFIT YOU?

The programme provides effective collaboration between a care manager and family practitioners, psychiatrists, psychologists and other healthcare professionals, who will work together to ensure that you are supported in a way that suits your individual needs. Your adherence and active participation in treatment is required to achieve the desired outcomes and we encourage you to make the most of the opportunities and support that this programme has to offer. While enrolled on the programme you may expect to receive the following support:

- Education for you and your family
- Referral to community support groups
- Support and guidance.

A telephonic helpline is available to any beneficiary suffering from a mental health condition or problems with substance (drug and alcohol) abuse. This will provide you with direct access to a care manager who will assess your eligibility for enrolment on the programme, explain the programme to you as well as inform you about the benefits available to manage your condition.

HOW CAN YOU ACCESS THE BENEFIT?

You may access the programme by either:

Calling 0860 106 155, or

Emailing Nedgroupmentalhealth@medscheme.co.za

Alternatively you may be identified through predictive modelling and contacted by one of the care managers for enrolment on the programme.

WHAT DOES THE BENEFIT CONSIST OF?

When you enrol on the mental health programme, a care template will be triggered which will provide additional benefit to ensure that your team of healthcare professionals may optimally manage your condition. This will be individualised based on your unique requirements, making this a tailored benefit structured specifically for you, ensuring the best possible outcome.

HIV AND AIDS MANAGEMENT PROGRAMME

Members and dependants of the Nedgroup Medical Aid Scheme have access to benefits for the treatment of HIV and AIDS. These benefits can be accessed by registering on the HIV and AIDS management programme and all Nedgroup Medical Aid Scheme members are entitled to join.

HIV/AIDS

For most people HIV/AIDS is a frightening disease, but today treatment is available that allows the majority of people living with HIV to lead healthy and productive lives for many years.

ACTION AND INFORMATION

The first step is to find out whether you have been infected with HIV and what you can do to protect your loved ones and stay healthy. Medicines are available to attack the virus, while vitamins, good nutrition and exercise can play a critical role in keeping your body strong and healthy. Starting treatment at the right time ensures the effectiveness of the medicines, improves quality of life and decreases the risk of serious infections or other complications. Our HIV and AIDS management programme can help you access benefits to assist you with the best way of managing HIV/AIDS.

WE CAN HELP YOU TO MANAGE YOUR CONDITION

Our HIV and AIDS management programme is specifically for HIV/AIDS related medicine. This programme is used to pay for medicine to attack the virus, vitamins to boost your immune system and regular monitoring tests.

YOUR CONDITION WILL STAY CONFIDENTIAL

HIV is a sensitive matter and every effort is made to keep your condition confidential. The staff members have all signed confidentiality agreements and are employed in a separate company from the Scheme or the administrator. Staff who manage the HIV and AIDS management programme will not reveal your HIV status to anyone without your permission. The HIV and AIDS management programme uses separate telephone, fax and private mailbag facilities from the Scheme or the administrator. Patients need to use these facilities to maintain confidentiality.

YOU MUST REGISTER ON OUR HIV AND AIDS MANAGEMENT PROGRAMME

If your test shows you are HIV-positive you must register on the HIV and AIDS management programme as soon as possible to make use of this benefit. Telephone in confidence and ask for an application form and the counsellor will also assist you with registering on the HIV and AIDS management programme. Your doctor can also contact us on your behalf.

AFTER YOU HAVE REGISTERED

After you receive the application form, you and your doctor must complete it and return it to the HIV and AIDS management programme by using the confidential, toll-free fax line number on the form. A highly qualified medical team will examine your details and if necessary, discuss an appropriate treatment with your doctor.

Once treatment has been agreed upon, you and your doctor will be sent a detailed treatment plan, which explains the approved medicine as well as the regular tests that need to be done to ensure that the medicines are working correctly.

WHAT THE HIV AND AIDS MANAGEMENT PROGRAMME OFFERS YOU

The Scheme's HIV and AIDS management programme is a complete HIV disease management programme that offers both members and beneficiaries:

- Medicine to treat HIV (including drugs to prevent mother-to-child transmission and infection after sexual assault or needle stick injury) at the most appropriate time.
- Treatment to prevent opportunistic infections like certain serious pneumonias and tuberculosis.
- Regular monitoring of disease progression and response to therapy.
- Regular monitoring tests to pick up possible side-effects of treatment.
- Ongoing patient support via a Treatment Support Line.
- Clinical guidelines and telephonic support for doctors.
- Help in finding a registered counsellor for emotional support.

Managed by Aid for AIDS (AfA)

Tel: 0860 100 646

Fax: 0800 60 0773

Email: afa@afadm.co.za

Website: www.aidforaids.co.za

Mobisite: www.aidforaids.mobi

SMS (call me): 083 410 9078

The HIV/AIDS Care Manager will assist with all your questions regarding the condition, its treatment, social issues or any concerns that you may have.

Pharmacy Direct and Clicks Pharmacy are now the Designated Service Providers for HIV medication. **See page 26.**

ONCOLOGY BENEFIT MANAGEMENT PROGRAMME
(FOR CANCER PATIENTS)

If you are diagnosed with cancer, it will be to your advantage to contact the Oncology Case Manager before starting any treatment. The Oncology Benefit Management Programme will not only help you to manage the high costs associated with treatment, but you will also receive help, support and education on your condition from the Oncology Case Manager.

The Scheme has appointed the Nedgroup Oncology Network as our Designated Service Provider for oncology. If you are referred to a provider for oncology-related treatment, please check with your administrator whether the provider is part of the Nedgroup Oncology Network.

WHY IS IT NECESSARY FOR ME TO REGISTER ON THE ONCOLOGY BENEFIT MANAGEMENT PROGRAMME?

By enrolling in the programme, you will qualify for the annual oncology family benefit limit. It will also ensure that health services related to oncology, such as your doctor's consultations, general and specialised radiology and pathology during follow-up visits to the doctor, will be covered from your oncology benefit. By obtaining authorisation you are also ensuring that your treatment is effectively managed within your available benefits.

This benefit forms part of your Hospital and Trauma Benefits. It is envisaged that in most cases this limit will be sufficient to cover well-managed costs.

UPGRADE TO ACCESS ENHANCED BENEFITS

If you or one of your dependants are diagnosed with cancer or have to undergo oncology treatment and your Plan does not provide adequately for the cancer treatment, you can apply to upgrade to **Traditional**, **Comprehensive** or **Platinum Plan** within two months (60 days) after the date of the first diagnosis of cancer, or having had to undergo oncology treatment.

If your care plan is not approved, you will not have access to the oncology benefit limit, and all your cancer-related accounts will be paid from your Everyday Services Benefits.

The Oncology Case Manager will address any concerns with the treating oncologist.

- Please submit your care plan to cancerinfo@medscheme.co.za.

If you have any queries regarding the Oncology Benefit Management Programme or your condition, please contact the Oncology Case Manager on 0860 100 572.

HOW TO OBTAIN AUTHORISATION FOR ASSOCIATED TREATMENT

1. Surgery/procedures/hospital admissions:

If you need to be admitted to hospital for chemo-therapy or radiotherapy, please contact the Oncology Management Department directly.

Surgery or related procedures are covered from the hospital benefits and not the oncology benefit, so you will need to obtain a pre-authorisation from the Hospital Pre-authorisation Department.

2. Specialised radiology (including PET scans):

If you require specialised radiology, such as CT, MRI or PET scans, you will need an additional authorisation from the Oncology Management Department for it to be covered from your oncology benefit.

When applying for a specialised radiology authorisation, the following information is required:

- membership number
- dependant number
- requesting doctor practice number
- radiology practice number
- codes to be charged and estimated cost
- reason for the scan

If you need an authorisation for a PET scan, your doctor must complete the PET scan form, which is available at all PET scan units.

3. Hospice, private nursing and medical admissions:

If you need services such as home nursing or hospice, you need to contact the Hospital Pre-authorisation Department. You can also contact this department if you have complications such as dehydration or excessive vomiting, or need to be hospitalised for pain control.

4. Social worker:

An Oncology Social Worker Benefit, subject to the Oncology Benefit limit, for the payment of seven sessions with a social worker affiliated to the Nedgroup Oncology Network in the case of terminal cases.

PLEASE NOTE

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

ACTIVE DISEASE RISK MANAGEMENT PROGRAMME

The Nedgroup Medical Aid Scheme Active Disease Risk Management Programme identifies members who are at risk of suffering complications or advancement of their chronic conditions. The programme will assist you to control, manage and monitor your conditions. With your prior consent, your health coach will work together with you and your GP.

If you have been diagnosed or are at potential risk of developing a chronic condition, you may have access to our dedicated health coaches who will be on hand to advise and provide guidance to you. This will be communicated to you by various ways to provide support, information and practical advice to better manage or prevent chronic conditions.

Members registered on the programme will have access to a health line to discuss any chronic conditions confidentially with a health coach, as well as be encouraged to access the YourHealth Portal on the Member Zone. This is an online educational web and mobile health portal that gives members access to a range of resources to assist with better health choices which includes e-tutorials and educational articles, tools and quizzes.

Please note the following

- The health coaches are not able to diagnose or treat health problems over the phone and the advice provided does not replace a visit to your doctor.
- All information regarding your medical condition will be kept strictly confidential.

Active Disease Risk Management Department

Telephone: 0860 106 155

Fax: 0860 106 245

Email: membercare@medscheme.co.za

RENAL DIALYSIS AND ORGAN TRANSPLANTS

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

A 12-month care plan must be submitted to, and approved by, the Case Manager.

This plan should include the following information:

- date of diagnosis
- the area concerned
- any prior surgery or treatment
- ICD10 code
- tariff code
- practice number of doctor or supplier
- new treatment requested as well as approximate costs.

Please submit your care plan to:

Hospital Benefit Management

Fax: 0860 21 22 23 or 021 466 1913

nedgroup.authorisations@medscheme.co.za

8

BENEFITS: EVERYDAY SERVICES

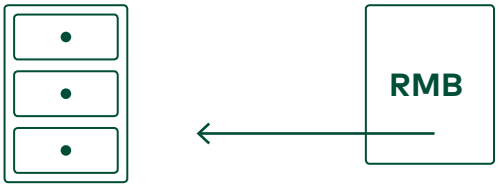
HOSPITAL NETWORK 1 x Network GP consultation per beneficiary per year. NEW

PLATINUM

Benefits are paid at up to 3 x MSR.

Sub-limits are available for certain benefits.

Other specific benefits are covered from the Routine Medical Benefit (RMB) limit.



Once these sub-limits are depleted, the available RMB limit can also be used to cover the above benefits.

Once your sub-limits and RMB are depleted, you will be liable for payment.

RMB **ROUTINE MEDICAL BENEFIT LIMIT**

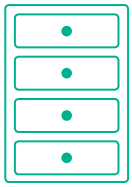
Member: R20 450
Member +1: R34 380
Member +2: R36 450
Member +3: R44 300

This benefit can also be used to pay for certain other services, once you have used up those limits.

COMPREHENSIVE

15% of your monthly contribution is allocated to your PMSA. Benefits with sub-limits are paid at MSR, while benefits payable from PMSA are covered at cost.

Sub-limits are available for certain benefits.



Other specific benefits are covered from your Personal Medical Savings Account (PMSA).

Once your sub-limits and/or PMSA (whichever is applicable to the specific benefit) are depleted, you will be liable for payment.

ANNUAL PMSA AMOUNT (AVAILABLE UPFRONT)

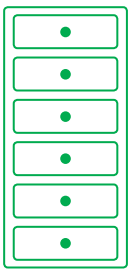
Use our online calculator!

Add up the amounts per beneficiary to calculate the total available for your family.

If you earn R4 500 pm or less	Member: R7 842 Adult: R6 117 Child (max 2): R1 740
If you earn between R4 500 and R6 000 pm	Member: R7 995 Adult: R6 237 Child (max 2): R1 782
If you earn between R6 001 and R10 000 pm	Member: R8 034 Adult: R6 267 Child (max 2): R1 794
If you earn more than R10 001 pm from April 2020	Member: R8 160 Adult: R6 366 Child (max 2): R1 839

TRADITIONAL

Benefits are paid at MSR.



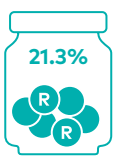
Sub-limits are available for certain benefits.

Once your sub-limits are depleted, you will be liable for payment.

SAVINGS

21.3% of your monthly contribution is allocated to your PMSA. Benefits with sub-limits are paid at MSR, while benefits payable from PMSA are covered at cost.

Most of the listed benefits are covered from your Personal Medical Savings Account (PMSA).



Sub-limits are available for certain maternity benefits only.

Once your sub-limits and/or PMSA (whichever is applicable to the specific benefit) are depleted, you will be liable for payment.

ANNUAL PMSA AMOUNT (AVAILABLE UPFRONT)

Use our online calculator!

Add up the amounts per beneficiary to calculate the total available for your family.

If you earn R6 000 pm or less	Member: R5 598 Adult: R4 812 Child (max 2): R1 710
If you earn between R6 001 and R10 000 pm	Member: R5 718 Adult: R5 088 Child (max 2): R1 785
If you earn more than R10 001 pm from April 2020	Member: R6 105 Adult: R5 988 Child (max 2): R2 028

	PLATINUM	COMPREHENSIVE	TRADITIONAL	SAVINGS
Consultations with General Practitioners and Homeopaths Visits, consultations, outpatients, procedures out of hospital not covered under Hospital and Trauma Benefits	Payable from Routine Medical Benefit limit.	Covered from available PMSA.	Member: **R2 750** Member +1: **R4 995** Member +2: **R5 450** Member +3: **R6 690**	Covered from available PMSA.
HOSPITAL NETWORK PLAN: 1 x Network GP consultation per beneficiary per year. NEW				
Specialists Benefits	Subject to referral from GP - please see *If you want to see a Specialist*. Limited to and included in above Consultations limit.	Subject to referral from GP - please see *If you want to see a Specialist*. Limited to and included in above Consultations limit.	Subject to referral from GP - please see *If you want to see a Specialist*. Limited to and included in above Consultations limit.	Subject to referral from GP - please see *If you want to see a Specialist*. Limited to and included in above Consultations limit.
Optical benefits • **Eye tests** • **Lenses, contact lenses and fittings** Eye tests are payable from this benefit limit. Lenses, contact lenses and fittings are paid up to the available sub-limits.	**R5 420** per beneficiary Once the limit is exhausted, this benefit will be paid from the Routine Medical Benefit limit.	Member: **R2 795** Member +1: **R4 365** Member +2: **R4 605** Member +3: **R5 390** A sub-limit of **R1 050** per beneficiary applies to frames for the 2-year cycle starting Jan 2019	Member: **R2 795** Member +1: **R4 365** Member +2: **R4 605** Member +3: **R5 390** A sub-limit of **R1 050** per beneficiary applies to frames for the 2-year cycle starting Jan 2019	Covered from available PMSA.
Maternity benefits • **Antenatal visits** • **Antenatal classes** • **Ultrasound scans** • **Child Vaccinations** • **Amniocentesis** NEW	**R8 300** combined maternity benefit per family Once the limit is exhausted, this benefit will be paid from the Routine Medical Benefit limit. **3 x 2D or 3D** scans per family At a private clinic: **R5 940** per family per year Medication cost only, excluding facility fee or nursing consultations 1 per beneficiary per year	**R4 500** per family **R1 660** per family **3 x 2D** scans per family	**R4 500** per family **R1 660** per family **3 x 2D** scans per family	**R4 500** per family **R1 660** per family **3 x 2D** scans per family
Dentistry benefits • **Basic dental services** Removal of teeth and roots, removal of wisdom teeth, exposure of teeth for orthodontic reasons and suturing of traumatic wounds, diagnosis and treatment of oral and associated conditions, plastic dentures.	**R8 880** per beneficiary per year for Basic and Advanced dentistry. Once the limit is exhausted, this benefit will be subject to the Routine Medical Benefit limit.	**R3 525** per beneficiary Once the limit is exceeded, claims will be paid from Advanced dentistry limit.	**R3 525** per beneficiary Once the limit is exceeded, claims will be paid from Advanced dentistry limit.	Covered from available PMSA.
• **Advanced dentistry** Inlays, bridgework, crowns excluding gold content, mounted study models, metal base partial dentures, orthodontics (up to age 21), periodontists, prosthodontists and dental technicians.		Member: **R4 705** Member +1: **R8 540** Member +2: **R8 810** Member +3: **R10 510**	Member: **R4 705** Member +1: **R8 540** Member +2: **R8 810** Member +3: **R10 510**	Covered from available PMSA.

	PLATINUM	COMPREHENSIVE	TRADITIONAL	SAVINGS
Medicines: • **Prescribed medicine (acute)** • **Antenatal vitamins prescribed during pregnancy** – excluding calcium supplements and Omega preparations	Payable from Routine Medical Benefit limit.	Covered from available PMSA. Paid at **Medicine Price or Medicine Price List**, whichever is the lesser.	Member: **R3 705** Member +1: **R5 770** Member +2: **R6 090** Member +3: **R7 130** Paid at **Medicine Price or Medicine Price List**, whichever is the lesser.	Covered from available PMSA.
• **Pharmacy advised therapy (PAT) -** Medicines supplied by a registered pharmacist without a prescription from a medical practitioner or dentist. Benefit excludes the pharmacy's administration fee. The funding of compound analgesics, for example, Myprodol®, Stilpane® and Syndol® will be restricted to a maximum supply of one hundred tablets or capsules per year. If your condition requires medication in excess of this limit, you, your doctor or pharmacist can contact the Scheme on 0860 100 080. He/she will be transferred to a clinical agent who will consider a verbal motivation.	Payable from Routine Medical Benefit limit.	Covered from available PMSA.	**R1 475** per family, subject to the prescribed medicine limit.	Covered from available PMSA.
Pathology DSPs (Ampath, Lancet, PathCare, Vermaak & Partners) paid at cost; non-DSPs paid at Medical Scheme Rate.	Payable from Routine Medical Benefit limit.	Member: **R2 225** Member +1: **R2 830** Member +2: **R2 875** Member +3: **R3 155**	Member: **R2 225** Member +1: **R2 830** Member +2: **R2 875** Member +3: **R3 155**	Covered from available PMSA.
Radiology (X-rays)	Payable from Routine Medical Benefit limit.	**R2 965** per family	**R2 965** per family	Covered from available PMSA.
Supplementary health services 20 practice areas including anthroscopical treatment, applied kinesiology, audiometry, audiology, autologous donation of blood, biokinetics, chiropody, chiropractic services, clinical technology, dieticians, genetic counselling, hearing aid acoustics, naturopaths, occupational therapy, orthoptic treatment, podiatry, private nurses, remedial therapy, speech therapists, and social workers	Payable from Routine Medical Benefit limit.	Covered from available PMSA.	Member: **R2 190** Member +1: **R4 045** Member +2: **R4 410** Member +3: **R5 410**	Covered from available PMSA.
Physiotherapy Physiotherapy following hospitalisation is covered under the Hospital and Trauma Benefits, provided it is pre-authorised by the Case Manager before discharge from hospital.	Payable from Routine Medical Benefit limit.	Covered from available PMSA.	**R3 510** per family	Covered from available PMSA.

	PLATINUM	COMPREHENSIVE	TRADITIONAL	SAVINGS
Psychology There is a difference in the benefits you receive for treatment by a psychiatrist and a psychologist. A psychiatrist is a medical specialist who may use psychotherapy as well as medication to treat patients. The consultation or treatment by a psychiatrist will be deducted from the General Practitioners and Specialists limit, where applicable. Psychotherapy by a clinical psychologist, who is not a specialist, will be deducted from the Psychology limit, where applicable.	Payable from Routine Medical Benefit limit.	**R6 580** per family	**R6 580** per family	Covered from available PMSA.
Medical appliances Not forming an integral part of an operation, for example, baumanometer, all orthopaedic braces, and crutches, as well as CPAP equipment. Maintenance and repairs are not covered by the Scheme, unless a full quote is received and pre-authorised by the Scheme. Approval for moulded insoles is subject to motivation from a relevant specialist. The frequency of the benefit will be subject to the Scheme's clinical protocols.	Payable from Routine Medical Benefit limit.	**R4 600** per family	**R4 600** per family	Covered from available PMSA.
Wheelchair and associated appliances Can be purchased or hired, if approved before acquisition.	**R13 120** per family	**R13 120** per family	**R13 120** per family	Covered from available PMSA.
Hearing aids This benefit covers the cost of the repair of the devices, subject to the quote being submitted to the Scheme and being approved. A registered provider must submit the claim. The cost of batteries is excluded.	Payable from Routine Medical Benefit limit.	**R36 560** per family for beneficiaries 6 years and younger **R25 010** per family for beneficiaries 7 years and older Benefit available per beneficiary every 2 years, starting 1 January 2019.	**R36 560** per family for beneficiaries 6 years and younger **R25 010** per family for beneficiaries 7 years and older Benefit available per beneficiary every 2 years, starting 1 January 2019.	Covered from available PMSA.
Oral Contraceptives Products must be prescribed for contraception and not for the treatment of acne or skin conditions, unless otherwise specified as per managed care protocols.	**R3 410** per beneficiary for the Mirena device, with a **R1 890** sub-limit for oral contraceptives, subject to managed care protocols. The cost of a GP or gynaecologist consultation will be covered from the Routine Medical Benefit.	Covered from available PMSA.	Payable from Prescribed medicine (acute) sub-limit.	Covered from available PMSA.

9

BENEFITS: CHRONIC MEDICINE

CONDITIONS COVERED

All Plans offer treatment for the official **PMB chronic conditions**, as well as for Major Depression.

All Plans except Hospital Network Plan offer treatment for a number of **additional Scheme-approved chronic conditions**.

HOW BENEFITS ARE PAID

It is important to understand the different ways in which the Plans cover chronic medicine (for example, although **Platinum** Plan is a higher-cost plan with richer day-to-day benefits, it is typically not suited to members with both PMB and non-PMB chronic conditions).

		Once the chronic medicine benefit limit is exhausted	
PLATINUM	All chronic medicine benefits (both PMB and non-PMB) are first covered from a set chronic medicine benefit limit (**R11 340** per family per year for 2020).	All chronic conditions are covered from available Routine Medical Benefit limit until depleted, then...	PMB conditions are covered unlimited.
SAVINGS	All chronic medicine benefits (both PMB and non-PMB) are first covered from a set chronic medicine benefit limit (**R11 340** per family per year for 2020).	Non-PMB conditions are covered from available savings.	PMB conditions are covered unlimited.
TRADITIONAL COMPREHENSIVE	A set chronic medicine benefit amount is used to cover non-PMB conditions (**R11 340** per family per year for 2020).	PMB conditions are covered separately, and unlimited.	
HOSPITAL NETWORK	A set chronic medicine benefit amount is used to cover Major Depression only (**R4 430** per family per year for 2020). Pharmacy Direct is the DSP.	PMB conditions are covered separately, and unlimited. Pharmacy Direct is the DSP.	

THE OFFICIAL PMB CONDITIONS:

Addison's disease, Asthma, Bipolar mood disorder, Bronchiectasis, Cardiac failure, Cardiomyopathy, Chronic renal disease, Chronic obstructive pulmonary disease (emphysema), Coronary artery disease (angina pectoris and ischaemic heart disease), Crohn's disease, Diabetes insipidus, Diabetes mellitus type 1 & 2, Dysrhythmias, Epilepsy, Glaucoma, Haemophilia, HIV/AIDS, Hormone replacement therapy, Hyperlipidaemia (high cholesterol), Hypertension (high blood pressure), Hypothyroidism, Multiple sclerosis, Parkinson's disease, Rheumatoid arthritis, Schizophrenia, Systemic lupus erythematosus and Ulcerative colitis.

ADDITIONAL SCHEME-APPROVED CHRONIC CONDITIONS:

Acne (cystic nodular), Allergic rhinitis (no criteria for **Platinum**, **Comprehensive** and **Traditional** Plans, while for **Savings** Plan will only be approved for children under the age of 12 years, or for patients on concurrent asthma therapy), Anxiety (if linked to another approved psychiatric chronic condition), Attention deficit syndrome (if prescribed by a specialist and under the age of 18 years), Behcet's Disease, Deep vein thrombosis, Depression/Mood disorders, Eczema, GORD, Gout, Hyperthyroidism, Hypofunction of the pituitary gland, Insomnia (sleep disorders) (if linked to another approved psychiatric chronic condition), Migraine prophylactics (prevention), Obsessive Compulsive Disorder, Paget's Disease, Psoriasis and Sjogren's Disease

In addition, for Platinum, Comprehensive and Traditional Plans: Alzheimer's disease, Urinary tract infections, Cystitis, Chronic Sinusitis, Osteoarthritis and Osteoporosis

Who are the Scheme's Designated Service Providers (DSPs) for medication?

Hospital Network Plan

Pharmacy Direct has been appointed as the DSP. If members obtain PMB medication from any other pharmacy, there will be a 25% co-payment. If medication for major depression is obtained from a non-network pharmacy, the member will be liable for the full cost.

Platinum, Comprehensive, Traditional and Savings Plans

Nedgroup Network Pharmacy has been appointed as the DSP.

PMB medication obtained from non-network pharmacies will result in a 25% co-payment. In the case of non-PMB medication obtained from a non-network pharmacy, the member will be liable for the full cost.

NEW **Pharmacy Direct and Clicks Pharmacy are now the Designated Service Providers for HIV medication.**

How to get your chronic medicine

You must register on the Chronic Medicine Management Programme before you can claim for chronic medicine from your Chronic Medicine Benefits.

To register, or for more information, contact **ScriptPharm Risk Management**:

Telephone: 011 100 7557

Fax: 086 679 1579

Email: nedgroup@scriptpharm.co.za

Website: www.scriptpharm.co.za (click on Locate a Nedgroup Pharmacy)

COURIER PHARMACIES

If you do not live within a reasonable distance of a Nedgroup Network Pharmacy, you may use one of the following courier pharmacies as your DSP.

PHARMACY DIRECT

Postal address: PO Box 7344, Centurion, 0046

Telephone: 086 002 7800

Fax: 0866 11 4000/1/2/3

Email: care@pharmacydirect.co.za

Please call me: 083 690 8934

DIS-CHEM DIRECT

Postal address: Private Bag X 21, Northriding, 2162

Telephone: 011 589 2788

Fax: 086 719 4568

Email: direct@dischem.co.za

CLICKS DIRECT MEDICINES

Postal address: PO Box 30480, Wibsey, 1717

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

General fax line: 0861 44 44 14

Accounts fax line: 0861 44 44 12

Email: clicksdirectmedicines@dirmed.co.za

Web: www.clicksdirectmedicines.co.za

10

BENEFITS: HOSPITAL AND TRAUMA

What are Hospital and Trauma benefits?

Hospital and Trauma Benefits generally cover major medical expenses that you would incur when undergoing surgery or while admitted in hospital, as well as specified procedures performed in the doctors' rooms (see *What services in doctors' rooms are covered?* below). Services not included will fall under the Everyday Services Benefits and are paid from the appropriate limit.

A visit to a hospital's Emergency Room does not qualify to be paid from your Hospital and Trauma Benefit, unless the incident is of such a serious nature that you are admitted to a ward in the hospital itself for further treatment. You may, however, submit a motivation to the Principal Officer for consideration.

PLEASE NOTE

Various hospital groups have introduced a set of tariff codes to levy a facility fee for accessing the emergency units. If you make use of the emergency unit, a separate fee will be charged over and above the cost of treatment. The tariffs are based on the severity of the emergency admission – the higher the priority of admission, the higher the facility fee charged.

What is our overall annual limit?

All members have access to unlimited Hospital and Trauma Benefits **at Medical Scheme Rate (MSR), no matter which Plan they belong to**. There are, however, sub-limits for certain services, depending on the Plan that you are on. Refer to the tables below for the sub-limits that apply to Hospital and Trauma Benefits under the various Plans.

What services in doctors' rooms are covered?

Provided you obtain a pre-authorisation number, certain procedures that are undertaken in doctors' rooms will be covered under your Hospital and Trauma Benefits at cost or **Medical Scheme Rate**, whichever is the lesser. **These include but are not limited to:**

- Bone marrow biopsy
- Colonoscopy
- Cystoscopy
- Functional endoscopy of sinuses
- Upper GI endoscopy (gastroscopy)
- Hysteroscopy
- Intravenous therapy
- Keloids (subject to motivation)
- Laser to scars (subject to motivation)
- Flexible sigmoidoscopy
- Sclerotherapy (subject to motivation)
- Surgical biopsies (needle biopsies) (subject to motivation)
- Tonsillectomy (laser)
- Vasectomy
- Stitching of wounds
- Excision and repair
- Drainage of subcutaneous abscess & avulsion of nail
- Removal of foreign body superficial to deep fascia
- Circumcision - clamp
- Any other minor surgical procedures if adequately motivated

Contact the Call Centre to confirm whether your in-room procedure, if not listed above, is covered.

You can still authorise your treatment on the first working day after the procedure, if your circumstances do not allow you to do so beforehand. These procedures are more cost effective when performed in a doctor's room and will be paid from the hospital and trauma benefit provided the procedure is authorised.

What treatments by a practitioner while in hospital are covered?

- If you are diagnosed and need to be admitted to hospital, it will be to your advantage if the admitting practitioner is part of the Nedgroup GP and Specialist Network, as you will obtain cover of up to 2 x Medical Scheme Rate. In addition, you will NOT be required to make a co-payment on the hospital claim.
- If your treating practitioner is not part of the Nedgroup GP and Specialist Network, all accounts will be covered at Medical Scheme Rate. In addition, you will be required to make a co-payment on the hospital claim (unless it was an emergency case). There will be no co-payment on the **Platinum** Plan, but payment will be limited to the Medical Scheme Rate.
- If you are referred to a specialist, you should check with your administrator whether the specialist is part of the Nedgroup specialist network, **as you will probably not be in a position to change your specialist at the time of requesting pre-authorisation or admission.**

To find out whether the practitioner is on the Nedgroup GP and specialist network, please contact Medscheme on 0860 100 080, or log onto the Member Zone via nmas.medscheme.com.

IMPORTANT!
If you are on any Plan other than Platinum and you are admitted to hospital by a GP or specialist who is not on the Nedgroup network, you will incur a R2 500 co-payment.

In addition, if you are on the Hospital Network Plan and you are voluntarily admitted to a non-network hospital, you will incur a R7 000 co-payment.

How does pre-authorisation before hospitalisation work?

IMPORTANT!
You need to pre-authorise any admission to hospital, or you will incur a penalty of R500 (unless it was an emergency).

- The purpose of pre-authorisation is not only to enable the Scheme to manage the exorbitant cost of hospitalisation, but also to ensure that our members receive the most appropriate and effective treatment available.
- Before you are admitted to hospital, other than for an emergency, you need to notify the Scheme at least three working days before the admission date. This is known as pre-authorisation.
- It is recommended that you obtain authorisation at least ten days before being hospitalised for a procedure where an implant or an internal prosthesis will be necessary, for example, a knee replacement (quote to be provided).
- Pre-authorisation is also required for MRI, radio-isotope and CAT scans. If you need these procedures, please follow the process in the table below.
- If you do not inform the Scheme of a planned stay in hospital, you will be charged a penalty of **R500.** The Scheme could also call for medical evidence explaining why the treatment took place in hospital and reserve the right not to pay for these medical expenses.

PLEASE NOTE
An authorisation is confirmation that the claims will be paid at Scheme tariff or the negotiated tariff, provided you are a registered beneficiary and your contributions are fully paid up at the time of receipt of the claims. If your provider charges more than the Scheme tariff or the negotiated tariff, you will be liable for the difference between the amount charged by the treating provider and the amount paid by the Scheme. It is recommended that you obtain a quote from the treating provider (if you select a non-network specialist) and confirm the Scheme tariff. This will enable you to negotiate with the treating provider specifically on the tariff (if you select a non-network specialist) prior to the procedure. Any shortfalls will be for your account.

To pre-authorise, please follow the process below (your GP/specialist or the hospital can also do this on your behalf)

- Contact Hospital Benefit Management on 0860 100 080 (or email nedgroup.authorisations@medscheme.co.za three working days before being admitted to hospital (ten days for implants or internal prostheses).
- In the case of an emergency, you must arrange to notify Medscheme on the first working day after being admitted.
- Please make sure that you have the following information on hand when calling:
  - your membership number
  - name and date of birth of patient
  - the name and the practice number of the hospital
  - the proposed treatment or procedure/tariff code (ICD10 code) and CCSA code
  - the planned date of admission to the hospital
  - name and practice number of the doctor who wishes to admit you to hospital and
  - contact person's details while you are in hospital
- The consultant will confirm the benefits available for the procedure and whether your hospital admission is approved.
- You will receive a pre-authorisation number, which the hospital will require when you are admitted. If your hospitalisation is postponed, you will need to update your pre-authorisation. If you are re-admitted to hospital, you will need to pre-authorise again.
- If you/your dependants are scheduled to undergo an operation in the afternoon, you should ask your doctor to admit you/them after 12:00. In this way the Scheme can avoid incurring unnecessary hospital costs.

THE PROCESS AFTER YOU ARE ADMITTED

The hospital must obtain approval from the Scheme (via the Case Manager) for stays that exceed the number of days that were initially pre-authorised.

On the day of discharge, patients should arrange to leave the hospital before 12:00. In this way the Scheme can avoid incurring unnecessary hospital costs.

What services and procedures are covered during hospitalisation?

- Services and procedures are usually covered at cost or **Medical Scheme Rate** (MSR), whichever is the lesser.
- See the tables further down for the full list of the services and procedures that are covered, as well as the sub-limits that apply.
- Any services provided in the hospital that are not related to the admitting diagnosis will not be covered (in other words, diagnostic tests not related to the reason for admission).
- For the Scheme to consider covering the additional medical services that were not authorised or approved at pre-authorisation stage, a clinical motivation from the member or treating provider will need to be submitted to the Scheme. The request will be considered and evaluated in accordance with the Scheme's evidence based managed care protocols and the member will be informed of the outcome. Any additional medical services which do not meet the Scheme's evidence based managed care protocols will be for your account.

DENTISTRY

- Hospitalisation will only be considered for basic dentistry procedures performed on beneficiaries who are 7 years or younger . In this case, the Hospital and the Anaesthetist will be paid from the Hospital and Trauma benefit and the Dental Practitioner will be paid from Everyday Services Benefit if your Plan has that benefit.

NEW **PLEASE NOTE: A R1 500 co-payment will apply to all dental admissions. There is no cover for in-hospital dental work on the Hospital Network Plan (other than for the removal of impacted wisdom teeth, in which case a R1 500 co-payment will apply) and any such claim will be for the member's own account.**

- All dental-related cases requiring surgery, which do not fall within the surgical class of tariffs, need to be motivated by the attending dental practitioner.
- **Orthodontic treatment** for persons over the age of **21 is excluded** from this benefit **for all Plans.**

LAPAROSCOPIC SURGERY AND OTHER SURGERIES WITH A CO-PAYMENT

- Laparoscopic procedures are more expensive, and the procedure may in general be performed as an open procedure. The Scheme has therefore decided, like many other medical schemes, to fund these procedures with a co-payment, rather than only cover open procedures.
- Members who undergo the following procedures will therefore be liable for the co-payments shown below (excluding PMB level of care):

PROCEDURE	CO-PAYMENT
Laparoscopic hernia repair	**R2 500**
Laparoscopic hysterectomy	**R2 500**
Laparoscopic radical prostatectomy	**R2 500**
Laparoscopic pyeloplasty	**R2 500**
Knee arthroscopy	**R2 500**
Upper GI endoscopy (gastroscopy)	**R500** (If performed in a doctor's rooms, no co-payment will apply.)
Balloon sinuplasty	**R2 500**

PSYCHIATRIC SERVICES

- This benefit covers hospitalisation and all associated accounts, for example, psychiatrist, psychologist, anaesthetist, general practitioner, occupational therapist, social worker, physiotherapist, pathology, radiology and medication.
- It also covers consultations with a psychiatrist on an outpatient basis in the place of hospitalisation, provided that this has been pre-authorised and approved.
- The Scheme covers a maximum of three days' hospitalisation for beneficiaries admitted by a GP or specialist physician.
- If a patient is not admitted to a registered psychiatric facility, the psychiatrist must arrange for a transfer to an accredited facility as soon as it is possible to do so. Alternatively the patient must be discharged.
- A psychiatrist must assess these admissions as appropriate.
- The Scheme does not pay for sleep therapy, since it is not recognised as therapeutic by the Association of Psychiatrists.

INTERNAL PROSTHESES

These are manufactured substitutes that are surgically implanted for a diseased or missing part of the body, or used to improve the function of a diseased or damaged organ.

PLEASE NOTE

The cost of prostheses may be more than what is covered by the Scheme, in which case you will be liable for the difference. Discuss the various alternatives with your service provider and ask for quotes that are more aligned with your benefit limit.

How does pre-authorisation by a case manager work?

Before you receive the treatment, you need to contact the Scheme and apply for the specific benefit. This applies to the following benefits – physiotherapy following an admission, home oxygen, hyperbaric oxygen therapy and renal dialysis.

PLEASE MAKE SURE THAT YOU PROVIDE THE FOLLOWING INFORMATION TO THE CASE MANAGER:

- your membership number
- name and date of birth of patient
- the proposed treatment or tariff code (ICD10 code)
- the quotation and/or treatment plan
- name and practice number of the doctor
- clinical motivation

Services and procedures covered during hospitalisation

The following services and procedures are covered at **cost or Medical Scheme Rate**, whichever is the lesser, unless otherwise stated. When multiple procedures are done, modifier 0005 is/could be applicable to the procedure (which reduces the chargeable amount); this means the treatment is paid at a sliding scale. The first procedure will be paid at Medical Scheme Rate (MSR), the second procedure at 0.75 x MSR, the third procedure at 0.5 x MSR and the fourth and subsequent procedures at 0.25 x MSR. It is recommended that you obtain a quote from your doctor (if you select a non-network specialist) and confirm the Scheme tariff. This will enable you to negotiate with your doctor to charge medical scheme rates or to give you a discount, if he or she has opted not to bill medical scheme rates. Any shortfalls for a non-network specialist (other than an emergency) will be for your account.

PLEASE NOTE

The Scheme may from time to time contract with or pilot with credentialed specific provider groups (networks) or centres of excellence in order to ensure cost effective and appropriate care. Beneficiaries are entitled to benefits from contracted networks appointed as the Scheme's DSP for PMB benefits and other benefits. The Scheme reserves the right to not fund, partially fund or impose a co-payment for services acquired outside of these networks provided reasonable steps are taken by the Scheme to ensure access to the network.

What if I need a knee or hip replacement?

If you meet the necessary criteria on examination by the orthopaedic surgeon, you must use the Scheme's Designated Service Providers (DSPs) for knee and hip replacements to ensure that you do not incur a co-payment for your surgery. A R10 000 co-payment will be payable by the member for the voluntary use of a non-DSP provider for hip and knee arthroplasties and/or replacement surgeries.

The DSPs are ICPS (Improved Clinical Pathway Services) and JointCare, two groups of orthopaedic surgeons that specialise in performing hip and knee replacements according to standardised clinical care pathways.

These care pathways have been developed in accordance with evidence-based outcomes to ensure that the quality of the hip and/ or knee replacement is of the highest standard and to ensure the best health outcomes. They use multidisciplinary teams dedicated to assist with rapid and successful recovery, keeping the patient as comfortable as possible during the healing period.

Hospital Network and Savings Plans only offer cover for procedures that qualify as PMB.

WHAT TO DO IF YOU NEED A HIP OR KNEE REPLACEMENT:

- Call the Contact Centre on 0860 100 080 and you will be given the details of a DSP orthopaedic surgeon closest to you.
- Consult with the DSP orthopaedic surgeon to see whether you meet the criteria for their clinical care pathway.
- If you meet the criteria, an application for an authorisation number will be arranged on your behalf by the admin staff at the practice. This will ensure payment in full, with no co-payment for the procedure.

For further enquiries regarding the DSPs for hip and knee replacements, please call the Contact Centre on 0860 100 080.

(Also see the chapter *Co-Payments, Penalties and Out-of-Pocket Expenses*.)

	SERVICE CATEGORY	BENEFIT
	Unlimited cover for major medical expenses, subject to the pre-authorisation and case management process and, for cases over R500 000, subject to the Medical Advisor's approval. Certain sub-limits apply.	
1	**Co-payments** (refer to the *Co-payments, Penalties and Out-of-Pocket Expenses* chapter.)	NEW • **Hospital Network** Plan members or beneficiaries who are voluntarily admitted to a non-network hospital will incur a **R7 000** co-payment. • Laparoscopic procedures listed under *Laparoscopic surgery and other surgeries with a co-payment* in the section above will attract a co-payment of **R2 500** for all admissions, except for PMB related conditions. • Where the admitting doctor is not on the Nedgroup specialist network (except for emergencies), the account will attract a hospital co-payment of **R2 500** (except for members on the **Platinum** Plan). • Dental admissions will attract a co-payment of **R1 500** for all admissions.
2	**Private and Public Hospital accommodation** To avoid incurring unnecessary hospital costs: • On the day of discharge, you should arrange to leave the hospital before 12:00. • If scheduled to undergo an operation in the afternoon, you should ask your doctor to admit you after 12:00.	**Medical Scheme Rate** for accommodation in: • a general ward • theatre • recovery rooms • intensive care unit • high care unit • specialised intensive care Benefits for private or isolated wards are paid at general ward rates, unless there is an acceptable medical reason and pre-approval is obtained from the Case Manager. You will be responsible to pay the difference. **Medical Scheme Rate** for operating theatres. The benefit for nursing homes applies to registered facilities only and for short-term episodes of acute care only, in the place of hospitalisation and excludes frail care and long-term care.
	• **Facility fees** (refer to *What are Hospital and Trauma benefits?* at the beginning of this chapter.	**Platinum** Plan: Paid from Routine Medical benefit limit. **Savings** and **Comprehensive** Plans: Paid from Personal Medical Savings Account. **Other Plans**: No benefit; for member's own account.
	• **Medicine on discharge (TTO)**	Limited to **R600** per beneficiary per admission, and must be supplied on the day of discharge from hospital.
3	**Nursing services**	**100% of cost** with a **sub-limit of R18 770** per family per year in a registered facility only and subject to pre-authorisation. **This benefit covers home services by a registered nurse for short-term episodes of acute care** as an alternative to hospitalisation for: • Wound care • Pre- and post-confinement treatment by a registered midwife • Infusions • Post-operative care Only necessary medical services will be covered. Activities relating to daily living such as cooking, laundry, telephone calls and hairdressing will not be covered under this category.

4	**Prescribed Medication** (Nursing homes/Hospice)	Medication provided may be covered from either the Everyday Services Benefits, or Personal Medical Savings Account, where applicable. Prescribed (acute) medicines will not be covered on the **Hospital Network** Plan, except for Major Depression and those conditions covered under Prescribed Minimum Benefits. **PLEASE NOTE:** ***You must apply for this benefit and it must be pre-authorised by the Case Manager.***
5	**Hospices**	**Cost or Medical Scheme Rate**, whichever is the lesser, limited to **R34 780** per family per year. The medication will be subject to your Prescribed medicine (acute) sub-limit.
6	**Ambulance services**	**Tariff** agreed with the Scheme's preferred provider, ER24.
7	**Maternity** • **Confinement in hospital**	**Cost or Medical Scheme Rate,** whichever is the lesser, subject to the overall annual limit. As per clinical guidelines and protocols. Further days will require motivation by the attending doctor and approval by a Case Manager.
	• **Midwife delivery**	Society for Private Nurse Practitioners' tariffs, including pre-and-post confinement costs, if a gynaecologist is not used.
	• **Confinement in a registered birthing unit**	**Cost or Medical Scheme Rate,** whichever is the lesser, subject to the overall annual limit. Including 4 x post-natal midwife consultations per event.
8	**General practitioners & medical specialists in hospital**	The Scheme has appointed a Nedgroup GP and Specialist Network as our Designated Services Provider. If you are referred to a specialist, please check with your administrator whether the specialist is part of the Nedgroup Specialist Network. **Scheme negotiated tariff** for a network specialist or **Medical Scheme Rate** for the specialist who is not part of the Nedgroup Specialist Network for the following services: • surgery • procedures in hospital • anaesthesia • applicable portion of assistant's fees at operations • hospital visits
	• **Dental practitioners in hospital**	**Platinum** Plan: Paid from Routine Medical Benefit limit **Comprehensive** Plan: Paid from Everyday Services Benefit limit **Traditional** Plan: Paid from Everyday Services Benefit limit **Savings** Plan: Paid from Personal Medical Savings Account **Hospital Network** Plan: No benefit; for member's own account.
9	**Radiology and Pathology** General Radiology and Pathology (in hospital)	**Medical Scheme Rate** subject to the overall annual limit.
	• **Specialised Radiology** (in and out of hospital) MRI scans, radio-isotope scans and CAT scans (wherever the service is provided – excluding PET scans), subject to pre-authorisation.	**Medical Scheme Rate** up to a maximum of **R19 080** per family per year
	• **Ultrasound scans** (in and out of hospital – other than pregnancy scans)	**Medical Scheme Rate** up to a maximum of **R7 350** per family per year.
10 NEW	**Dental implants or Building up of Teeth** (In and out of hospital) On the **Comprehensive**, **Traditional** and **Savings** Plans a **R1 500** co-payment will apply for in-hospital procedures..	**Hospital Network** Plan: No benefit; for member's own account. **Savings** Plan: Paid from Personal Medical Savings Account **Platinum**, **Comprehensive** and **Traditional** Plans: **Medical Scheme Rate**, with a sub-limit of **R16 120** per family per year for the cost of implant placements and implant components or the building up of a tooth. Please note: The building up of a lost tooth refers to the actual implant and implant components. The structure that is placed on the implant refers to the crown – in this case the implant-supported crown. A crown is categorised as advanced dentistry and will therefore be payable from your available Everyday Services Benefits. Hospital-related costs such as accommodation, specialist fees, theatre fees as well as associated services are subject to the normal Hospital and Trauma Benefit limits. A dental treatment plan will be required for every phase of treatment and needs to be submitted to the Scheme and approved before the procedure.

11	**Orthognathic surgery** (Functional correction of malocclusions)	**Platinum**, **Comprehensive**, and **Traditional** Plans: Limited to and included in the overall annual limit. **Savings** Plan: Paid from Personal Medical Savings Account. **Hospital Network** Plan: No benefit; for member's own account. Includes all services rendered, including the cost of special investigations, hospitalisation, all general and specialist dental practitioners, their assistants and anaesthetists as well as the cost of materials, all implant components, plates, screws and bone or bone-equivalent in respect of the orthognathic surgery procedure.
12	**Maxillofacial and oral surgery**	**PMB only**
13	**Physiotherapy** • **In hospital**	**Cost or Medical Scheme Rate**, whichever is the lesser, subject to the overall annual limit.
	• **After hospitalisation, if linked to the hospital admission**	**Cost or Medical Scheme Rate**, whichever is the lesser. This benefit must be pre-authorised by the Case Manager before discharge from hospital. It is limited to a maximum of ten appointments and treatment within 30 days of discharge from hospital or within a reasonable period of discharge.
14	**Physical Rehabilitation**	**Medical Scheme Rate** with a sub-limit of **R79 770** per family per year, subject to approval by the Case Manager. This benefit will only be allowed for the following non-progressive conditions: acute disablement as a result of a stroke, spinal cord injury or brain injury (where injury refers to a lesion relating to the above only and is caused by trauma, infection, surgery, bleeding or infarction). This benefit includes all associated accounts.
15	**Mental health** • **Psychiatric treatment**	**Negotiated tariff** up to a maximum of 21 days per beneficiary per year or **outpatient psychotherapy, up to 15 days' contact sessions**. This benefit is subject to pre-authorisation. This benefit covers all related costs.
	• **Treatment and accommodation for substance abuse**	**Negotiated tariff** up to a maximum of 21 days per beneficiary per year. This benefit is subject to pre-authorisation. This benefit covers all related costs.
16	**Oncology** (Including approved, related medication, MRI, CAT and radio-isotope scans as well as chemotherapy, radiotherapy, oncologists' consultations, mammograms, radiology and pathology fees)	**The Scheme has appointed the Nedgroup Oncology Network and Pharmacy Direct as our Designated Service Providers for oncology.** If you are referred to a provider for oncology related treatment, please check with your administrator whether the provider is part of the Nedgroup Oncology Network. **Medical Scheme Rate** for non-DSP, or **negotiated tariff** for DSP, with the following sub-limits, provided the patient enrols on the Oncology Benefit Management Programme. **Platinum**, **Comprehensive**, and **Traditional** Plans: **R655 310** per family per year (with ICON Enhanced Protocols) **Savings** and **Hospital Network** Plans: PMB only (with ICON Standard Protocols) A 12-month care plan must be submitted to the Case Manager, and is subject to approval by the Case Manager in terms of the Scheme's managed care protocols for the diagnosis. The care plan should include the date of diagnosis, the area concerned, any prior surgery or treatment, new treatment requests, as well as approximate costs. • The cost of a mammogram will be covered if it forms an integral part of the care plan, submitted by your oncologist. • Vitamins, antibiotics, alternative medicine, sleeping tablets, anti-anxiety and medicines for depression will not be covered. • Medicines must be registered with and approved by the South African Health Products Regulatory Authority for the specific diagnosed condition. **Platinum**, **Comprehensive** and **Traditional** Plans: Herceptin 12-month course of treatment will be covered as per clinical protocols and guidelines for adjuvant treatment of early breast cancer. Limited to and included in the Oncology benefit during the remission period following the active treatment period.
	• **Social worker – Oncology treatment**	**Medical Scheme Rate or cost**, whichever is the lesser, for consultations with a social worker, up to a sub-limit of **R3 280** per family per benefit year on referral from the Nedgroup Oncology Network for terminal cases.
	• **PET scans**	**Medical Scheme Rate** with a sub-limit of **R33 110** per family per year, subject to the approval of the Case Manager.
	• **Brachytherapy** (Including seeds, disposables and equipment. Subject to the Oncology Managed Healthcare Programme.)	**Medical Scheme Rate** with a sub-limit of **R50 020** per family per year.

	• **Specialised drugs for Oncology** (Subject to the relevant managed healthcare programme and to its prior authorisation. The Oncology Specialised Drug List is a continuously evolving list of drugs used for the treatment of cancers and certain haematological conditions. This list includes but is not limited to targeted therapies, for example, biologicals, tyrosine kinase inhibitors and other non genericised chemotherapeutic agents. Subject to a published list.)	**Platinum**, **Comprehensive**, and **Traditional** Plans: **Medicine price** with a sub-limit of **R221 340** per year, subject to the Overall Oncology Benefit (with ICON Enhanced Protocols). **Savings** and **Hospital Network** Plans: PMB only (ICON Standard Protocols) A member on the **Hospital Network** or **Savings** Plans will have the choice to upgrade to a plan with enhanced Oncology benefits within 60 days of the member or one of his/her dependants being diagnosed with cancer or having to undergo Oncology treatment. Any request to upgrade after 60 days will require motivation and approval by the Scheme. **Pharmacy Direct is the Designated Service Provider for specialised drugs for oncology.**
17	**Non-Oncology specialised drugs** (The non-oncology specialised drug list is a continuously evolving list of high cost drugs used for the treatment of chronic conditions. This list includes but is not limited to biological drugs (biological therapy for inflammatory arthritides, inflammatory bowel disease, chronic demyelainating polyneuropathies, chronic hepatitis, botulinum toxin, palivizumab). Unless otherwise stated, for any other diseases where the use of the drug is deemed appropriated by the managed health care organisation, drugs will be funded from this benefit. Subject to a published list.)	**Platinum**, **Comprehensive**, and **Traditional** Plans: **Medicine price** with a sub-limit of **R198 730** per family per year, subject to application and approval under the Scheme's managed care protocols. **Savings** and **Hospital Network** Plans: PMB only **Pharmacy Direct is the Designated Service Provider for non-oncology specialised drugs.**
18	**Macular degeneration drugs**	**Platinum**, **Comprehensive**, and **Traditional** Plans: **Medicine price** with a sub-limit of **R62 440** per family per year, subject to a motivation received from the provider and subsequent approval. **Savings** and **Hospital Network** Plans: PMB only
19	**Blood transfusions**	**Cost or Medical Scheme Rate**, whichever is the lesser (cost of material, apparatus and operator's fee).
20	**Perfusion services**	**Cost or Medical Scheme Rate**, whichever is the lesser (cost of material, apparatus and clinical technologist's fee).
21	**Organ Transplant / donor services** • **Organ transplant**	**Cost, subject to Prescribed Minimum Benefits.** Proposed transplants need to be pre-authorised. An application, together with the relevant treatment plan, which the patient must obtain from his/ her doctor, should be submitted, after which the relevant Case Manager will contact the patient. **Medicine price** for anti-rejection drugs, subject to pre-authorisation, provided that drugs from a preferred provider are used.
	• **Organ donors**	Subject to pre-authorisation, the benefit is only available to live donors who are beneficiaries of the Scheme. A donor belonging to the Scheme will also be covered when donating to a recipient who is not a member of the Scheme.
22	**Corneal graft (material)**	**Cost, limited to R35 000**, subject to the relevant managed healthcare programme and to pre- authorisation, as well as approval by the Scheme before starting work-up for transplantation. Associated costs are covered from the Overall Annual Limit.
23	**HIV/AIDS Benefit**	Benefits are unlimited, subject to approval for medication and medical management. Mother-to-child, accidental exposure and rape-prophylactics must be pre-authorised by the HIV/AIDS Care Manager. For a rape case, the hospital will provide a three-day "starter kit" of anti-retroviral treatment, which will fall under the HIV/AIDS limit. If this medication is required for a further 28 days, the additional benefit needs to be pre-authorised by the Care Manager.
	• **HIV Testing**	It covers the following services: • Pre-testing counselling • Testing and post-test counselling

24	**Internal prostheses (devices surgically implanted)** Including all accompanying temporary or permanent devices used to assist with the guidance and alignment of these internal prostheses and devices. Patients may pre-authorise 10 working days prior to admission for a joint replacement or spinal fusion operation. ICPS (Improved Clinical Pathway Services) and JointCare are the Scheme's DSP for hip and knee replacement. They are two groups of orthopaedic surgeons that specialise in performing hip and knee replacements according to standardised clinical care pathways, for knee and hip replacements. These care pathways have been developed in accordance with evidence-based outcomes to ensure that the quality of the hip and/or knee replacement is of the highest standard and to ensure the best health outcomes. Call us on 0860 100 080 and ask for the details of an ICPS orthopaedic surgeon closest to you.	**Cost** for specific prosthesis applied for, subject to the relevant managed healthcare programme and to prior authorisation. The following specific sub-limits apply per beneficiary per year (unless stated otherwise): ***Cardiac system:*** • Cardiac pacemakers: **R80 500** per beneficiary per year • Cardiac stents (including the carrier) and drug eluting-balloons. **R33 470** per stent per beneficiary, limited to 3 x stents • Cardiac valves: **R47 410** per valve per year, limited to 2 x valves. On the **Platinum**, **Comprehensive**, and **Traditional** Plans, inoperable patients who meet the required criteria may qualify for Transcatheter Aortic Valve Implementation (TAVI) to the value of **R228 790**. NEW • Cardiac Resynchronisation Therapy (CRT): **R55 630** ***Central nervous system:*** • Neuro-stimulation (ablation devices for Parkinson's): **R53 010** • Vagal stimulator (for intractable epilepsy): **R44 730** ***Endovascular devices:*** • Aorta stent grafts: **R137 720** per stent (including the delivery system), limited to 1 stent. • Carotid stents: **R23 360** • Detachable platinum coils: **R58 130** • Embolic protection devices: **R57 970** • Endovascular aneurysm repair (EVAR) stent grafts: **R150 000** • Peripheral arterial stent grafts: **R48 020** ***Orthopaedic prostheses and devices including cement and antibiotic cement:*** • Elbow replacements: **R51 350** per elbow • Total hip replacement: **R60 840** per hip • Total knee replacement: **R67 260** per knee] **Hospital Network** and **Savings** Plans **PMB only** NEW • Total shoulder replacement: **R58 500** per shoulder • Spinal instrumentation: **R72 310** • Bone lengthening devices: **R52 160** • Other approved spinal implantable devices and intervertebral discs: **R58 130** ***Opthalmic system:*** • Intraocular lenses: **R3 710** per lens, limited to 2 lenses. ***Any other prostheses not listed above:*** • **R65 310**, subject to Case Management approval. The following prostheses are also covered by the Scheme: Cables, Plates: screws, orthopaedic staples, K-wires and rods, Staples (bones), Exo-skeletal apparatus, Cardiac and rings, Silicone bands (intra-ocular surgery), Ventriculo-peritoneal/ Pleural shunt, Tension-free vaginal tapes/slings, Coral implants, Bone Cement, Aortic grafts, Artificial sphincter (M), Aortic modular stents (M), Hepatic stents, Breast prosthesis (M). The items above indicated by an "M" must be motivated by a medical practitioner.
25	**All refractive procedures** (Including Lasik, radial keratotomy, and phakic lenses)	**Cost or Medical Scheme Rate**, whichever is the lesser. **Platinum**, **Comprehensive** and **Traditional** Plans: **R15 290** per family per year for hospital and associated services. Hospital related costs such as accommodation and theatre fees, as well as associated services, are subject to this limit. Benefits will only be granted if medical reports, as required by the Scheme, are submitted to prove that this operation is necessary, based on medical grounds and within the set refraction limit of the Scheme's guidelines. **Platinum** Plan: Once this limit has been exceeded, claims will be paid from the Routine Medical Benefit. **Savings** Plan: Paid from Personal Medical Savings Account. **Hospital Network** Plan: No benefit; for member's own account.
26	**Artificial limbs and artificial eyes**	**Cost** according to clinical protocols, subject to the relevant managed healthcare programme and to the following sub-limits: • Artificial leg: **R83 720** per beneficiary (every 2-3 years for children and every 5 years for adults) • Artificial arm: **R83 720** per beneficiary (every 2-3 years for children and every 5 years for adults) • Artificial eye: **R29 190** per beneficiary (every 2-3 years for children and every 5 years for adults)

27	**Renal dialysis** (Including related pathology, scans and consultations.)	**Cost or Medical Scheme Rate**, whichever is the lesser. **Savings** and **Hospital Network** Plans: PMB only **PLEASE NOTE:** *A 12-month treatment plan must be submitted to the Case Manager and is subject to approval in terms of the Scheme's managed care protocols. This plan should include the following information:* • date of diagnosis • area concerned • any prior surgery or treatment • ICD10 code • tariff code • doctor's practice number • new treatment requested • the approximate cost Subject to pre-authorisation for the related medication from a preferred provider.
28	**Home oxygen therapy** (Subject to the relevant managed healthcare programme and pre-authorisation.)	**Cost** with a sub-limit of **R19 700** per family per year. **PLEASE NOTE:** *You must apply for this benefit and it must be pre-authorised by the Case Manager.*
29	**Hyperbaric oxygen therapy**	**Cost or Medical Scheme Rate**, whichever is the lesser, with a sub-limit of **R64 390** per family per year. **PLEASE NOTE:** *This benefit must be motivated by a specialist and pre-authorised by the Case Manager. It will not be approved for the treatment of strokes, cerebral palsy, diabetic wounds and ulcers. The therapy is used to treat arterial gas embolism, carbon monoxide poisoning, crush injuries, thermal burns and many other conditions.*
30	**Stoma care products**	**Cost** with a sub-limit of **R22 910** per family per year.
31	**Breast reduction**	**Cost or Medical Scheme Rate**, whichever is the lesser. Subject to submission of a motivation by the treating provider and submission of medical reports as required by the Scheme. Benefits are subject to approval of the procedure by the Scheme's medical advisor on the grounds that patient meets the clinical criteria (such as Body Mass Index) applied by the Scheme in terms of the Scheme's managed care protocols.
32	**Cochlear implants**	**R250 000** per implant Subject to one implant per beneficiary per ear for life. **R125 000** maintenance or replacement of processors per beneficiary every 5 years

PLEASE NOTE

All hospitalisation is subject to the Scheme's contracted managed healthcare programmes, which include the application of treatment protocols, formularies, pre-authorisation and case management.

The Scheme reserves the right not to pay for procedures performed by non-recognised providers (where applicable).

Certain procedures may be associated with a significant learning curve and/or are not taught routinely at local universities and/or require special training and experience, including that aimed at maintenance of expertise, and/or need access to certain infrastructure for quality outcomes. Where such procedures have been identified by the Scheme's managed care provider, recognised providers are those who have been acknowledged by meeting minimum training and practice criteria for the safe and effective performance of such procedures. Recognition occurs as a result of a formal application process by interested providers and adjudication of relevant information against competency guidelines by the managed care provider and/or appointed credentialing body. Criteria for formal recognition are informed by clinical evidence, clinical guidelines and/or expert opinion.

The Scheme (or contracted managed care company on behalf of the Scheme) may from time to time contract with or credential specific provider groups (networks) or centres of excellence as determined by the Scheme in order to encourage high-quality, cost effective and appropriate care. The Scheme reserves the right not to fund or partially fund services acquired outside of these networks, provided reasonable steps are taken by the Scheme to ensure access to the network.

IMPORTANT!
Medical care abroad can be very expensive (depending on the country you will be travelling to) and, given our exchange rate, it would probably not be fully covered, so it may be wise to take out additional medical cover. Your travel agent will be able to assist you with this.

11

BENEFITS: HEALTHCARE COSTS WHILE TRAVELLING

What should I keep in mind if I plan to travel outside South Africa?

You will be glad to know that you can claim from the Scheme for medical expenses incurred while travelling outside South Africa. However, you need to be aware of the following:

- You will be responsible for settling the account upfront. You can then submit the claim to the Scheme when you return.
- If your account is in a foreign language, it must be fully translated and detailed before you submit it to the Scheme.
- When you send in foreign claims, please add a cover letter or email explaining the situation. The more detailed your cover letter and claim, the quicker the Scheme can process the claim. You need to clearly indicate the following details:
  - The name of the country in which you were treated
  - Treatment dates
  - Whether there was anaesthesia involved and if so, how long it was for
  - The medicine, materials, treatment, procedures and operations involved. These must all be clearly specified and charged individually.
  - The patient's name
  - The currency in which the claim was paid
- Submit your claim to: foreign.hos@medscheme.co.za
- Your claim will be subject to the Scheme's Rules as if the treatment was rendered in South Africa. In other words, the same exclusions, benefits and limits will apply.

PLEASE NOTE
In the event of the claim being covered under your travel insurance policy, you will not qualify for a refund for the claim from the Scheme. Should you claim from the Scheme and fail to disclose that you have been indemnified by your insurer for this claim, this will be regarded as fraud.

- Your claims will be paid according to the equivalent tariff and will be refunded to you in Rands, at the exchange rate that applied on the treatment date.

TIP **If you or one of your accompanying dependants use chronic medicine, you must also remember to arrange for advance supplies by contacting ScriptPharm on 011 100 7557, or visiting www.scriptpharm.co.za, for an extended supply form. The completed form, together with a copy of the flight tickets and travel initerary must reach ScriptPharm at least ten working days before you leave, to ensure that you receive your medication in time.**

What if we have a medical emergency outside the borders of South Africa?

Members outside the borders of South Africa (members in Lesotho, Swaziland, Zimbabwe, Botswana, Namibia, Mozambique and Angola) may call ER24 by dialling +27 10 205 3052 for the following services:

- Life-threatening emergency (primary)
- For primary service, but not life-threatening
- Any inter-hospital transfers

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BENEFITS: EMERGENCY SERVICES

CALL 084 124

IN AN EMERGENCY

You and your loved ones have access to emergency medical transportation (if authorised by ER24) 24 hours a day, 7 days per week, in South Africa, Lesotho, Swaziland, Zimbabwe, Botswana, Namibia, Mozambique and Angola. (Call +27 102 053 038 if outside the borders of South Africa.)

FOR MEDICAL ADVICE

ER24 also has an "Ask the Nurse" medical advice and information line. Although it is not possible to make an accurate diagnosis over the phone, this can help you decide whether you need an ambulance, see your doctor, or simply go to the pharmacy.

What to do in an emergency situation

You and your registered dependants will have access to emergency medical transportation in South Africa 24 hours a day, 7 days per week, provided that this is authorised by ER24 (the Scheme's DSP for emergency medical services). Services offered by ER24 include:

- 24-hour access to the ER24 Emergency Call Centre
- Dispatch of emergency response
- Medical transportation by ambulance or aircraft as deemed medically necessary
- Authorised inter-hospital transfers

In addition to emergency transportation, you also have access to emergency medical advice and assistance.

ER24's operators will guide you through a medical crisis situation, provide emergency advice and arrange for you to receive the support you require – available at all times.

Remember that, in the case of an emergency where you (or your dependants) are admitted to hospital, you must notify the Scheme on the first working day after being admitted.

The Nedgroup Medical Aid Scheme does offer cover for emergency medical assistance outside the borders of South Africa. The cover is limited to Lesotho, Swaziland, Zimbabwe, Botswana, Namibia, Mozambique and Angola.

What else do I need to know if I have to visit an emergency unit?

Medical emergencies are not something you can plan for. However, knowing what to expect in terms of the processes followed at an emergency unit is helpful, as it will allow you to concentrate on your or your loved ones' well-being, should you be involved in a medical emergency.

The first thing you need to be aware of is that you may have to wait for medical attention, and that you should not become anxious about this. The reason for this potential wait is that, when patients arrive at the hospital emergency unit, every patient is assessed and given a score that indicates how severe their condition is. This process is called triage.

According to the triage system, a colour code is assigned to each patient based on this score (which is given according to a checklist of symptoms). Red indicates that very urgent medical intervention is required, while green indicates the least urgent attention required. The colour code therefore reflects how urgently the patient needs treatment. In practice this could mean that some patients who are already waiting for treatment might have to wait a little longer, and that persons arriving later than they have, may be treated first.

The triage system is used internationally to ensure that patients in danger receive immediate attention, rather than having emergency units that operate on a first-come, first-served basis.

A visit to the emergency unit that results in an admission will be covered under the authorisation provided by the Scheme and paid from the Hospital and Trauma Benefit.

Where the visit to the emergency unit does not result in an admission, you will be responsible for the account and may make representations to the Scheme to consider payment of the account. Please note that only where you required urgent treatment will the account be considered by the Scheme.

Avoid having a claim for an ambulance rejected by understanding exactly when you should, and when you should not, arrange for an ambulance to take you to hospital. The most important differentiator in deciding whether an ambulance is appropriate or not, is whether the situation is a real emergency, or not. Read on to see the difference...

Ambulances should always be available for real emergencies. An ambulance should never be used as a transport mechanism when you could have travelled in a private vehicle.

Nedgroup Medical Aid Scheme and ER24 have embarked on a stringent programme to decrease the misuse of ambulances and to try to ensure that ambulance transports are reserved for patients who fit the definition for emergencies:

WHAT IS AN EMERGENCY?

The definition is as follows: *"An emergency medical condition means the sudden and, at the time, unexpected onset of a health condition that requires immediate medical treatment and/or an operation. If the treatment is not available, the emergency could result in weakened bodily functions, serious and lasting damage to organs, limbs or other body parts, or even death."*

All ambulance cases will be audited to assess whether the patient was admitted into hospital and/or whether there was a need for specialised emergency care. If the patient was not admitted and did not require specialised care, the ambulance claim may be rejected and the member may be billed for the transportation.

WHEN SHOULD YOU CALL AN AMBULANCE OR GO TO ER, AND WHEN NOT?

To help members understand when calling an ambulance or visiting a hospital's Emergency Rooms is advisable, and when it will probably just end up costing them money, ER24 has put together the following handy comparison of emergencies versus non-emergencies. If you are uncertain whether a situation is a real emergency, you can also call ER24's helpline on **084 124** for advice.

EMERGENCY CALL AN AMBULANCE / GO TO ER	NOT AN EMERGENCY REFER TO YOUR PHARMACIST / GP
• When a person has or is reasonably believed to have suffered an acute injury or illness requiring medical attention and/or medical transportation by ambulance • A doctor / registered nurse / paramedic has requested the urgent transport of a patient by ambulance • Acute life-threatening scenario	• Patient's life or usual activities would not be immediately threatened by referral to an alternative care facility for treatment at a later time. • Non-urgent health need outside of usual office hours • Alternative transport/ home remedy available
Persistent shortness of breath / Wheezing / Ongoing chest pain that worsens on breathing. Wheezing and difficulty of breathing associated with asthma (with no response to usual medications)	Coughs, colds, flu, bronchitis, earache, sore throat - with or without fever, general weakness
Acute or persistent, severe chest pain, especially if it radiates to the arm or jaw and is accompanied by sweating, vomiting or shortness of breath.	Ongoing, dull, nagging chest discomfort
Sudden, severe onset of abdominal pain (the kind that makes it impossible to walk and wakes one up in agony)	Abdominal pain caused by menstruation, constipation and / or other minor abdominal complaints.
Difficulty speaking, confusion / altered mental state, weakness / paralysis, sudden loss of balance, especially with a history of high blood pressure / in the elderly, sudden loss of vision, seizures, unconsciousness	Fainting, dizziness and headaches in an otherwise healthy person
Fever: >40°C, does NOT respond to Paracetamol, associated with all-over body rash, children under 2 months with fever >38.5°C	**Fever:** <38.5°C, responds to use of Paracetamol, no rash
Ongoing, persistent diarrhoea & vomiting with dehydration (usually > 8 episodes/ day)	Diarrhoea and / or vomiting, patient able to walk around
Trauma: Deep cuts that require stitches – especially on the face, bleeding that won't stop, large open wounds, broken bones / dislocated joints, head injuries with loss of consciousness, eye injuries	**Trauma:** Common sprains & strains, superficial cuts, bleeding stopped with pressure
Severe testicular discomfort	Painful urination, blood in the urine
Burns: Large surface area, burns to the face or a large part of the hand, where the burn encircles the limb, electrical burns	**Burns:** Minor burns and scalding, small surface area
Major allergic reaction: Breathing difficulties, swelling of lips / tongue or throat, dizziness or fainting, rash and itching over entire body	**Minor allergic reactions:** watery eyes, runny nose, minor rash and itching
Poisoning – accidental or intentional	
Back pain after trauma (such as falling), or after back surgery <3 months previously	Back pain after heavy lifting, generalised back spasm
Suicidal thoughts expressed, sudden aggression / psychosis, previous history of psychiatric admission, possible relapse requiring emergency admission	Depression/ emotional trauma

PLEASE NOTE

Treatment received in a hospital's Emergency Room is not an admission to hospital and is regarded as treatment received out of hospital/everyday services. If approved by the Scheme, the claim is payable from your available Everyday Services Benefit.

Furthermore, if you are transported to hospital by an ER24 ambulance (even though approved), and on examination you are found to be fit enough to return home, you will be responsible for arranging your own transport home.

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IF YOU WANT TO SEE A SPECIALIST

To ensure co-ordinated care, and to minimise unnecessary costs, members should be referred to any specialists by their GP. To create a specialist referral, the GP needs to access the Medscheme interactive voice system to obtain a specialist referral number.

The referral number will apply to either a type of specialist (for example, a dermatologist) or a specific specialist for a period of time that the GP decides on, which can be up to 6 months. The patient still has the choice of which specialist to visit.

There are some exceptions to this rule and members will not need a specialist referral number in the following instances:

- 1 visit per year to a gynaecologist for a gynaecological check-up and pap smear for female patients
- 1 visit per year to a urologist for a check-up for male patients
- Visits to a paediatrician for children under 1 year of age
- Visits to optical and dental specialists
- Maternity consultations by a gynaecologist
- Medical management under the Prescribed Minimum Benefit treatment plan

In case of an emergency, where a patient had to consult a specialist without prior authorisation, a referral number can be obtained after the visit. The patient would need to contact his/her GP to obtain the referral number within 72 hours of the emergency.

Members should remember that obtaining a referral number from a GP is not a guarantee of full payment – specialist consultations will be paid up to the Medical Scheme Rate, or such rate as agreed with the specialist, and subject to available benefits. Authorisation will only be valid for six months.

Please remember that all members except those on the **Platinum Plan** will in future have a 30% co-payment for consultations with specialists if they were not referred by their GP.

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CO-PAYMENTS, PENALTIES AND OUT-OF-POCKET EXPENSES

In an effort to manage escalating healthcare costs and over-utilisation of benefits, the Scheme has implemented certain co-payments that would apply under certain circumstances. For ease of reference, this section gives an overview of all the co-payments that you may incur. Depending on your decisions, you may incur one or a combination of these.

HOSPITALISATION

If you are admitted to hospital ...	... you will have to pay	What you can do to avoid additional costs:
for a non-emergency and your admitting practitioner is not part of the Nedgroup GP or Specialist Networks, your claims will be covered at **Medical Scheme Rate**, and...	• the difference between what you are charged by the medical service provider and **Medical Scheme Rate** (on ALL Plans), PLUS • a **co-payment of R2 500** at the point of admission to the hospital (on all Plans except **Platinum**).	Make sure that your admitting practitioner is on the Nedgroup Network, as your hospital claims will then be covered up to **2 x Medical Scheme Rate** and you will not have a **R2 500 co-payment** on hospital bills.
for a non-emergency and you do not contact the Scheme before you are admitted to hospital to pre-authorise your admission (unless it is a valid emergency), ...	a penalty of **R500** (and even run the risk of not having your hospital claims covered).	Always pre-authorise a hospital admission, as well as in-hospital tests such as MRI, radio-isotope or CAT scans, at least three days beforehand. In an emergency, the Scheme must be notified on the first working day after the admission.
for back and neck pain and you did not have an assessment via the Back and Neck Rehabilitation Programme ...	a co-payment of **R2 500**, at the point of admission to the hospital.	If you have back and neck pain, register on the Scheme's Back and Neck Rehabilitation Programme for an assessment.

In addition, for members/beneficiaries on the **HOSPITAL NETWORK PLAN**

NEW

If you are admitted to a NON-NETWORK hospital ...	... you will have to pay	What you can do to avoid additional costs:
for a non-emergency	a co-payment of **R7 000**, at the point of admission to the hospital.	Use only hospitals that are on the specified list of hospitals for the **Hospital Network** Plan.

LAPAROSCOPIC SURGERY AND OTHER PROCEDURES WITH CO-PAYMENTS

Laparoscopic procedures are more expensive, and the procedure may in general be performed as an open procedure. The Scheme, like many other medical schemes, funds these procedures with a co-payment, rather than only cover open procedures.

If you have any of the following procedures*...	... you will have a co-payment of	What you can do to avoid additional costs:
Upper GI endoscopy (gastroscopy)	**R500**	If performed in a doctor's rooms, no co-payment will apply.
Laparoscopic hernia repair	**R2 500**	The alternative, if you do not want to incur the co-payment, would be to undergo open surgery.
Laparoscopic hysterectomy	**R2 500**	
Laparoscopic radical prostatectomy	**R2 500**	
Laparoscopic pyeloplasty	**R2 500**	
Knee arthroscopy	**R2 500**	Certain hospital gap cover products may cover the procedure co-payment.
Balloon sinuplasty	**R2 500**	
In-hospital dental work and you are on the **Comprehensive**, **Traditional** or **Savings** Plan (or **Hospital Network** Plan for removal of impacted wisdom teeth only)	**R1 500**	

*These co-payments will not apply if the procedure qualifies under the Prescribed Minimum Benefits.

NON-EMERGENCY SPINAL FUSION AND HIP/KNEE REPLACEMENTS

If you ...	... you will have to pay	What you can do to avoid additional costs:
live reasonably close to a DBC Centre but declined going for an assessment via the Back and Neck Rehabilitation Programme before undergoing non-emergency spinal fusion surgery	a **R25 000** co-payment (unless you do not live within 30km of a DSP).	Register on the Scheme's Back and Neck Rehabilitation Programme for an assessment.
went for an assessment at DBC and were deemed eligible for the Back and Neck Rehabilitation Programme, but declined to enrol on the programme before going for non-emergency spinal fusion surgery	a **R25 000** co-payment (unless you do not live within 30km of a DSP).	Register on the Scheme's Back and Neck Rehabilitation Programme.
are on the **Platinum**, **Comprehensive** or **Traditional** Plan and have a non-emergency hip or knee replacement that is not under-taken by the Scheme's Designated Service Providers, ICPS or JointCare	a **R10 000** co-payment (unless you do not live within 30km of a DSP).	Choose ICPS or JointCare, two groups of orthopaedic surgeons that specialise in performing hip and knee replacements, for your surgery. Call 0860 100 080 for details of a DSP orthopaedic surgeon closest to you.
are on the **Savings** or **Hospital Network** Plan and want to have a non-emergency hip or knee replacement that does not qualify as PMB	the full cost of the procedure from your own pocket.	Consider upgrading to one of the higher-end Plans that cover hip and knee replacements.

NEW

CONSULTATIONS WITH SPECIALISTS

If you ...	... you will have to pay	What you can do to avoid additional costs:
consult a specialist, without your GP getting a referral for the visit from the Scheme	a **30% co-payment** on the cost of the consultation with the specialist.	Make sure your GP gets a referral number from the Scheme.

ONCOLOGY CONSULTATIONS

If you claim for ...	... you will to pay	What you can do to minimise your costs and make your benefits go further.
a consultation with a non-ICON oncologist	The difference between what is charged and the cover of Medical Scheme Rate.	Use the Scheme's DSP for oncology treatment, Independent Clinical Oncology Network (ICON), as consultations are covered at a negotiated fee. ICON is a dedicated network of oncologists committed to the comprehensive management of members with cancer.

MANAGEMENT OF PRESCRIBED MINIMUM BENEFITS (PMB) CONDITIONS

If you ...	... the following will apply:	What you can do to minimise your costs and make your benefits go further.
are diagnosed with a PMB condition and choose to consult with a GP or specialist that is not on the Nedgroup Network	• Your claims for consultations will be covered at **Medical Scheme Rate** and be paid from your available Everyday Services Benefits (except for **Hospital Network** Plan). • If your Everyday Services Benefits become exhausted, or you are on the **Hospital Network** Plan, the service will be covered from your PMB benefit, with a 25% co-payment that you will need to cover from your own pocket. • If you are admitted to hospital for a PMB condition and it is not an emergency, - you will incur a **R2 500 admission co-payment** (unless you are on **Platinum Plan**), and - your hospital-related claims will only be paid at **Medical Scheme Rate** and you will be liable for the difference. • If you are on the **Hospital Network** Plan and you are admitted to a non-network hospital for a PMB condition and it is not an emergency, - you will incur a **R7 000** admission co-payment and - your hospital-related claims will only be paid at **Medical Scheme Rate** and you will be liable for the difference.	Choose a GP or specialist on the Nedgroup Network, as your PMB-related accounts will then be paid from the PMB benefit at a Scheme-agreed rate, and you will not be liable for any co-payment on your specialist's claim, should you be admitted to hospital.

PHARMACY CLAIMS - PMB, NON-PMB AND ONCOLOGY

If you claim for ...	... then	What you can do to minimise your costs and make your benefits go further.
medication dispensed by a non-Nedgroup Network Pharmacy	For PMB chronic medication, only 75% of the medicine cost will be covered from the chronic medicine benefit. There will be a 25% co-payment at the point of sale, for which you will be liable. For non-PMB chronic medication, in other words medication used to treat Scheme-approved additional chronic conditions (which are Plan-specific), you will be liable for 100% of the cost at the point of sale.	Use a Nedgroup Network Pharmacy for all your PMB and non-PMB chronic medication – refer to the website for a pharmacy locator or call the chronic medicine department for a Nedgroup Network Pharmacy provider in your area.
oncology specialised drugs	You need to make use of the Scheme's DSP, Pharmacy Direct. If you obtain your medication from a pharmacy other than Pharmacy Direct, there will be a 25% co-payment at the point of sale, for which you will be liable.	Use Pharmacy Direct to obtain oncology specialised drugs.

CHRONIC MEDICINE BENEFITS

If you claim for a medicine ...	... then	What you can do to avoid co-payments or additional costs
that is not approved on the chronic medicine programme (benefit) or is not an approved formulary generic	The claim will be not be processed and paid from the chronic benefit. It may be covered from a different benefit or you may be liable to pay for the medication.	• Apply for the chronic medicine programme before claiming any chronic related medicine. • Ensure that your application form is accompanied by relevant supporting documentation and a copy of a valid doctor's prescription. Please note clinical entry criteria and formularies are applied, which will determine the outcome of your chronic application
that is not listed on the Chronic Medicines Formulary or is not the approved item(s) on your chronic authorisation decision letter	The claim for the medication will be rejected and you will be liable to pay for the medication.	If you do not want to incur this cost, use medicine on the Chronic Medicines Formulary. This list of cost-effective medicines is based on local and international studies, and complies with the criteria developed by the Council for Medical Schemes. Members should take their chronic decision letter with them to their pharmacy provider, to ensure that the correct product is claimed.
that is changed in terms of the strength or dosage or medicine type	The claim for the medication will be rejected and you will be liable to pay for the medication.	Send any prescription updates to the chronic medicine department for review and for authorisation updates before claiming any new medication deemed to be chronic.
for a chronic condition that is not on the list of PMB chronic conditions, or on the list of additional Scheme approved conditions (which are Plan-specific)	The claim will be paid from your available Everyday Services Benefits (from the acute medicine sub-limits, where applicable), not from your Chronic Medicine Benefits.	You can apply for an *ex gratia* payment, which will then be considered by the Scheme's *ex gratia* committee. Please note, however, that *ex gratia* applications are only granted in exceptional and deserving cases.
PMB medication and you are on the **Hospital Network** Plan, but you do not use Pharmacy Direct	You will have to make a 25% co-payment.	Use only Pharmacy Direct, the DSP for the Hospital Network Plan, for PMB medication claims.
for depression and you are on the **Hospital Network** Plan, but you do not use Pharmacy Direct	You will have to pay in full for the medicine, as it is not PMB medication.	Use only Pharmacy Direct, the DSP for the Hospital Network Plan, for depression medication claims.
HIV medication	You need to make use of one of the Scheme's DSPS, Pharmacy Direct or Clicks Pharmacy. If you obtain your medication from a pharmacy other than these DSPs, there will be a 25% co-payment at the point of sale, for which you will be liable.	Use Pharmacy Direct or Clicks Pharmacy to obtain HIV medication.

NEW

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INFORMATION FOR RETIREES AND OTHER CONTINUATION MEMBERS

What happens when a member retires?

If you belong to the Scheme before you retire, you can choose to continue to belong to the Scheme, in which case you will be called a continuation member. (Retirees who were not members of the Scheme before retirement do not qualify for membership after retirement.)

PLEASE REMEMBER THAT:

- If you choose to leave the Scheme after retirement, you cannot join the Scheme again at a later stage.

What happens if the member passes away?

If the member passes away, dependants have the choice to become continuation members. In such a case, the Scheme needs to receive the following documents within three months of the member's date of death to ensure continuation membership for the dependants:

A. Copy of the death certificate of the member.

B. Copy of the ID of the surviving spouse/ beneficiary.

C. Copy of bank statement or cancelled cheque to upload bank details for debit order/refund purposes.

D. Proof of income of the continuation member who will become the new main member - SARS assessment (ITA34) or Scheme affidavit.

PLEASE REMEMBER THAT:

Dependants of a deceased member who elect not to join the Nedgroup Medical Aid Scheme following the member's death do not qualify to join the Scheme at a later stage.

16 HOW TO SAVE MONEY AND MAKE THE MOST OF YOUR BENEFITS

This is how you can save yourself and the Scheme money:

Use the Scheme's pharmacy network to avoid unnecessary co-payments.

Use a doctor/specialist on the network, to avoid unnecessary co-payments.

Consider paying in cash and then claiming back to get discounts (unless you are registered on the Chronic Medicine Management programme).

Get a quote from the doctor before undergoing any procedure and check with the Contact Centre how much will be paid.

Ask for **generic medicine** whenever possible.

If you are registered for chronic medicine, consider using Pharmacy Direct as **courier pharmacy**, so that you can save travelling costs and avoid the possibility that your medication may be out of stock.

Think twice about undergoing elective surgery procedures.

If your doctor recommends a particular line of treatment and you feel uncertain about whether it is necessary, ask for a **second opinion**.

If an operation is scheduled for the afternoon or evening, **arrange for hospital admission after 12pm**.

Maintain a healthy lifestyle, as prevention is always the better option.

Make healthier choices to avoid or better **manage lifestyle-related chronic conditions**.

Use the screening tests and vaccines offered as part of your **Health Screening Benefits** to identify potential lifestyle diseases early.

HOSPITAL NETWORK PLAN

If you are on this Plan, ensure that you use only hospitals on the Network, to avoid incurring unnecessary co-payments.

Although every effort has been made to ensure that this document gives an accurate summary of the benefits offered by the Nedgroup Medical Aid Scheme, it does not replace the Rules of the Scheme, which take precedence over any wording in this document. You can view the Rules of the Scheme on the logged-in Member Zone of the Scheme's website, nmas.medscheme.com.

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