The benefits in this guide are valid from 1 January 2015 to 31 December 2015 and will be reviewed at the end of that period.
**CONTACT DETAILS**

<table>
<thead>
<tr>
<th>Administrator</th>
<th>Hospital Plan, Savings Plan, Traditional Plan and Platinum Plan</th>
<th>Traditional Plus Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Postal address</strong></td>
<td>Nedgroup Medical Aid Scheme</td>
<td>ONECARE Health</td>
</tr>
<tr>
<td></td>
<td>PO Box 74, Vereeniging, 1930</td>
<td>PO Box 44991, Claremont, 7735</td>
</tr>
<tr>
<td><strong>Internal mail</strong></td>
<td>Nedgroup Medical Aid Scheme</td>
<td>Nedgroup Medical Aid Scheme</td>
</tr>
<tr>
<td></td>
<td>37 Conrail Road, Florida North, Roodepoort, 1709</td>
<td>ONECARE Health</td>
</tr>
<tr>
<td></td>
<td></td>
<td>10 Mill Street, Newlands</td>
</tr>
<tr>
<td><strong>E-mail</strong></td>
<td><a href="mailto:nedgroup.enquiries@medscheme.co.za">nedgroup.enquiries@medscheme.co.za</a></td>
<td><a href="mailto:nedgroup@onecarehealth.co.za">nedgroup@onecarehealth.co.za</a></td>
</tr>
<tr>
<td><strong>General Enquiries</strong></td>
<td>Tel: 0860 100 080 / 011 671 6833</td>
<td>Tel: 0860 103 491</td>
</tr>
<tr>
<td></td>
<td>Fax: 0860 111 784 / 011 758 7041</td>
<td>Fax: 021 673 1811</td>
</tr>
<tr>
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<td>Faxed accounts: 0860 111 784</td>
<td>Faxed accounts: 021 673 1811</td>
</tr>
<tr>
<td></td>
<td>Scanned accounts: Current First-Time Claims (including refund claims)</td>
<td>Claims/scanned accounts: <a href="mailto:nedgroupclaims@onecarehealth.co.za">nedgroupclaims@onecarehealth.co.za</a></td>
</tr>
<tr>
<td></td>
<td>All claims for services rendered outside the borders of RSA</td>
<td>Benefit enquiries: <a href="mailto:nedgroup@onecarehealth.co.za">nedgroup@onecarehealth.co.za</a></td>
</tr>
<tr>
<td></td>
<td>Email: <a href="mailto:foreign.hos@medscheme.co.za">foreign.hos@medscheme.co.za</a></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Benefit enquiries: <a href="mailto:nedgroup.enquiries@medscheme.co.za">nedgroup.enquiries@medscheme.co.za</a></td>
<td></td>
</tr>
<tr>
<td><strong>Hospital Benefit Management</strong></td>
<td>Tel: 0860 100 080</td>
<td>Tel: 0860 102 183</td>
</tr>
<tr>
<td></td>
<td>Fax: 0860 21 22 23 or 021 466 1913</td>
<td>Fax: 021 413 0512</td>
</tr>
<tr>
<td></td>
<td>E-mail: <a href="mailto:nedgroup.authorisations@medscheme.co.za">nedgroup.authorisations@medscheme.co.za</a></td>
<td>Email: <a href="mailto:crc@onecarehealth.co.za">crc@onecarehealth.co.za</a></td>
</tr>
<tr>
<td><strong>HIV and AIDS Management</strong></td>
<td>Programme with Aid for AIDS</td>
<td>Programme with CareWorks</td>
</tr>
<tr>
<td></td>
<td>Tel: 0860 100 646/021 466 1700</td>
<td>Tel: 0860 101 110</td>
</tr>
<tr>
<td></td>
<td>Fax: 0800 600 773</td>
<td>or 021 413 1606</td>
</tr>
<tr>
<td></td>
<td>Email: <a href="mailto:aidho@aidhmo.co.za">aidho@aidhmo.co.za</a></td>
<td>Fax: 0860 105 147</td>
</tr>
<tr>
<td></td>
<td>Website: <a href="http://www.aidsforaids.co.za">www.aidsforaids.co.za</a></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Mobi: <a href="http://www.aidsforaids.mobi">www.aidsforaids.mobi</a></td>
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</tr>
<tr>
<td></td>
<td>SPHS (call me) 083 410 9078</td>
<td></td>
</tr>
<tr>
<td><strong>Oncology Management Programme (for cancer patients)</strong></td>
<td>Tel: 0860 100 572</td>
<td>Tel: 0860 102 183</td>
</tr>
<tr>
<td></td>
<td>Fax: 021 466 2303</td>
<td>Fax: 021 413 0512</td>
</tr>
<tr>
<td></td>
<td>E-mail: <a href="mailto:cancerinfo@medscheme.co.za">cancerinfo@medscheme.co.za</a></td>
<td>E-mail: <a href="mailto:crc@onecarehealth.co.za">crc@onecarehealth.co.za</a></td>
</tr>
<tr>
<td></td>
<td>or <a href="mailto:oncology@onecarehealth.co.za">oncology@onecarehealth.co.za</a></td>
<td></td>
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<tr>
<td><strong>Chronic Medicine Authorisation (PMB and other Scheme-approved chronic conditions only)</strong></td>
<td>ScripPharm Risk Management</td>
<td>ScripPharm Risk Management</td>
</tr>
<tr>
<td></td>
<td>Tel: 010 591 0150</td>
<td>Tel: 010 591 0150</td>
</tr>
<tr>
<td></td>
<td>Fax: 086 679 1579</td>
<td>Fax: 086 679 1579</td>
</tr>
<tr>
<td></td>
<td>E-mail: <a href="mailto:nedgroup@scrippharm.co.za">nedgroup@scrippharm.co.za</a></td>
<td>E-mail: <a href="mailto:onecare@scrippharm.co.za">onecare@scrippharm.co.za</a></td>
</tr>
<tr>
<td></td>
<td>Web: <a href="http://www.scripnet.co.za">www.scripnet.co.za</a></td>
<td>Web: <a href="http://www.scripnet.co.za">www.scripnet.co.za</a></td>
</tr>
<tr>
<td><strong>PMB Treatment Plans</strong></td>
<td>Tel: 0860 100 080</td>
<td>Tel: 0860 102 183</td>
</tr>
<tr>
<td></td>
<td>E-mail: <a href="mailto:nedgroupapmb@medscheme.co.za">nedgroupapmb@medscheme.co.za</a></td>
<td>Fax: 021 413 0512</td>
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<tr>
<td></td>
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<td>Email: <a href="mailto:nedgroup@onecarehealth.co.za">nedgroup@onecarehealth.co.za</a></td>
</tr>
<tr>
<td><strong>Nedgroup Specialist Network</strong></td>
<td>Tel: 0860 100 080</td>
<td>Tel: 0860 102 183</td>
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</table>

**Administrators**

<table>
<thead>
<tr>
<th>Administrator</th>
<th>Hospital Plan, Savings Plan, Traditional Plan and Platinum Plan</th>
<th>Traditional Plus Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Emergency Medical Services</strong></td>
<td>Medscheme's convenient and secure website gives you access to your membership details, claims status, savings balance and available benefits, as well as an electronic version of member communications.</td>
<td>ONECARE's secure website gives you access to your claims status, available benefits as well as member statements.</td>
</tr>
<tr>
<td><strong>Website</strong></td>
<td><a href="http://www.medscheme.co.za">www.medscheme.co.za</a></td>
<td><a href="http://www.carecross.co.za">www.carecross.co.za</a></td>
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</table>

**Disclaimer:** Although every effort has been made to ensure that this member guide is an accurate explanation of the benefits offered by the Nedgroup Medical Aid Scheme, please note that this guide does not replace the Rules of the Scheme, which take precedence over any wording in this guide. A copy of the Scheme Rules is available on the Medscheme website for members’ perusal.
1. Welcome p.2
   - Why have a medical scheme?
   - How can this Member Guide help me?
   - What are my responsibilities as a member?

2. How to choose your Plan for 2015 p.4
   - What are the main changes for 2015?
   - What are the employee contributions for 2015?
   - Can I have a quick overview of the Plans?
   - How should I decide which Plan is best for me?
   - What should I do before I make my final choice?

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   (These benefits are the same across all Plans.)
   - What are Hospital and Trauma benefits?
   - What is our overall annual limit?
   - What services in doctors’ rooms are covered?
   - What treatments by a specialist while in hospital are covered?
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   - What services and procedures are covered during hospitalisation?

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   - Renal dialysis and organ transplants
   - What to do in an emergency situation

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   - Why do we have PMB?
   - Which PMB conditions are covered by the Scheme?
   - Who are the Scheme’s Designated Service Providers for PMB?
   - How do I register on the PMB Medical Management Programme?

6. Benefits: Chronic Conditions p.43
   (Cover depends on Plan selected.)
   - What is a chronic condition?
   - Which basic chronic conditions are covered by all Plans?
   - What additional chronic medicine benefits are covered under each Plan?
   - How does payment for chronic medication work under each Plan?
   - How do I apply for the Chronic Medicine Benefit?
   - How do I make changes to my chronic medication?
   - How do I obtain an additional month’s supply of chronic medication?
   - Who are the Scheme’s Designated Service Providers for chronic medication?

   (These benefits are the same across all Plans.)
   - How can the Wellness Benefits help me?
   - What is available under the pharmacy-based wellness benefit?
   - Where can I access these benefits?

   (Cover depends on Plan selected.)
   - What types of everyday services are covered?
   - How do the following Plans work?
     - Platinum Plan
     - Traditional Plus Plan
     - Traditional Plan
     - Savings Plan
     - Hospital Plan

9. More about your medical scheme p.72
   - Who administers my medical scheme?
   - When does the benefit year start?
   - What is the difference between medical scheme rates and private provider rates?
   - What services are not covered by the Scheme?

10. All about membership p.75
    - Who can be a member of the Scheme?
    - Who is regarded as a dependant of the member?
    - How are waiting periods applied?
    - What do I need to do if my dependants/membership details change?
    - What will happen when my Scheme membership comes to an end?
    - What will happen to my personal medical savings account balance?

11. How to claim p.80
    - How do I submit a claim?
    - How can service providers submit claims electronically?
    - How can I see my claims online?
    - Whom should I contact if I have any queries about claims?

12. Frequently Asked Questions p.84
    - What medical scheme cover will I have while outside South Africa on holiday or on business?
    - What rules apply if I have been involved in a motor car accident?
    - How can I claim in terms of the Compensation for Occupational Injuries and Diseases Act?
    - What is the escalation process if I am unhappy with the service that I receive?
    - What can I do if I have a complaint against my medical scheme?
    - How can I keep my medical costs low?
    - What do I do if I suspect fraudulent activity against the Scheme?
    - When do I get my tax certificate from the Scheme and how can I request a copy of the tax certificate?
    - Where can I obtain a membership certificate?
    - How can I replace or get additional medical scheme membership cards?
    - As a retiree, why am I entitled to maternity benefits when the Scheme could rather increase my other benefits?

13. Jargon guide p.90
     - What medical scheme cover will I have while outside South Africa on holiday or on business?
Why have a medical scheme?
You never know when you or one of your family members may need medical care, which could cost a substantial amount. Fortunately, as a member of the Nedgroup Medical Aid Scheme, you can enjoy peace of mind knowing that you and your family are protected by the comprehensive benefits available on the various Plans offered by your medical scheme.

How can this Member Guide help me?
This guide will give you all the information on the benefits that you are entitled to as a member, irrespective of the Plan you choose. It also contains information on the various Plans, to help you choose the one that suits you best, plus information on claims processes, chronic medication and more. Use the side tabs and colour coding to find the information you need, when you need it.

What are my responsibilities as a member?
• Understand how the Scheme and specific Plans work by reading this Member Guide.
• Keep the Scheme up to date on any changes to your membership details.

Please note: It is your responsibility as a member to check whether the correct contributions are deducted from your salary/pension or bank account. Child dependants over the age of 23 will pay the adult dependant contribution.

Abbreviations used in this guide:
- DSP – Designated Service Provider
- MRI – Magnetic Resonance Imaging
- MSR – Medical Scheme Rate
- PET – Positron Emission Tomography
- PMB – Prescribed Minimum Benefits
- PPR – Private Provider Rates
- PSA – Personal Savings Account
- RMB – Routine Medical Benefit
- SEP – Single Exit Price (for medicines)
- TTO – To-take-out (medicine to take home from hospital)
The benefit structure for the 2015 benefit year will continue to offer a choice of five Plans, catering to our various members’ needs.

Before the new benefit year starts on 1 January 2015, you will need to decide whether your current Plan still meets your medical needs or whether you should consider switching to a more suitable Plan.

This section offers a quick and easy comparison of the five Plans to help you to determine which Plan will work for you. When making this important decision, you will basically have to weigh up the benefits and contributions of the various Plans with your needs – so please read this member guide carefully to get all the information you need before making your decision.

If you have any questions after reading this guide, or need help in making your choice, please contact Medscheme (Hospital, Savings, Traditional or Platinum Plan enquiries) on 0860 100 080 or contact ONECARE (Traditional Plus Plan enquiries) on 0860 103 491.

**What are the main changes for 2015?**

The following changes will take effect from 1 January 2015:

**Hospital and Trauma Benefits**

- Procedures (those that every provider should be able to do in his/her rooms) performed in a doctor’s room, rather than in a hospital, will be funded as if the procedures were done in a hospital. Co-payments will be applied to the account on all hospital admissions as well as procedures performed in doctor’s room where the specialist is not on the Nedgroup specialist network. If a member is admitted by a specialist or GP on the Nedgroup network or has a procedure performed in the doctor’s room, no co-payment will apply. This will apply to the voluntary usage of non-network doctors for all conditions, but will exclude emergencies. In an emergency situation, an admission by a non-network specialist will not incur a co-payment for the claim.

- No benefits will apply for Dental implants on the Hospital Plan.

**Everyday Services Benefits**

- The limits for GP, Homeopaths and Specialist consultations, Acute medication, Advanced dentistry, Radiology and Pathology to be increased by 6.6%.

**Chronic Medication Benefits**

- PMB chronic medicine on the Savings Plan will be funded from the limited chronic medicine benefit first, together with the non-PMB chronic medicine. Once the chronic medicine benefit is exhausted, PMB chronic medicine will be funded from the unlimited PMB benefit, subject to collection at a DSP (Nedgroup Network Pharmacy).

**Managed Care Programmes**

- The treatment plans for PMB will be revised and be more GP-focused in 2015.
What are the employee contributions for 2015?

Please note:
- Contributions for active employees are based on Total Guaranteed Package (TGP).
- Contributions are payable per child, up to a maximum of two child dependants.
- Child dependants over the age of 23 will pay the adult dependant contribution.
- No contributions may be made towards the personal medical savings account except on the Savings Plan.
- Contributions are payable in arrears and your revised contributions will come into effect on 1 April 2015.

The following tables reflect the contributions from 1 January to 31 March 2015.

M = Member | A= Additional Adult | C= Child
Maximum children under age 23 charged for is 2 (two per family)

<table>
<thead>
<tr>
<th></th>
<th>M</th>
<th>A</th>
<th>C</th>
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<tbody>
<tr>
<td>PLATINUM</td>
<td>All levels</td>
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<tr>
<td>M</td>
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<td>R1 787</td>
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<td>R4 501 – R6 000.99 pm</td>
<td>R2 602</td>
<td>R1 966</td>
<td>R 581</td>
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<tr>
<td>R6 001 + pm</td>
<td>R2 654</td>
<td>R2 002</td>
<td>R 599</td>
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<td>R2 340</td>
<td>R1 772</td>
<td>R 514</td>
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<tr>
<td>R6 001 + pm</td>
<td>R2 387</td>
<td>R1 808</td>
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<td>R6 001 + pm</td>
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<th>SAVINGS Everyday Services Benefits Contributions (Included in monthly contributions)</th>
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<td>R6 001 + pm</td>
<td>R1 026</td>
<td>R1 011</td>
<td>R 353</td>
</tr>
</tbody>
</table>

From 1 April 2015 the following contributions will apply:

M = Member | A= Additional Adult | C= Child
Maximum children under age 23 charged for is 2 (two per family)
Can I have a quick overview of the Plans?

The Plans, from most expensive (and most extensive Everyday Services Benefits cover) to least expensive (and least extensive Everyday Services Benefits cover) are as follows:

<table>
<thead>
<tr>
<th>Platinum Plan</th>
<th>Traditional Plus Plan</th>
<th>Traditional Plan</th>
<th>Savings Plan</th>
<th>Hospital Plan</th>
</tr>
</thead>
</table>

**EVERYDAY SERVICES BENEFITS**

**Routine Medical Benefit (RMB) with sub-limits**
Benefits paid at 3 x MSR from the Routine Medical Benefit limit with additional dentistry, optical and maternity benefits as well as wheelchair and associated appliances. Once your sub-limits and Routine Medical Benefit are depleted, you will be liable for payment.

**Sub-limits on each category of service**
Benefits paid at MSR or cost, whichever is the lesser, up to sub-limits. Once sub-limits are depleted you **continue to have access to additional basic primary healthcare cover**, subject to formularies and approved tariff lists via your network GP. Once sub-limits are depleted, you will be liable for payment.

**Sub-limits on each category of service**
Benefits paid at MSR or cost, whichever is the lesser, up to the sub-limit. Once sub-limits are depleted, you will be liable for payment.

**Personal Savings Account allocation.**
21.3% of your monthly contribution allocated towards your PSA.
12 months up-front PSA allocation at the beginning of the year. When you have used up all your savings, you will be liable for payment.

**WELLNESS BENEFITS**

**PRESCRIBED MINIMUM BENEFITS (PMB)**

**CHRONIC MEDICINE BENEFITS (PMB and other Scheme-Approved chronic conditions)**
Limited to R8 650 per family per year at Nedgroup Network pharmacies. Once limit is reached, PMB chronic medicine paid from PMB benefit at Nedgroup Network pharmacies.

**CHRONIC MEDICINE BENEFITS (PMB and other Scheme-Approved chronic conditions)**
Limited to R8 650 per family per year at Nedgroup Network pharmacies. Once limit is reached, PMB chronic medicine paid from PMB benefit at Nedgroup Network pharmacies.

**HOSPITAL AND TRAUMA BENEFITS** at Medical Scheme Rate (MSR), including Managed Healthcare Programmes for HIV/Aids, cancer & organ transplants

**HOSPITAL AND TRAUMA BENEFITS**
No cover for Everyday Services.
Benefits

### Major Medical Benefits
Hospital and Trauma Benefits available on all Plans at Medical Scheme Rate (MSR)
- Cover for the:
  - 26 Chronic Disease List (CDL) conditions as well as
  - Other Scheme-approved chronic conditions

### Everyday Services Benefits
Routine Medical Benefit with sub-limits
Benefits paid at 3 x MSR from the Routine Medical Benefit limit with additional sub-limits for dentistry, optical and maternity benefits, as well as wheelchair and associated appliances. Once your sub-limits and Routine Medical Benefit are depleted, you will be liable for payment.

Sub-limits on each category of service
Benefits paid at MSR or cost, whichever is the lesser, up to sub-limits. Once sub-limits are depleted you continue to have access to additional basic primary healthcare cover, subject to formularies via contracted providers (ONECARE).

### Wellness Benefits
- Personal Savings Account allocation
  - 21.3% of your monthly contribution allocated towards your PSA. 12 months up-front PSA allocation at the beginning of the year. When you have used up all your savings, you will be liable for payment.

### Hospital and Trauma Benefits (including chronic cover)

<table>
<thead>
<tr>
<th>BENEFIT CATEGORY</th>
<th>PLATINUM PLAN</th>
<th>TRADITIONAL PLUS PLAN</th>
<th>TRADITIONAL PLAN</th>
<th>SAVINGS PLAN</th>
<th>HOSPITAL PLAN</th>
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<td><strong>Major Medical Benefits</strong></td>
<td>Available on all Plans</td>
<td>Unlimited cover for Major Medical expenses, paid at Medical Scheme Rate or cost or medicine price, whichever is the lesser, subject to sub-limits</td>
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<td>cost or medicine price, whichever is the lesser, subject to sub-limits</td>
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<td><strong>Chronic conditions</strong></td>
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<td>26 Chronic Diseases List (CDL)</td>
<td>26 Chronic Disease List (CDL)</td>
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<td>26 Chronic Disease List (CDL)</td>
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<td>Other Scheme-approved chronic conditions</td>
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<td>Other Scheme-approved chronic conditions</td>
<td>Other Scheme-approved chronic conditions</td>
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### Day-to-day benefits

M = Member, A = Additional Adult, C = Child, PSA = Personal Savings Allocation will vary according to your income and the number of dependants registered.

<table>
<thead>
<tr>
<th>BENEFIT CATEGORY</th>
<th>PLATINUM PLAN</th>
<th>TRADITIONAL PLUS PLAN</th>
<th>TRADITIONAL PLAN</th>
<th>SAVINGS PLAN</th>
<th>HOSPITAL PLAN</th>
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<tbody>
<tr>
<td><strong>Routine Medical Benefits limits 3 x MSR</strong></td>
<td>M = R14 230, A = R10 550, C = R3 520 (2 children max)</td>
<td>No Routine Medical Benefits</td>
<td>M = R1 885, A = R1 880, C = R 560 (2 children max) Register with the Nedgroup Network GP. Once limit has been exceeded, you will have access to unlimited medically necessary visits to the Nedgroup GP and additional Specialist benefits, subject to referral and authorisation, subject to limit of Single M = 1 visit</td>
<td>M = R1 885, A = R1 880, C = R 560 (2 children max)</td>
<td>No Everyday Services Benefits</td>
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<tr>
<td><strong>Optical benefits</strong></td>
<td><em>R4 135 per beneficiary per year</em>*</td>
<td>M = R2 135, A = R1 430, C = R 355 (2 children max) Frames: Sub-limit of R 805 per beneficiary every 2 years</td>
<td>M = R2 135, A = R1 430, C = R 355 (2 children max) Frames: Sub-limit of R 805 per beneficiary every 2 years</td>
<td><strong>R2 455 per family per year 2 x 2D scans per family per year R1 270 per family per year</strong></td>
<td><strong>R2 455 per family per year 2 x 2D scans per family per year R1 270 per family per year</strong></td>
</tr>
<tr>
<td><strong>Maternity benefits</strong></td>
<td>R6 320 per family per year **</td>
<td>**</td>
<td>R6 320 per family per year</td>
<td>**</td>
<td>**</td>
</tr>
<tr>
<td><strong>Basic dental services</strong></td>
<td>*R6 780 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.</td>
<td>M = R2 690 per beneficiary per year</td>
<td>M = R2 690 per beneficiary per year</td>
<td><strong>Subject to your Personal Savings Allocation</strong></td>
<td><strong>Subject to your Personal Savings Allocation</strong></td>
</tr>
<tr>
<td><strong>Advanced dentistry</strong></td>
<td>**</td>
<td>**</td>
<td>**</td>
<td>**</td>
<td>**</td>
</tr>
<tr>
<td><strong>Medicines:</strong> Prescribed medicine (acute)</td>
<td>Routine Medical Benefit limit</td>
<td>M = R2 825, A = R1 885, C = R 470 (2 children max) Once limit exceeded, you will have access to additional acute medicine as per the formulary and requested by the Nedgroup Network GP.</td>
<td>M = R2 825, A = R1 885, C = R 470 (2 children max)</td>
<td><strong>R1 130 per family per year subject to the prescribed medicine limit</strong></td>
<td><strong>R1 130 per family per year subject to the prescribed medicine limit</strong></td>
</tr>
<tr>
<td><strong>Pathology</strong></td>
<td>Routine Medical Benefit limit</td>
<td>M = R1 690, A = R 565, C = R 100 (2 children max)</td>
<td>M = R1 690, A = R 565, C = R 100 (2 children max)</td>
<td>**</td>
<td>**</td>
</tr>
<tr>
<td><strong>Radiology (X-rays)</strong></td>
<td>Routine Medical Benefit limit</td>
<td>M = R2 255 per family per year</td>
<td>M = R2 255 per family per year</td>
<td>**</td>
<td>**</td>
</tr>
<tr>
<td><strong>Supplementary health services</strong></td>
<td>Routine Medical Benefit limit</td>
<td>M = R1 675, A = R1 670, C = R 500 (2 children max)</td>
<td>M = R1 675, A = R1 670, C = R 500 (2 children max)</td>
<td>**</td>
<td>**</td>
</tr>
</tbody>
</table>

Network GP. Approved tariff list and protocols apply. Additional benefits if requested by the Nedgroup Network GP. Once limit has been exceeded, you will have access to additional acute medicine as per the formulary and requested by the Nedgroup Network GP. Approved tariff list and protocols apply. Additional benefits if requested by the Nedgroup Network GP. Once limit has been exceeded, you will have access to additional acute medicine as per the formulary and requested by the Nedgroup Network GP. Approved tariff list and protocols apply.
| 11 | Physiotherapy | Routine Medical Benefit limit | R2 675 per family per year | R2 675 per family per year |
| 12 | Psychology | Routine Medical Benefit limit | R5 010 per family per year | R5 010 per family per year |
| 13 | Medical appliances | Routine Medical Benefit limit | R3 500 per family per year | R3 500 per family per year |
| 14 | Wheelchair and associated appliances | R10 000 per family per year | R10 000 per family per year | R10 000 per family per year |
| 15 | Hearing aids | Routine Medical Benefit limit | R27 870 per family for beneficiaries 6 years and younger every 2 years, R19 080 per family for beneficiaries 7 years and older every 2 years | R27 870 per family for beneficiaries 6 years and younger every 2 years, R19 080 per family for beneficiaries 7 years and older every 2 years |
| 16 | CPAP and accessories | Routine Medical Benefit limit | Limited to R3 500 per family per year, if referred by Nedgroup GP Network Provider. | Limited to R3 500 per family per year |

**Annual health check**

**Wellness Benefits**

- 100% of cost for the following prevention tests. Two sets of tests per beneficiary per year:
  - Blood sugar
  - Cholesterol
  - Body Mass Index calculation
  - Blood pressure

*Claims will be paid from the Everyday Services Benefit once this limit is exceeded

### A closer look at the chronic benefits

<table>
<thead>
<tr>
<th>BENEFIT CATEGORY</th>
<th>PLATINUM</th>
<th>TRADITIONAL PLUS PLAN</th>
<th>TRADITIONAL PLAN</th>
<th>SAVINGS PLAN</th>
<th>HOSPITAL PLAN</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>26 PMB Chronic Conditions</strong></td>
<td>100% of medicine price for PMB and non-PMB chronic medicine claims, provided it is obtained from a DSP (Nedgroup Network pharmacy). Subject to the Scheme’s treatment protocols.</td>
<td>100% of cost for chronic medication, provided it is obtained from a DSP (Nedgroup Network pharmacy). Paid from PMB Benefits.</td>
<td>100% of cost for chronic medication, provided it is obtained from a DSP (Nedgroup Network pharmacy). Paid from PMB Benefits.</td>
<td>100% of cost for PMB and non-PMB chronic medication, provided it is obtained from a DSP (Nedgroup Network pharmacy). Subject to the Chronic Medicine Benefit of R8 650 per family per year.</td>
<td>100% of cost for chronic medication. Provided it is obtained from a DSP (Nedgroup Network pharmacy). Standard Medicine Formulary list applies.</td>
</tr>
<tr>
<td><strong>Other Scheme-approved chronic conditions</strong></td>
<td>100% of medicine price for PMB and non-PMB chronic medicine claims, provided it is obtained from a DSP (Nedgroup Network pharmacy). Subject to the Scheme’s treatment protocols.</td>
<td>100% of medicine price, limited to R8 650 per family per year, if obtained from a DSP (Nedgroup Network pharmacy).</td>
<td>100% of medicine price, limited to R8 650 per family per year, if obtained from a DSP (Nedgroup Network pharmacy).</td>
<td>No cover for other Scheme-approved chronic conditions.</td>
<td>Standard Medicine Formulary list applies.</td>
</tr>
</tbody>
</table>

### Medical Management of 26 PMB Chronic Conditions

- 100% of cost at DSP paid from PMB benefit, subject to the Scheme’s treatment Everyday Services Benefit and thereafter be covered by the PMB benefit, with a Nedgroup GP and Specialist network is the DSP for the medical management of 26 PMB chronic conditions as per the PMB protocols. If you choose a GP or specialist outside of the network, your claims will first be paid from your co-payment of 25% that you will need to cover from your own pocket, the 26 PMB chronic conditions.

### DSP for Chronic Medication

- Nedgroup Network pharmacy is the DSP for Chronic medication.
How should I decide which Plan is best for me?

All five Plans offer the same Hospital and Trauma cover, with different Everyday Services Benefits. See who would typically choose the various Plans:

**Platinum Plan**
When you want maximum flexibility for you and your healthy family! You will have peace of mind knowing that your everyday services will be covered at 3 x MSR. The Platinum Plan caters for young families, preferably without any chronic ailments. It offers extensive cover with a comprehensive Routine Medical Benefit limit and sub-limits on certain benefits.

**Traditional Plus Plan**
Managing your chronic condition is crucial to you, and you need comprehensive medical benefits. Your everyday services will be covered up to pre-determined sub-limits with freedom of choice and thereafter unlimited medically-necessary access to additional GP consultations, Prescribed Medication, Radiology and Pathology benefits at a Nedgroup Network GP, subject to ONECARE formularies and approved tariff limits.

**Traditional Plan**
The Traditional Plan offers all-inclusive medical benefits. Your everyday services will be covered up to the pre-determined sub-limits with freedom of choice.

**Savings Plan**
You want to manage your benefits, yet still need peace of mind knowing that you are covered for everyday services from your annual savings allocation. On a monthly basis approximately 21.3% of your contributions will be allocated towards your Personal Medical Savings Account. It gives you the power to decide how to spend your annual savings allocation. Any balance remaining in your personal medical savings account at the end of the year will be carried forward to the following year.

**Hospital Plan**
So, you are healthy and rarely visit a doctor. However, you need to be prepared for those unforeseen hospital procedures and diseases. The Hospital Plan is the best Plan for you. You will have peace of mind knowing that you have hospital and trauma benefits with the freedom of choice to select your hospital and cover for the 26 PMB chronic conditions.

What should I do before I make my final choice?

- Review the benefits offered by each of the five Plans to make sure that you choose the Plan most suited to your medical needs.
- Review your past medical claims history (in other words, what your medical expenses were during the previous benefit year).
- Estimate your anticipated medical expenses during the coming year.
- Consider any medical procedures that are planned for the next benefit year.
- Think about the number of dependants you have and whether they may require chronic medication and treatment.
- Consider whether you have an existing chronic ailment that may require chronic medication and treatment.
- Calculate the monthly contribution rates of each Plan to make sure that you can afford the Plan you select. At the same time, there is no point in moving down to a cheaper Plan if that Plan doesn’t provide you with enough benefits and requires you to make regular co-payments.
- Check if your GP and Specialist are part of the Nedgroup network.
IN THIS SECTION:
What are Hospital and Trauma benefits?
What is our overall annual limit?
What services in doctors’ rooms are covered?
What treatments by a specialist while in hospital are covered?
How does pre-authorisation before hospitalisation work?
What services and procedures are covered during hospitalisation?
What is our overall annual limit?

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.

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 Rates (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 page 25 - 31 for a detailed breakdown of 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 100% of 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
- Gastroscopy
- Hysteroscopy
- Intravenous therapy
- Keloids (subject to motivation)
- Laser to scars (subject to motivation)
- Flexible sigmoidoscopy
- Surgical biopsies (needle biopsies) (subject to motivation)
- tonsillectomy (laser)
- Upper GI endoscopy
- Vasectomy
- 0300 Stitching of wound
- 0301 Stitching of additional wound
- 0307 Excision and repair
- 0255 Drainage of subcutaneous abscess & avulsion of nail
- 2133 Circumcision-clamp
- Any other minor procedures (subject to motivation)
- Excision of lymphoma
- Biopsy of skin

What treatments by a specialist while in hospital are covered?
- If you are diagnosed and need to be admitted to hospital for a procedure, it will be to your advantage if the admitting specialist is part of the Nedgroup 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 claim.
- 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.

Please note:
If your treating specialist is not part of the Nedgroup specialist network, a co-payment of R2 500 will be applied to the claim (unless it was an emergency case).

What are Hospital and Trauma benefits?

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.

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.

Hospital Plan, Savings Plan, Traditional Plan and Platinum Plan

<table>
<thead>
<tr>
<th>Hospital Plan, Savings Plan, Traditional Plan and Platinum Plan</th>
<th>Traditional Plus Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>To find out whether the specialist is on the Nedgroup specialist network, please contact Medscheme at 0860 100 080, or log onto <a href="http://www.medscheme.co.za">www.medscheme.co.za</a> or visit <a href="http://instagib.co.za/63347687/provider/">http://instagib.co.za/63347687/provider/</a>.</td>
<td>To find out whether the specialist is on the Nedgroup specialist network, please contact ONECARE at 0860 103 491, or log onto <a href="http://www.carecross.co.za">www.carecross.co.za</a> or visit <a href="http://instagib.co.za/63347687/provider/">http://instagib.co.za/63347687/provider/</a>.</td>
</tr>
</tbody>
</table>

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How does pre-authorisation before hospitalisation work?

- 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.

To pre-authorise, please follow the process below:

<table>
<thead>
<tr>
<th>Hospital Plan, Savings Plan, Traditional Plan and Platinum Plan</th>
<th>Traditional Plus Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Contact Hospital Benefit Management at 0860 100 080 (or send an email to <a href="mailto:nedgroup.authorisations@medscheme.co.za">nedgroup.authorisations@medscheme.co.za</a>) three working days before being admitted to hospital (ten days for implants or internal prostheses).</td>
<td>• Contact ONECARE on 0860 102 183 (or send an email to <a href="mailto:crc@onecarehealth.co.za">crc@onecarehealth.co.za</a>) at least three working days before being admitted to hospital.</td>
</tr>
<tr>
<td>• In the case of an emergency, you must arrange to notify Hospital Benefit Management on the first working day after being admitted.</td>
<td>• In the case of an emergency, you must arrange to notify ONECARE on the first working day after being admitted.</td>
</tr>
</tbody>
</table>

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 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.

⚠️ 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 negotiate with the treating provider specifically on the tariff (if you select a non-network specialist) prior to the procedure.

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 on the next pages 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. (i.e. 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.

Dentistry
- Hospitalisation will only be considered for basic dentistry procedures performed on beneficiaries who are younger than 8 years. 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, otherwise there is no cover for the Dental Practitioner on the Hospital Plan.
- 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.
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):

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Co-payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Laparoscopic appendectomy</td>
<td>R2 500</td>
</tr>
<tr>
<td>Laparoscopic hernia repair</td>
<td>R2 500</td>
</tr>
<tr>
<td>Laparoscopic assisted vaginal hysterectomy</td>
<td>R2 500</td>
</tr>
<tr>
<td>Laparoscopic radical prostatectomy</td>
<td>R2 500</td>
</tr>
<tr>
<td>Laparoscopic nephrectomy</td>
<td>R2 500</td>
</tr>
<tr>
<td>Laparoscopic pyeloplasty</td>
<td>R2 500</td>
</tr>
<tr>
<td>Knee arthroscopy</td>
<td>R2 500</td>
</tr>
<tr>
<td>Hip arthroscopy</td>
<td>R2 500</td>
</tr>
<tr>
<td>Upper GI endoscopy (gastroscopy)</td>
<td>R500 (If performed in a doctor’s rooms, no co-payment will apply.)</td>
</tr>
<tr>
<td>Balloon sinuplasty</td>
<td>R2 500</td>
</tr>
</tbody>
</table>

Psychiatric services

- This benefit covers hospitalisation and all associated accounts, e.g. 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.
- Where practical, all patients/beneficiaries with a psychiatric illness should be admitted to a psychiatric unit where they will benefit from the case management process.
- 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.

Please note:

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.

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.
- This list is constantly reviewed and updated. Where new products or technology are considered, a medical practitioner should motivate for these.
- Application for or use of any item not on the list must always be submitted to the Scheme with a motivation from the treating practitioner.

Maternity benefits

Maternity benefits are available for members and their dependants during their pregnancy, the birth of the baby and the period after the birth.

Do I need a pre-authorisation number for my stay in hospital?

Yes. On the day of your admission or within one working day, you have to pre-authorise your stay by contacting Hospital Authorisations at 0860 102 183 if you are on the Traditional Plus option and 0860 100 080 if you are on any of the other options. Remember that if you do not pre-authorise your stay in hospital, you will have to pay a penalty on your hospital account.

The following services are covered under the maternity benefits, in addition to the benefits you receive under Hospital and Trauma benefits:

- Antenatal consultations funded up to R2 455 per family per year, including 2 x 2D pregnancy scans per member family per year.
- Antenatal classes conducted by a midwife up to R1 270 per family per year.
- Antenatal vitamins: available from Everyday Services Benefit (excluding calcium supplements and Omega preparations).

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.

Savings, Traditional Plus and Traditional Plan

- Antenatal consultations funded up to R2 455 per family per year, including 2 x 2D pregnancy scans per member family per year.
- Antenatal classes conducted by a midwife up to R1 270 per family per year.
- Antenatal vitamins: available from Everyday Services Benefit (excluding calcium supplements and Omega preparations).

Platinum Plan

- Antenatal classes conducted by a midwife, 2 x 2D or 2 x 3D pregnancy scans per member family per year and antenatal consultations (covered for up to 3 x MSR).
- Antenatal vitamins: available from Routine Medical Benefit (excluding calcium supplements and Omega preparations).
Antenatal classes cover the following content:

- Normal delivery and labour
- Breathing exercises
- Caesarean section
- Pain relief
- Breastfeeding
- Post-delivery body changes
- Care of the baby during the first few weeks

It is recommended that you attend antenatal classes between the 25th and 30th week of pregnancy. Most often there are about six to eight classes, each two hours long, presented by a nurse or midwife.

After-birth care services, for example home visits by a registered nurse and phototherapy treatment for your baby at home (if necessary) are subject to managed healthcare protocols and prior authorisation.

Must I register my baby as a dependant?

Yes. Even though you have pre-authorised your confinement, you will still have to notify the Scheme of the birth of your baby, and arrange for him/her to be registered as a dependant on the Scheme. If you do not register the baby as a dependant within 30 days of birth, the Scheme will not register your baby from date of birth and therefore will not cover any medical claims incurred for the baby during that time. Refer to page 76 to find out which dependants are covered and which procedure to follow to register them.

Contact the Customer Service Centre for more information:

Telephone: 0860 100 080 / 011 671 6833 | Fax: 0860 111 784 / 011 758 7041

Internal mail: Nedgroup Medical Aid Scheme, 37 Conrad Road, Florida North, Roodepoort 1709

Email: nedgroup.enquiries@medscheme.co.za

Traditional Plus Option

Tel: 0860 102 183 | Fax: 021 413 0512 | E-mail: crc@onecarehealth.co.za

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; and
- clinical motivation.

Services and procedures covered during hospitalisation

The following services and procedures are covered at 100% of cost or Medical Scheme Rate; whichever is the lesser, unless otherwise stated. When multiple procedures are done, modifier 005 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 rates (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 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.

<table>
<thead>
<tr>
<th>Service Category</th>
<th>Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. Co-payments</strong></td>
<td>Laparoscopic procedures listed on page 22 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 co-payment of R2 500. Where the doctor performing a procedure in the doctor’s rooms is not on the Nedgroup specialist network, the account will attract a co-payment of R2 500.</td>
</tr>
</tbody>
</table>
| **2. Private and Public Hospital accommodation** | Medical Scheme Rate as determined in the Rules 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 as determined in the Rules 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. |
| | **Platinum Plan**: Paid from Routine Medical benefit limit. **Savings Plan**: Paid from Personal Medical Savings Account. **Other Plans**: No benefit, for member’s own account. |
| | **Limited to R450 per beneficiary per admission** |
| **3. Nursing services** | 100% of cost with a sub-limit of R14 310 per family per year in a registered facility only and subject to pre-authorisation. This benefit covers home services by a registered nurse, pre-and post-confinement treatment by a registered midwife and is for short-term episodes of acute care only in the place of hospitalisation. Items such as laundry, telephone calls, hairdressing, etc. will not be covered under this category. Only necessary medical services will be covered. |
8. Radiology and Pathology

<table>
<thead>
<tr>
<th>Service Category</th>
<th>Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Radiology and Pathology (in hospital)</td>
<td>Medical Scheme Rate, subject to the overall annual limit.</td>
</tr>
<tr>
<td>Specialised Radiology (in and out of hospital)</td>
<td>Medical Scheme Rate, limited to R14 540 per family per year.</td>
</tr>
<tr>
<td>MRI scans, radio-isotope scans and CAT scans (wherever the service is provided – excluding PET scans)</td>
<td>subject to pre-authorisation.</td>
</tr>
</tbody>
</table>

9. Maxillofacial & oral surgery

<table>
<thead>
<tr>
<th>Service Category</th>
<th>Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ultrasound scans (in and out of hospital – other than pregnancy scans)</td>
<td>Medical Scheme Rate, whichever is the lesser, up to a maximum of R5 600 per family per year.</td>
</tr>
</tbody>
</table>

10. Dental implants or Building up of Teeth (in and out of hospital)

<table>
<thead>
<tr>
<th>Service Category</th>
<th>Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Scheme Rate, whichever is the lesser, subject to the overall annual limit.</td>
<td>with a sub-limit of R12 290 per family per year.</td>
</tr>
</tbody>
</table>

11. Orthognathic surgery (functional correction of malocclusions)

<table>
<thead>
<tr>
<th>Service Category</th>
<th>Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Platinum Plan: 100% of tariff agreed with the hospital group for private wards for confinement.</td>
<td>subject to submission and approval of a quotation.</td>
</tr>
</tbody>
</table>

12. Physiotherapy

<table>
<thead>
<tr>
<th>Service Category</th>
<th>Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Scheme Rate</td>
<td>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.</td>
</tr>
</tbody>
</table>

13. Physical Rehabilitation

<table>
<thead>
<tr>
<th>Service Category</th>
<th>Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Scheme Rate</td>
<td>This benefit with a sub-limit of R60 810 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.</td>
</tr>
</tbody>
</table>

14. Mental health

<table>
<thead>
<tr>
<th>Service Category</th>
<th>Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>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.</td>
<td>subject to submission and approval of a quotation.</td>
</tr>
</tbody>
</table>

Medical Scheme Rate

- Psychiatric treatment
- Treatment and accommodation for substance abuse

Medical Scheme Rate

- Ultrasound scans (in and out of hospital – other than pregnancy scans)
- Maxillofacial & oral surgery
15. Oncology

- Specialised drugs for Oncology
  - Biological drugs applicable to monoclonal antibodies and interleukins, Tyrosine Kinase inhibitors, Proteasome Inhibitors, e.g. Bortezomib and Azacitidine.

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.

**Medical Scheme Rate** with a sub-limit of R277 740 per family per year, provided the patient enrols on the Oncology Benefit Management Programme.

- 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 following information:
  - date of diagnosis, the area concerned, any prior surgery or treatment, new treatment requests, as well as approximate costs.

**Platinum, Traditional Plus and Traditional Plans:** Extended formulary.

**Savings** and **Hospital Plans:** Standard formulary.

- 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 Medicines Council for the specific diagnosed condition.

**Medical Scheme Rate** with a sub-limit of R25 230 per family per year, subject to the approval of the Case Manager.

**Medical Scheme Rate** with a sub-limit of R38 120 per family per year.

**Medicine price** with a sub-limit of R151 500 per year, subject to the Overall Oncology Benefit limit.

16. Non-Oncology

- Specialised drugs
  - Biological drugs applicable to monoclonal antibodies and interleukins, Human Immunoglobulin for chronic use, Iron chelating agents for chronic use and Palivizumab (Synagis) for prevention of RSV infection, as well as Botulinum toxin (Botox®) where deemed appropriate by the managed healthcare company for the treatment of cancer and other diseases.

**Medicine price** with a sub-limit of R151 500 per family per year, provided the patient registers on the Chronic Medicine Management Programme subject to the Overall Annual Limit.

17. Macular degeneration drugs 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.

**Medicine price** with a sub-limit of R47 640 per family per year, subject to a motivation received from the provider and subsequent approval.

Cost for specific prosthesis applied for, subject to the relevant managed healthcare programme and to prior authorisation. The following specific sub-limits apply:

- **Cardiac system:**
  - Cardiac pacemakers: Limited to R61 360 per beneficiary per year.
  - Cardiac stents (including the carrier) and drug eluting-balloons: Limited to R25 510 per stent per beneficiary, limited to 3 x stents per beneficiary per year.
  - Cardiac valves: Limited to R36 140 per valve per year.
  - Cardiac Resynchronisation Therapy (CRT): Limited to R42 400 per beneficiary per year.

**Endovascular devices:**

- Aorta stent grafts: R104 990 per stent (including the delivery system), limited to 1 stent per beneficiary per year.
- Carotid stents: R17 940 per stent per beneficiary per year.
- Detachable platinum coils: R44 320 per stent per beneficiary per year.
- Embolic protection devices: R44 190 per stent per beneficiary per year.
- Peripheral arterial stent grafts: R36 600 per stent per beneficiary per year.

**Orthopaedic prostheses and devices including cement and antibiotic cement:**

- Elbow replacements: R39 140 per elbow per beneficiary per year.
- Total hip replacement: R46 380 per hip per beneficiary per year.
- Total knee replacement: R51 270 per knee per beneficiary per year.
- Total shoulder replacement: R44 590 per shoulder per beneficiary per year.
- Bone lengthening devices: R39 760 per beneficiary per year.
- Spinal instrumentation: R55 120 per beneficiary per year.
- Other approved spinal implantable devices and intervertebral discs: R44 320 per beneficiary per year.

**Ophthalmic system:**

- Intraocular lenses: R2 650 per lens, subject to 2 lenses per beneficiary per year.

Any other prostheses not listed above:

- R49 780 per beneficiary per year, 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.

**Service Category**

<table>
<thead>
<tr>
<th>Service Category</th>
<th>Benefit</th>
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<tbody>
<tr>
<td>15. Oncology</td>
<td></td>
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<tr>
<td>16. Non-Oncology</td>
<td></td>
</tr>
<tr>
<td>17. Macular degeneration drugs surgically implanted</td>
<td></td>
</tr>
<tr>
<td>18. Internal prostheses (devices applied for)</td>
<td></td>
</tr>
</tbody>
</table>
20. Perfusion services
Medical Scheme Rate (cost of material, apparatus and clinical technology’s fee).

Subject to pre-authorisation, the benefit is only available to live donors and consultations (including related pathology, scans and medical management (including visits to general practitioners) and 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.

21. Organ Transplant / donor services
Organ transplant

Medical Scheme Rate
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, provided that drugs from a preferred provider are used. These must be pre-authorised by the Chronic Benefit Management Department.

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 grafts
Limited to R21 200 per beneficiary per year, subject to the relevant managed healthcare programme and pre-authorisation, as well as approval by the Scheme before starting work-up for transplantation.

23. Renal dialysis (including related pathology, scans and consultations).
Medical Scheme Rate.

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, and
- the approximate cost.

Pre-authorisation is required from the Chronic Benefit Management Department for the related medication from a preferred provider.

24. HIV/AIDS Benefit
On diagnosis, please register on the HIV/AIDS Management Programme. Benefits are unlimited, subject to the Scheme’s guidelines for patients who are registered on the HIV/AIDS Management Programme for medication and medical management (including visits to general practitioners) and blood tests (provided that the tests are done by Designated Service Providers). This is subject to compliance with the Scheme’s protocols and guidelines regarding the management of HIV/AIDS. Mother-to-child, accidental exposure and rape-psychotherapy must be pre-authorised by the HIV/AIDS Care Manager. For a rape case, the hospital will provide a three days “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.

Limited to 2 tests per beneficiary per year and subject to the preferred provider negotiated rate.

25. All refractive procedures (including excimer laser, radial keratotomy, holmium procedures and LASIK phakic lenses).
Medical Scheme Rate with a sub-limit of R11 660 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.

26. Artificial limbs and artificial eyes
Cost according to clinical protocols, subject to the relevant managed healthcare programme and to the following sub-limits:

- R63 830 per artificial leg per beneficiary (every 2-3 years for children and every 5 years for adults).
- R63 830 per artificial arm per beneficiary (every 2-3 years for children and every 5 years for adults).
- R22 240 per artificial eye per beneficiary (every 2 years for a glass eye and every 5 years for an acrylic eye).

27. Home oxygen therapy
Subject to the relevant managed healthcare programme and pre-authorisation.

Cost with a sub-limit of R15 010 per family per year.

Please note: You must apply for this benefit and it must be pre-authorised by the Case Manager.

28. Hyperbaric oxygen therapy
Cost with a sub-limit of R49 090 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.

29. Stoma care products
Cost with a sub-limit of R17 460 per family per year.

30. Breast reduction
Medical Scheme Rate.

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 criteria applied by the Scheme in terms of the Scheme’s managed care protocols.

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

- Oncology Benefit Management Programme (for cancer patients)
- HIV and AIDS management programme
- Renal dialysis and organ transplants
- What to do in an emergency situation

**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 on 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.

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 Benefit.

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

<table>
<thead>
<tr>
<th>Hospital Plan, Savings Plan, Traditional Plan and Platinum Plan</th>
<th>Traditional Plus Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Please submit your care plan to Medscheme via email to: <a href="mailto:cancerinfo@medscheme.co.za">cancerinfo@medscheme.co.za</a>.</td>
<td>- Please submit your care plan by fax to the Oncology Case Manager, ONECARE Clinical Referral Centre.</td>
</tr>
<tr>
<td>- If you have any queries regarding the Oncology Benefit Management Programme or your condition, please contact the Oncology Case Manager on 0860 100 572.</td>
<td>- Fax: 021 413 0512.</td>
</tr>
<tr>
<td>- Email: <a href="mailto:oncology@onecarehealth.co.za">oncology@onecarehealth.co.za</a></td>
<td>- Email: <a href="mailto:oncology@onecarehealth.co.za">oncology@onecarehealth.co.za</a></td>
</tr>
<tr>
<td>- If you have any queries regarding the Oncology Benefit Management Programme or your condition, please contact the Oncology Case Manager on 0860 102 183.</td>
<td></td>
</tr>
</tbody>
</table>

**How to obtain authorisation for associated treatment**

1. **Surgery/procedures/hospital admissions:**
   
   If you need to be admitted to hospital for chemotherapy 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,


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.

Please note:

That 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.

4. Social worker

An Oncology Social Worker Benefit of R2 500 per family per year, subject to the Oncology Benefit limit, has been introduced for the payment of seven sessions with a social worker affiliated to the ICON network in the case of terminal cases.

HIV and AIDS management programme

Remember

Even if you are not registered on this programme, you are covered for two HIV tests per beneficiary per year. See page 31 for more information.

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 TB.
• 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.

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

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 (see page 20 for more information).

ER24 (24-hour evacuation & emergency transport)
Telephone:
084 124 or 0861NED911 (0861 633 911)
**What are PMB?**

The regulations published in terms of the Medical Schemes Act No. 131 of 1998 stipulate the scope and level of the minimum benefits to which members of the Scheme are entitled. Prescribed Minimum Benefits (PMB) are a set of defined benefits that ensure that all medical scheme members have access to certain minimum health services, regardless of the benefit Plan they have selected.

PMB are fully covered by your medical scheme, provided you follow the guidelines. The cover is related to the diagnosis, treatment and care of:

- any emergency medical condition;
- a limited set of 270 Diagnostic Treatment Pairs (DTP) defined in the Regulations and published on the Council for Medical Schemes website; and
- 26 chronic conditions (defined in the Regulations and published under the PMB Chronic Condition List on page 46 of this member guide).

When deciding whether a condition is a PMB, the doctor should look only at the symptoms and not any other factors, such as how the injury or condition was contracted. This approach is called diagnosis-based. Once the diagnosis has been made, the appropriate treatment and care is decided upon, as well as where the patient should receive the treatment (at a hospital, as an outpatient or at a doctor’s rooms).

**Why do we have PMB?**

There are two reasons why PMB is in place:

- To ensure that medical scheme beneficiaries have continuous cover for PMB related conditions. This means that even if a member’s benefits for the year run out, the Scheme will continue to pay for the treatment of PMB conditions. These benefits are subject to the medical management treatment protocols.

- To ensure that healthcare is paid for by the correct parties. Medical Scheme members with PMB conditions are treated according to the specified treatments and these have to be covered by their medical scheme, irrespective of where the patient is treated.

**Which PMB conditions are covered by the Scheme?**

**Emergency Medical Conditions**

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.

In an emergency it is not always possible to diagnose the condition before admitting the patient for treatment. However, if a doctor suspects that the patient is suffering from a condition which is covered in terms of PMB, the Scheme is required to approve the treatment. Schemes may request that the diagnosis be confirmed by supplying supporting evidence within a reasonable period of time.

**Diagnostic Treatment Pairs (270 medical conditions)**

The Regulations to the Medical Schemes Act provide a long list of conditions identified as PMB. The list is in the form of Diagnosis and Treatment Pairs (DTP). A DTP links a specific diagnosis to a treatment and therefore broadly indicates how each of the approximately 270 PMB conditions should be treated.

Here is an example of a DTP as it appears in the Medical Schemes Act:
If your PMB condition is not an emergency or a PMB chronic condition, but is a once-off PMB condition as diagnosed by your doctor, you will be covered as per the Scheme Rules. If you are unsure of whether your diagnosed acute condition is covered as a PMB you can contact the Scheme to clarify this. The administrator will require the ICD10 code to determine whether the condition is an acute PMB condition.

Once the condition has been identified as an acute PMB condition, the administrator will request that you submit your claim, together with the ICD10 code, relevant tariff codes, doctor’s practice number and any test results (including pathology and radiology) that support the diagnosis.

To avoid PMB claims being rejected
- Check that your doctor/service provider has included the correct ICD10 code on your account.
- ICD10 codes provide accurate information on your diagnosis and this assists in determining which benefits you are entitled to and how these benefits could be paid.
- Your PMB condition will be identified by the ICD code, so if the incorrect code is used, your PMB-related condition will be paid from the wrong benefit.
- ICD10 codes must also be provided on medicine prescriptions and referral notes to other healthcare providers.

If your PMB claim is rejected

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<tr>
<th>Hospital Plan, Savings Plan, Traditional Plan and Platinum Plan</th>
<th>Traditional Plus Plan</th>
</tr>
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<tbody>
<tr>
<td>• You can contact the Scheme at 0860 100 080 to enquire about the reason for the rejection and process to follow.</td>
<td>• You can contact ONECARE 0860 103 491 to enquire about the reason for the rejection of the claim.</td>
</tr>
</tbody>
</table>

It is important to check that your practitioner has put the correct codes on your invoice.

Please note:
The Scheme is obliged by law to treat information about members’ conditions with the utmost confidentiality. No information pertaining to a member’s condition will be disclosed to any other party, including the member’s employer or family.

Who are the Scheme’s Designated Service Providers for PMB?

GP or specialist visits
- If you are diagnosed with a PMB condition, it would be to your benefit to make use of the general practitioner or specialist on the Nedgroup GP and specialist network for your medical management where general practitioner or specialist visits are clinically indicated for the condition. If you choose a GP or specialist on the Nedgroup GP and specialist network, your PMB-related account will 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.

• Alternatively, you may wish to continue consulting your own general practitioner or specialist, even if he/she is not part of the network. In such a case the service provider will be covered at Medical Scheme Rate, and paid from your available Everyday Services Benefits. Thereafter the service will be covered from the PMB benefit, with a co-payment of 25% that you will need to cover from your own pocket.

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<th>Hospital Plan, Savings Plan, Traditional Plan and Platinum Plan</th>
<th>Traditional Plus Plan</th>
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<tbody>
<tr>
<td>• To find out whether the specialist is on the Nedgroup specialist network, please contact Medscheme at 0860 100 080, or log onto <a href="http://www.medscheme.co.za">www.medscheme.co.za</a>.</td>
<td>• To find out whether the specialist is on the Nedgroup specialist network, please call 0860 103 491, or log onto <a href="http://www.carecross.co.za">www.carecross.co.za</a>.</td>
</tr>
<tr>
<td>• The consultant will confirm whether the specialist is part of the Nedgroup specialist network, or provide details of the specialists on the network.</td>
<td>• The consultant will confirm whether the specialist is part of the network, or provide details of specialists on the network.</td>
</tr>
</tbody>
</table>

Pharmacies
Nedgroup Network Pharmacies is the Designated Service Provider (DSP) Pharmacy network for chronic medicine. Members, who voluntarily use a non-designated pharmacy service provider for their approved PMB medication, will be liable for a 25% co-payment at the point of sale at the pharmacy. In other words, the Scheme will only pay 75% of the claim for the approved/authorised medication.

Members who use a non-DSP pharmacy provider for their chronic medicine (the additional 20 conditions which fall outside of the 26 PMB conditions), will have their account paid from their available Everyday Services Benefits. Once the Everyday Services Benefits are depleted, you will be liable for the full account at point of sale at the pharmacy. Chronic medicines will only be paid from your chronic medicine benefit if obtained from a Nedgroup Network pharmacy.

Further to this, the Regulations stipulate that a member’s personal medical savings account (for Savings Plan members only) may not be used to fund any co-payment costs related to PMB claims. Members must therefore settle the co-payment directly with the service provider.

<table>
<thead>
<tr>
<th>Hospital Plan, Savings Plan, Traditional Plan, Traditional Plus Plan, Traditional Plan and Platinum Plan</th>
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<tr>
<td>• To apply for authorisation for chronic medicines, please contact ScriptPharm Risk Management on (010) 591 0150 Monday to Friday, 08:00 – 17:00 or fax the application form to 0866 791 579 or email <a href="mailto:nedgroup@scriptpharm.co.za">nedgroup@scriptpharm.co.za</a></td>
</tr>
</tbody>
</table>

Hospitals
The hospital that your doctor refers you to is the DSP for hospitalisation.
How do I register on the PMB Medical Management Programme?

<table>
<thead>
<tr>
<th>Hospital Plan, Savings Plan, Traditional Plan and Platinum Plan</th>
<th>Traditional Plus Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Please contact 0860 100 080 or email: <a href="mailto:nedgroupapmb@medscheme.co.za">nedgroupapmb@medscheme.co.za</a>.</td>
<td>• Please contact the ONECARE Clinical Referral Centre at 0860 102 183.</td>
</tr>
</tbody>
</table>

Please have the following information readily available before calling:

• Name of member;
• Name of beneficiary applying for benefits;
• Membership number;
• Date of birth or identity number (for member registering on the programme);
• Treating doctor’s name and practice number;
• Condition to be covered – ICD10 code to be supplied by treating doctor; and
• Whether you are already registered as a chronic medicine user.

If your condition requires basic primary healthcare treatment and/or diagnostic tests, you will be informed of your PMB treatment plan, in writing, on your monthly member statement. This communication is triggered if the correct ICD10 and tariff codes are submitted on the claim. For Traditional Plus Plan members a Treatment Plan will be provided at the beginning of the benefit year for those members who are registered for PMB chronic conditions.

What is a chronic condition?
A chronic condition is one that requires on-going, long-term or continuous medical treatment. However, the Scheme’s chronic medicine benefit does not necessarily cover all these conditions.

Which basic chronic conditions are covered by all Plans?

PMB Chronic Conditions
There are 26 PMB chronic conditions that must be covered in terms of the regulations governing medical schemes, referred to as the PMB Chronic Conditions – see PMB Chronic Conditions listed on the next page. To manage the risk and ensure that appropriate standards of health are applied, so-called treatment algorithms were developed for these PMB Chronic Conditions. These algorithms, which have been published in the Government Gazette, can be regarded as benchmarks, or minimum standards, for treatment. This means that the treatment your medical scheme must cover is not allowed to be inferior to the published algorithms.

If you have one or more of the 26 PMB chronic conditions and meet the clinical entry criteria, your medical scheme not only has to cover chronic medication, but also the doctor’s consultations and certain tests related to your condition. The Scheme may make use of protocols, formularies (list of specified medicines) and Designated Service Providers to manage this benefit.
The Scheme also covers Diagnosis and Treatment Pairs (DTP). A DTP links a specific diagnosis to a treatment and therefore broadly indicates how each of the approximately 270 PMB conditions should be treated.

Where the DTP includes chronic medicine as the appropriate treatment, this will be covered by the Scheme (subject to protocols, formularies and the use of DSPs). The following conditions that were previously listed under ‘Other Scheme-approved Chronic Conditions’ are part of the DTP list:

- Deep vein thrombosis
- Hormone replacement therapy
- Hypofunction of the pituitary gland
- Hyperthyroidism
- Hypoparathyroidism

To better understand this benefit, it helps to be familiar with the following terms and what they mean:

**Chronic Medicine Formularies**

A Formulary is a list of cost effective evidence-based medicines that the Scheme will cover for the treatment of your chronic condition. These lists are compiled by the Scriptpharm Risk Management and are constantly reviewed.

Reimbursement is subject to clinical guidelines and protocols. The Scheme applies a Standard Formulary and an Advanced Formulary as part of the guidelines.

- **The Standard Formulary**, applicable to the Hospital and Savings Plans, contains a list of medicines that provide cover for the listed chronic conditions.
- **The Advanced Formulary**, applicable to the Platinum, Traditional Plus and Traditional Plans, provides access to a wider range of medicines than the Standard formulary.

If you choose to use a medicine that is not on your Plan’s Formulary, and you do not have a motivation for this non-formulary medicine (which would then be reviewed and considered for approval), you will have to pay for it from your own pocket. The Formularies are updated throughout the benefit year. Any products that are removed from the Formulary will be communicated to you during the year. It is important for you to discuss changing to an alternative medicine with your treating doctor or you will have to make co-payments.
Registered Chronic Conditions
The Scheme covers the following approved chronic conditions listed in the right-hand side of the table below.

<table>
<thead>
<tr>
<th>PMB Chronic Conditions</th>
<th>Other Scheme-approved Chronic Conditions</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Addison's disease</td>
<td>1. Anxiety (if linked to another approved psychiatric chronic condition)</td>
</tr>
<tr>
<td>2. Asthma</td>
<td>2. Acne (cystic nodular)</td>
</tr>
<tr>
<td>3. Bipolar mood disorder</td>
<td>3. Allergic rhinitis (if beneficiary has asthma or is under 12 years)</td>
</tr>
<tr>
<td>4. Bronchiectasis</td>
<td>4. Attention deficit syndrome (if prescribed by a specialist and under the age of 18 years)</td>
</tr>
<tr>
<td>5. Cardiac failure</td>
<td>5. Alzheimer's disease</td>
</tr>
<tr>
<td>6. Cardiomyopathy disease</td>
<td>6. Depression/mood disorders</td>
</tr>
<tr>
<td>7. Chronic renal disease</td>
<td>7. GORD (with the necessary motivation and/or gastroscopy report)</td>
</tr>
<tr>
<td>8. Chronic obstructive pulmonary disease (emphysema)</td>
<td>8. Gout (if linked to hypertension and/or diabetes)</td>
</tr>
<tr>
<td>9. Coronary artery disease (angina pectoris and ischaemic heart disease)</td>
<td>9. Hypotension</td>
</tr>
<tr>
<td>11. Diabetes insipidus</td>
<td>11. Insomnia (sleep disorders) (if linked to another approved psychiatric condition)</td>
</tr>
<tr>
<td>12. Diabetes mellitus type 1 &amp; 2</td>
<td>12. Macular degeneration and oedema</td>
</tr>
<tr>
<td>15. Glaucoma</td>
<td>15. Osteoporosis</td>
</tr>
<tr>
<td>17. HIV/AIDS*</td>
<td></td>
</tr>
<tr>
<td>18. Hyperlipidaemia (high cholesterol)</td>
<td></td>
</tr>
<tr>
<td>19. Hypertension (high blood pressure)</td>
<td></td>
</tr>
<tr>
<td>20. Hypothyroidism</td>
<td></td>
</tr>
<tr>
<td>21. Multiple sclerosis</td>
<td></td>
</tr>
<tr>
<td>22. Parkinson's disease</td>
<td></td>
</tr>
<tr>
<td>23. Rheumatoid arthritis</td>
<td></td>
</tr>
<tr>
<td>24. Schizophrenia</td>
<td></td>
</tr>
<tr>
<td>25. Systemic lupus erythematosi</td>
<td></td>
</tr>
<tr>
<td>26. Ulcerative colitis</td>
<td></td>
</tr>
</tbody>
</table>

* Please refer to HIV AND AIDS MANAGEMENT PROGRAMME under the Hospital and Trauma Benefits section for more information about benefits available.

What additional chronic medicine benefits are covered under each Plan?

<table>
<thead>
<tr>
<th>26 PMB chronic conditions</th>
<th>Platinum Plan</th>
<th>Traditional Plus Plan</th>
<th>Traditional Plan</th>
<th>Savings Plan</th>
<th>Hospital Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>100% of medicine price for PMB and non-PMB chronic medicine subject to R8 650 per family per year; provided it is obtained from a DSP (Nedgroup Network pharmacy). Advanced Medicine Formulary list applies.</td>
<td>100% of cost for chronic medication paid from PMB benefit, provided it is obtained from a DSP (Nedgroup Network pharmacy).</td>
<td>100% of medicine price, limited to R8 650 per family per year; provided it is obtained from a DSP (Nedgroup Network pharmacy).</td>
<td>100% of cost for chronic medication paid from PMB benefit, provided it is obtained from a DSP (Nedgroup Network pharmacy).</td>
<td>No cover for other Scheme-approved chronic conditions on this Plan.</td>
<td></td>
</tr>
</tbody>
</table>

Other Scheme-approved chronic conditions

| 100% of medicine price, limited to R8 650 per family per year; provided it is obtained from a DSP (Nedgroup Network pharmacy). | 100% of cost for chronic medication paid from PMB benefit, provided it is obtained from a DSP (Nedgroup Network pharmacy). |
|                                                                 | Once your Everyday Services Benefit is depleted, you will be liable for payment from your own pocket. |
|                                                                 | Standard Medicine Formulary list applies. |

*Note: Benefits available are subject to the PMB Formulary list applies. Formulary for other approved chronic conditions paid from PMB benefit, provided it is obtained from a DSP (Nedgroup Network pharmacy).
Once you have used the benefits for other Scheme-approved Chronic Conditions for the year, any additional costs will be covered as follows:

<table>
<thead>
<tr>
<th>Plan</th>
<th>Payment Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Platinum Plan</td>
<td>From your Routine Medical Benefit limit. If no more benefits are available, you will have to pay in full at the point of sale.</td>
</tr>
<tr>
<td>Traditional Plus Plan</td>
<td>From your Prescribed Medicines limit. If no more benefits are available, you will have to pay in full at the point of sale.</td>
</tr>
<tr>
<td>Traditional Plan</td>
<td>From your Prescribed Medicines limit. If no more benefits are available, you will have to pay in full at the point of sale.</td>
</tr>
<tr>
<td>Savings Plan</td>
<td>From your Personal Medical Savings Account, if there are funds available. Otherwise you will need to pay in full at the point of sale.</td>
</tr>
<tr>
<td>Hospital Plan</td>
<td>No benefit for other Scheme-approved Chronic Conditions. You will need to pay in full at the point of sale.</td>
</tr>
</tbody>
</table>

How to apply for the Chronic Medicine Benefit?

Should you or one of your dependants be diagnosed with a chronic condition for which you are currently not registered on the Chronic Medicine Management programme, you should follow the steps below to apply for this benefit:

- Check the PMB and other Scheme-approved Chronic Conditions list to ensure that your condition is covered on your selected Plan. Refer to page 46 for a full list of conditions covered.
- Complete a chronic medicine benefit application form. Application forms can be obtained from the ScriptPharm (ScriptNet) website at www.scriptnet.co.za, or call ScriptPharm on 010 591 0150 to request an application form and it will be faxed, emailed or posted to you.
- Take note of the instructions on the application form and ensure that both you and your doctor(s) sign the application form.
- Certain diseases require additional test results, motivation and supporting documentation and in some cases a specialist must complete the application form.
- All completed applications should be posted, faxed or emailed (see details on next page).
- Incomplete application forms will cause a delay in processing your application.
- Do not submit the original prescription. It must be presented to your pharmacist, to obtain the medication, once approval has been obtained.

Your application will be processed as follows:

- Clinical Entry Criteria will be applied, which means that your application must meet certain clinical criteria before chronic medicine benefits will be authorised. ScriptPharm pharmacists, supported by medical advisers, will review your application to ensure that the most appropriate and cost-effective medication is authorised. The use of cost-effective medication ensures cost containment without compromising the quality of care.
- Medicines will be covered in full, without co-payments, if they are listed 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.
- Chronic medicines will be approved from the date of receipt of the prescription/application, provided that the application is fully completed and includes all supporting documentation. The Scheme will not backdate chronic medicine authorisations prior to the date of the prescription/application.

How does payment for chronic medication work under each Plan?

Members will receive unlimited Chronic Medicine Benefits for the 26 PMB chronic conditions. This applies to members on all Plans, provided that you use a DSP and the medicine has been approved by the Scheme. There is, however, a sub-limit for the other Scheme-approved Chronic Conditions, which is applicable to all Plans except the Hospital Plan. The Hospital Plan does not have any cover for the other Scheme-approved Chronic Conditions.

For members on the Platinum Plan, both the PMB and non-PMB chronic medicine claims are paid from the chronic medicine benefit sub-limit, provided that you use a DSP. Once this sub-limit is exceeded, claims will be paid from the overall Everyday Services Routine Medical Benefit and thereafter you will have unlimited cover for PMB chronic medicine from the PMB benefit, provided the approved chronic medicine is obtained from a DSP.

For members on the Savings Plan, both the PMB and non-PMB chronic medicine claims are paid from the chronic medicine benefit sub-limit, provided that you use a DSP. Once the chronic medicine benefit is exhausted, PMB medicine will be funded from the unlimited PMB benefit, subject to members using a DSP (Nedgroup Network Pharmacy).

Once you have used the benefits for other Scheme-approved Chronic Conditions for the year, any additional costs will be covered as follows:

- **Platinum Plan**: From your Routine Medical Benefit limit. If no more benefits are available, you will have to pay in full at the point of sale.
- **Traditional Plus Plan**: From your Prescribed Medicines limit. If no more benefits are available, you will have to pay in full at the point of sale.
- **Traditional Plan**: From your Prescribed Medicines limit. If no more benefits are available, you will have to pay in full at the point of sale.
How do I make changes to my chronic medication?
If you need new, additional medication or have a change in your current medication strength and/or dosage for a registered chronic condition, your medical practitioner or pharmacist may contact ScriptPharm to process your requested change. Unprocessed authorisation changes will result in your claims being rejected or being processed from your Everyday Services Benefit. Certain medicines require additional information for approval, and your doctor will be asked to submit this information. Please note that a copy of a valid prescription must be sent to ScriptPharm within seven working days following the telephonic authorisation.

If you have any queries, please call 010 591 0150. Alternatively, you may fax or post a copy of your new prescription to ScriptPharm. Please ensure that your membership number and details are clearly indicated on the prescription.

When a prescription changes, you should include the following information and submit the request to ScriptPharm:

- Membership number;
- Member’s initials and surname;
- Patient’s initials and surname; and
- Patient’s contact details; for example, telephone number, fax number, postal address and/or e-mail address.

How do I obtain an additional month’s supply of chronic medication?
If you are travelling and require an additional month’s supply of chronic medication, please supply the following information two weeks before departure:

- A completed “Extended supply” application form (obtainable from the intranet or ScriptPharm’s website at www.scriptnet.co.za) with a copy of your air tickets/itinerary attached.

If you don’t supply this information, there could be a delay in processing your request. Applications must be received for review at least two weeks before your date of departure.

Who are the Scheme’s Designated Service Providers for chronic medication?
You must obtain your authorised chronic medication for PMB and other Scheme-approved chronic conditions from the Scheme’s Designated Service Providers (DSP).

The Scheme’s DSP for chronic medication are as follows:

- Nedgroup Network Pharmacies: The Nedgroup Pharmacies network has been identified as the Scheme’s DSP for chronic medication. To find out where the nearest Pharmacy to you is, you may contact:
IN THIS SECTION:

How can the Wellness Benefits help me?

What is available under the pharmacy-based wellness benefit?

Where can I access these benefits?

How can the Wellness Benefits help me?

This is a preventative benefit that is available on all the Plans.

What is available under the pharmacy-based wellness benefit?

You have access to the Nedgroup Network Pharmacy Screening Programme, allowing you and your dependants to visit a participating Nedgroup Network wellness pharmacy, or attend a Scheme Wellness 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 of tests R120 per set of tests including VAT) per beneficiary per year, to the value of R240 including VAT per beneficiary per year:

- Blood sugar
- Blood pressure
- Cholesterol
- Measurement of height, weight and waist circumference
- Body Mass Index calculation
In addition, beneficiaries will have the flexibility to choose:

1. To have all the tests at one encounter, either at a Wellness event or at a Nedgroup Network Pharmacy, or
2. To have multiple individual tests over the benefit year, subject to the benefit limit shown above.

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

**Where can I access these benefits?**

To find out where the nearest participating Nedgroup Network Pharmacy is, you may contact:

Scriptpharm Risk Management
Tel: 010 591 0150
E-mail: nedgroup@scriptpharm.co.za

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**What types of everyday services are covered?**

Everyday Services Benefits typically cover medical treatment that you receive out of hospital or as an outpatient at a hospital. Unlike the services and procedures covered under Hospital and Trauma Benefits, these are expenses that occur more frequently. Examples include visits to your doctor or dentist, as well as prescribed medicines.

The services you receive before being admitted to hospital are covered by your Everyday Services Benefits, even if these services are directly related to your hospital admission. Similarly, any follow-up services after you have been discharged from hospital also fall under Everyday Services Benefits. (However, there is a sub-limit under Hospital and Trauma Benefits for physiotherapy treatment after hospitalisation, if approved by the Case Manager.) Please refer to the tables that follow for more information.

Flu injections, anti-malaria tablets and contraceptives (excluding condoms) are covered under Everyday Services Benefits. Other vaccines are only covered on the Savings and Platinum Plan, otherwise the cost for these will be for your own account. Baby immunisation vaccinations are subject to the acute medication benefit on all plans, except the Platinum Plan. Please refer to the tables below for more information. In addition, you may claim from your Everyday Services Benefits for prescribed vitamins and treatments for pregnancy-related anaemia as well as other supplements prescribed during pregnancy.
How do the following Plans work?

P Platinum Plan
T Traditional Plus Plan
T Traditional Plan
S Savings Plan
H Hospital Plan

The Platinum Plan provides maximum flexibility and peace of mind, with Everyday Services Benefits paid at up to 3 x MSR.

- The benefits structure is such that once the sub-limits for dentistry, optical and maternity benefits, as well as for wheelchair and associated appliances have been depleted, claims will continue to be paid from the Routine Medical Benefit limit.
- No personal medical savings account allocation can be made on this Plan.
- The cover of Private Provider Rates (PPR) applies only to Everyday Services Benefits, while all in-hospital benefits are covered at Medical Scheme Rate. The Routine Medical Benefit limit covers all your routine medical needs at Private Provider Rates (PPR), up to 3 x of MSR. These include general practitioner and specialist visits, procedures out of hospital not covered under Hospital and Trauma Benefits, acute medicines, antenatal vitamins, supplementary health services, physiotherapy, medical appliances, hearing aids, psychotherapy, radiology and pathology.
- Should there be a shortfall between the benefit covered (at PPR) by the Scheme and the actual cost of the service, you will need to pay this difference at the point of sale. Refer to the detailed tables below for more information on what is covered on the Platinum Plan.

Routine Medical Benefit limit

The total benefit available to a member or any dependant is equal to the maximum of M + A (max 1) + C (max 2). This limit covers all your routine medical needs, paid at PPR (capped at 3 x MSR) up to the following available limits:

<table>
<thead>
<tr>
<th>Single M</th>
<th>A</th>
<th>C</th>
</tr>
</thead>
<tbody>
<tr>
<td>R14 230</td>
<td>R10 550</td>
<td>R3 520</td>
</tr>
</tbody>
</table>

M = Member | A = Additional Adult | C = Child dependant

The Routine Medical Benefit covers the following:

- Procedures out-of-hospital not covered under the Hospital and Trauma benefits.
- Prescribed (acute) medicine including Pharmacy Advised therapy (excluding the administration fee). The funding of compound analgesics e.g. 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. Antenatal vitamins prescribed during pregnancy (excluding calcium supplements and Omega preparations).
- Supplementary health services - applied kinesiology, audiometry/audiology, autologous donation of blood, biokinetics, chiropractic, chiropactic services, clinical technology, dieticians, naturopaths, occupational therapy, orthopotic treatment, podiatry, remedial therapy, speech therapists, social workers.
- Physiotherapy following hospitalisation is covered under the Hospital and Trauma Benefits, provided it is 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.
- X-rays – out of hospital.
- Pathology – out of hospital.
- Eye tests.
- Once the Optical benefits limit has been exceeded, you may submit claims under this benefit.
- Medical appliances.
- Hearing aids – Benefit available per beneficiary every 24 months, from the date of the last hearing aid received.
- Psychology – out of hospital.
- Once the Maternity benefit limit has been exceeded, you may submit claims under this benefit.
- Chronic medicine (PMB and non-PMB) - Once the chronic limit has been exceeded, you may submit claims under this benefit.
- All refractive procedures – Claims will be paid from this benefit once you have exceeded your limit under the Hospital and Trauma Benefit.

Sub-limits for certain services

The following benefits are paid at 3 x MSR up to the specified sub-limits. Once these sub-limits have been exceeded, claims will be paid from the Routine Medical Benefit limit:
Benefits: Everyday Services

### Traditional Plus Plan

The Traditional Plus Plan is managed by ONECARE and any queries that you have about the Plan should be directed to ONECARE. This Plan offers comprehensive benefits up to pre-determined sub-limits, with services paid at cost or MSR, whichever is the lesser. Once these sub-limits have been reached, the Plan continues to offer access to primary healthcare cover, on condition that you register/consult with a Nedgroup Network GP for these additional services (a network of more than 2 600 GPs). This Plan ensures that you do not run out of medically necessary access to GP consultations, prescribed medicines, radiology and pathology benefits obtained at a Nedgroup Network GP, subject to the ONECARE formulary and approved tariff list.

You will find a list of contracted GPs on the ONECARE website, www.carecross.co.za / www.onecarehealth.co.za. As with any GP consultation, you need to make an appointment before you see your chosen Nedgroup Network doctor.

### Everyday Services Benefits

The following services are covered within various sub-limits:

- General practitioners and specialists (visits, consultations, outpatients, procedures out of hospital not covered under Hospital and Trauma Benefits).
- Basic and Advanced dentistry
- Intermediate and advanced dentistry (inlays, crowns, bridgework, mounted study models, metal base partial dentures, treatment by periodontists, treatment by prosthodontists and dental technicians fees), paid at Medical Scheme Rate.
- Prescribed medicines paid at Medicine Price or Medicine Price List and antenatal vitamins prescribed during pregnancy (excluding calcium supplements and Omega preparations).
- Pathology
- Radiology (including x-rays and mammograms)
- Supplementary health services (23 practice areas including acupuncturists, anthroposophical treatment, applied kinesiology, audiology/audiometry, autologous donation of blood, ayurvedic treatment, biokinetics, chiropody, chiropractic services, clinical technology, dieticians, herbalists, naturopaths, occupational therapy, orthoptic treatment, osteopaths, phytotherapy, podiatry, reflexology, remedial therapy, speech therapists, social workers).
- Physiotherapy
- Psychology
- Medical appliances
- Hearing aids
- Optical benefits (unlimited eye tests, but frames and lenses are subject to limits).
- Maternity benefit (sub-limits for antenatal visits, ultrasound scans and antenatal classes).

### Service Details

<table>
<thead>
<tr>
<th>Service</th>
<th>M</th>
<th>A (max1)</th>
<th>C (max2)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Basic and Advanced dentistry</strong></td>
<td>R6 780 per beneficiary per year</td>
<td></td>
<td></td>
</tr>
<tr>
<td>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. Inlays, bridgework, crowns excluding gold content, mounted study models, metal base partial dentures, orthodontics, periodontists, prosthodontists and dental technicians.</td>
<td>Once this limit is exceeded, claims will be paid from the Routine Medical Benefit.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Optical</strong></td>
<td>R4 135 per beneficiary per year</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lenses, contact lenses, fitting of lenses and frames.</td>
<td>Once this limit is exceeded, claims will be paid from the Routine Medical Benefit.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Maternity</strong></td>
<td>R6 320 per family per year</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Antenatal visits, antenatal classes and ultrasound scans: Two 2D or 3D ultrasound scans</td>
<td>Once this limit is exceeded, claims will be paid from the Routine Medical Benefit.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child Vaccinations: At a private clinic:</td>
<td>R4 520 per family per year</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medication cost only, excluding facility fee or nursing consultations.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Wheelchair and associated appliances</strong></td>
<td>R10 000 per family per year</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Can be purchased or hired and will be paid for, subject to approval by the Scheme before acquisition.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Wellness Benefit</strong></td>
<td>Limited to 1 test per female beneficiary over the age of 50 per benefit year.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Any medical expenses not covered under the Wellness Benefit (such as any consultation costs, which are excluded from this benefit) will be paid from the Routine Medical Benefit.</td>
<td>Limited to 1 test per female beneficiary per benefit year.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mammmogram</td>
<td>Limited to 1 test per male beneficiary over the age of 50 per benefit year.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pap smear (tariff code 4566)</td>
<td>Limited to 1 test per male beneficiary per benefit year.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prostate Specific Antigen</td>
<td>Colorectal screening</td>
<td>Limited to 1 test per beneficiary over the age of 50 per benefit year.</td>
<td></td>
</tr>
</tbody>
</table>
Access to additional General Practitioner benefits once sub-limit has been reached

Once you have exhausted the GP, Homeopath and Specialist consultations sub-limit, certain procedures performed in your chosen Nedgroup Network GP’s surgery, as well as radiology and pathology tests as requested by this Nedgroup Network GP subject to the Scheme’s protocols and approved tariff lists, are covered.

Access to additional Prescribed Medicines once the medicine sub-limit has been reached

Once the medicine sub-limit has been exhausted, you will also enjoy additional cover for acute medication as prescribed or dispensed by your chosen Nedgroup Network GP according to a comprehensive Scheme’s medicine formulary list. Your doctor will refer to this list when dispensing or prescribing medicines. If your Nedgroup Network GP is a licensed dispensing doctor, the practice will provide you with acute medication as per the Scheme’s acute medicine formulary. If your Nedgroup Network GP is not a licensed dispensing doctor, you will be given a prescription that should be taken to your nearest Nedgroup Network Pharmacy. The pharmacist will claim directly from the Scheme and you will not have to pay for these medicines. Where the medicine prescribed is not on the formulary, you can ask the pharmacist for an equivalent on the formulary, otherwise you will be required to pay for the medicines out of your own pocket at point of sale and no benefit will be allowed. If you consult a GP who is not part of the network and the GP gives you a prescription, you will be required to pay for this medication out of your own pocket. To find out whether your prescribed medicines are on the Scheme’s acute medicine formulary, refer to the ONECARE website (www.carecross.co.za / www.onecarehealth.co.za) for a copy of the latest acute medicine formulary, or contact 0860 103 491. You will find a list of contracted pharmacies on the Scriptpharm website at www.scriptnet.co.za (click on Locate a ScriptNet Pharmacy).

Access to additional Specialist benefits

Once the sub-limit for GP, Homeopath and Specialist consultations services has been reached, you can only access the additional specialist consultations as well as procedures in specialists’ rooms if you are referred by a Nedgroup Network GP and you use a specialist authorised by the Scheme. You will need to contact the ONECARE Clinical Referral Centre to obtain the necessary authorisation number before visiting the specialist. You will be liable in the following instances:

- If your chosen Nedgroup Network GP prescribes medication that is not on the Scheme’s Prescribed Medicine Formulary list. You will claim directly from the Scheme and you will not have to pay for these medicines. Where the medicine prescribed is not on the formulary, you can ask the pharmacist for an equivalent on the formulary, otherwise you will be required to pay for the medicines out of your own pocket at point of sale and no benefit will be allowed. If you consult a GP who is not part of the network and the GP gives you a prescription, you will be required to pay for this medication out of your own pocket.
- If the annual sub-limit for prescribed medicine has been reached and your chosen Nedgroup Network GP performs surgical procedures not covered by the Scheme’s benefit and tariff structure.
- If your annual sub-limit for prescribed medicine has been reached and your chosen Nedgroup Network GP prescribes medication that is not on the Scheme’s Prescribed Medicine Formulary list.
- If the annual radiology and pathology sub-limits have been reached and the services received from a radiologist or pathologist are not covered by the benefit and tariff structure of the Scheme (i.e. tests are requested by a specialist or non-Nedgroup Network GP).

Pathology and Radiology Services

All pathology and radiology services will initially be paid from the pathology and radiology sub-limits. Once these limits have been reached, you will have access to additional pathology and radiology services out of hospital, provided that the services were requested by the Nedgroup GP and that these services are in accordance with the Scheme’s approved tariff list.
### Traditional Plus Plan

**What supplementary health services are available?**

Supplementary health services include 23 practice areas including applied kinesiology, audiology/audiology, autologous donation of blood, biokinetics, chiroprapy, chiropractic services, clinical technology, dieticians, naturopaths, occupational therapy, orthoptic treatment, podiatry, remedial therapy, speech therapists, social workers. These will be paid at cost or Medical Scheme Rate, whichever is the lesser, up to the available limit.

#### Traditional Plus Plan

The total benefit available to a member or any dependant is equal to the maximum of \( M + A \) (max 1) + \( C \) (max 2). For example: If a membership is comprised of a member, 2 adult dependants and 3 children, the total family benefit for GP, homeopath and specialist consultations available for the year is \( R1\ 885 + R1\ 880 + R560 + R560 = R4\ 885 \). The available family benefit of R4 885 can be claimed by any of the dependants and is not restricted to the allocation for that dependant.

<table>
<thead>
<tr>
<th>Services</th>
<th>M</th>
<th>A (max 1)</th>
<th>C (max 2)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. GP, Homeopath and Specialist consultations</td>
<td>R1 885</td>
<td>R1 880</td>
<td>R560</td>
</tr>
<tr>
<td>Visits, consultations, outpatient visits and procedures out-of-hospital not covered under Hospital and Trauma Benefits, as stated on page 25 - 31, paid at cost or Medical Scheme Rate, whichever is the lesser, up to the available limit.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Access to additional GP visits once limit is exceeded.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Access to additional procedures performed in a Nedgroup Network GP’s rooms once limit is exceeded (Surgery that would have necessitated hospital admission.)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>100% of cover for basic primary care at your chosen Nedgroup GP. Code 0887 Limb cast, including cost of plaster of Paris and other material and procedures out-of-hospital not covered under Hospital and Trauma benefits, as stated on page 25 - 31. You will be reimbursed according to the approved diagnosis and procedure codes.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 visit per year</td>
<td>3 visits per family per year</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Access to additional Specialist consultations (subject to referral and authorisation) once limit is exceeded.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Access to additional procedures performed in a specialist’s room, if referred by your Nedgroup Network GP. Pre-authorisation needs to be obtained for specialist consultation, paid at cost or Medical Scheme Rate, whichever is the lesser.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

---

2. **Basic dentistry**

**Paid at cost or Medical Scheme Rate,** whichever is the lesser.

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.

3. **Advanced dentistry**

**Paid at cost or MSR** whichever is the lesser.

Inlays, bridgework, crowns excluding gold content, mounted study models, metal base partial dentures, orthodontics, periodontists, prosthodontists and dental technicians.

4. **Medicine**

- **Prescribed (acute)** medicines paid at Medicine Price or Medicine Price List, whichever is the lesser.
- **Pharmacy advised therapy (PAT)** – medicines supplied by a registered pharmacist without a prescription from a medical practitioner or dentist.
- **Antenatal vitamins** prescribed during pregnancy – excluding calcium supplements and Omega preparations.

5. **Pathology**

**Paid at cost or Medical Scheme Rate,** whichever is the lesser, up to the available limit.

- **Access to additional Pathology benefits once limit exceeded**

6. **Radiology**

**Paid at cost or Medical Scheme Rate,** whichever is the lesser, up to the available limit.

---

**Services**

- **R2 690** per beneficiary per year. Once this limit is exceeded, claims will be paid from the Advanced dentistry limit.

- **R3 580**
- **R3 580**
- **R595**

- **R2 825**
- **R1 885**
- **R470**

- **R1 130** per family (subject to the prescribed medicines limit)

Once the limit is exceeded, **100% cover** for acute medicine prescribed or dispensed by your contracted Nedgroup Network provider according to the ONECARE prescribed medicine formulary. No benefit paid for medicines not included in the ONECARE prescribed medicine formulary.

**R1 690**
**R565**
**R100**

100% of cover for pathology tests requested by Nedgroup Network GP and on the ONECARE approved tariff list.

**R2 255** per family per year.
### Everyday Services

**Services**

<table>
<thead>
<tr>
<th>Services</th>
<th>M</th>
<th>A (max 1)</th>
<th>C (max 2)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>7. Supplementary health services</strong>&lt;sup&gt;a&lt;/sup&gt;</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(e.g. chiroprapy, chiropractic services, speech therapists, biokinetics)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>paid at <a href="#">cost or Medical Scheme Rate</a>, whichever is the lesser, up to the available limit</td>
<td>R1 675</td>
<td>R1 670</td>
<td>R500</td>
</tr>
<tr>
<td><strong>8. Physiotherapy</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Paid at <a href="#">cost or Medical Scheme Rate</a>, whichever is the lesser, up to the available limit</td>
<td>R2 675</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>9. Psychology</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Paid at <a href="#">cost or Medical Scheme Rate</a>, whichever is the lesser, up to the available limit</td>
<td>R5 010</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>10. Medical appliances</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not forming an integral part of an operation, e.g. baumanometer, all orthopaedic braces, and crutches. These are paid at <a href="#">cost or Medical Scheme Rate</a>, whichever is the lesser, up to the available limit. Maintenance and repairs are not covered by the Scheme, unless a full quote is received and pre-authorized by the Scheme. Approval for moulded insoles is subject to motivation from a relevant specialist.</td>
<td>R3 500</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>11. Wheelchair and associated appliances</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Can be purchased or hired and will be paid for, subject to approval by the Scheme before acquisition.</td>
<td>R10 000</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- Access to additional Radiology benefits once limit exceeded where requested by the Nedgroup Network GP in accordance with the ONECARE approved tariff list.

**Traditional Plan Querries:** Tel: 0860 100 080 / 011 671 6833 | Email: nedgroup.enquiries@medscheme.co.za

### Services

<table>
<thead>
<tr>
<th>Services</th>
<th>M</th>
<th>A (max 1)</th>
<th>C (max 2)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>12. Hearing aids</strong>&lt;sup&gt;b&lt;/sup&gt;</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>These are paid at <a href="#">cost or Medical Scheme Rate</a>, whichever is the lesser, up to the available limit</td>
<td>R2 135</td>
<td>R1 430</td>
<td>R355</td>
</tr>
<tr>
<td>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.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The cost of batteries is excluded.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>13. Optical benefits</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eye test unlimited (payable from the Optical benefit limit and, once exceeded, payable from the Overall Annual Limit)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lenses, contact lenses and fittings paid at <a href="#">cost or Medical Scheme Rate</a>, whichever is the lesser, up to the available limit.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Frames</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>14. Maternity benefits</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Paid at <a href="#">cost or Medical Scheme Rate</a>, whichever is the lesser, up to the available limit.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>15. Wellness Benefit</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Any medical expenses not covered under the Wellness Benefit (such as any consultation costs, which are excluded from this benefit) will be paid from the appropriate Everyday Services Benefit.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mammogram</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pap smear (tariff code 4566)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prostate Specific Antigen</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Colorectal screening</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>16. Traditional Plan</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**The Traditional Plan offers comprehensive benefits up to pre-determined sub-limits, with services paid at cost or MSR, whichever is the lesser. No medical savings account allocation can be made on this Plan.**

**The following services are covered, with specific sub-limits for each:**

- Antenatal visits: R2 455 per family per year.
- Ultrasound scans: 2 x two-dimensional scans per family per year.
- Antenatal classes: R1 270 per family per year.

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<sup>*</sup> Refer to the previous pages for a full list of services.
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- General practitioners and specialists (visits, consultations, outpatients, procedures out of hospital not covered under Hospital and Trauma Benefits)
- Basic dental services
- Intermediate and advanced dentistry (inlays, crowns, bridgework, mounted study models, metal base partial dentures, treatment by periodontists, treatment by prosthodontists and dental technicians fees), paid at Medical Scheme Rate
- Prescribed medicines paid at Medicine Price or Medicine Price List (MPL) and antenatal vitamins prescribed during pregnancy (excluding calcium supplements and Omega preparations)
- Pathology
- Radiology (including x-rays and mammograms)
- Supplementary health services (23 practice areas including acupuncturists, anthroposophical treatment, applied kinesiology, audiometry/audiology, autologous donation of blood, ayurvedic treatment, biokinetics, chiropracy, chiropractic services, clinical technology, dieticians, herbalists, naturopaths, occupational therapy, orthotic treatment, osteopathy, phytotherapy, podiatry, reflexology, remedial therapy, speech therapists, social workers)
- Physiotherapy
- Psychology
- Medical appliances
- Hearing aids
- Optical benefits (unlimited eye tests, but frames and lenses are subject to limits)
- Maternity benefit (sub-limits for antenatal visits, ultrasound scans and antenatal classes).
- Specific sub-limits are set out in the table below. If there is a shortfall between the benefit covered by the Scheme and the actual cost of the service, you will need to pay this difference at the point of sale.

Please note:

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.

Traditional Plan

The total benefit available to a member or any dependant is equal to the maximum of M + A (max 1) + C (max 2).

<table>
<thead>
<tr>
<th>Services</th>
<th>M</th>
<th>A (max 1)</th>
<th>C (max 2)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. General practitioners, homeopaths and specialists:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Visits, consultations, outpatient visits and procedures out-of-hospital not covered under Hospital and Trauma Benefits, as stated on page 25 - 31, paid at cost or Medical Scheme Rate, whichever is the lesser, up to the available limit.</td>
<td>R1 885</td>
<td>R1 880</td>
<td>R560</td>
</tr>
<tr>
<td>2. Basic dentistry</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Paid at cost or Medical Scheme Rate, whichever is the lesser. Removal of teeth and roots, removal of wisdom teeth, exposure of teeth for orthodontic reasons and touting of traumatic wounds, diagnosis and treatment of oral and associated conditions, plastic dentures.</td>
<td>R2 690 per beneficiary per year. Once this limit is exceeded, clams will be paid from the Advanced dentistry limit.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Advanced dentistry</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Paid at cost or Medical Scheme Rate, whichever is the lesser, up to the available limit. Inlays, bridgework, crowns excluding gold content, mounted study models, metal base partial dentures, orthodontics, periodontists, prosthodontists and dental technicians.</td>
<td>R3 580</td>
<td>R3 580</td>
<td>R595</td>
</tr>
<tr>
<td>4. Medicine</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Prescribed (acute) medicines paid at Medicine Price or Medicine Price List, whichever is the lesser.</td>
<td>R2 825</td>
<td>R1 885</td>
<td>R470</td>
</tr>
<tr>
<td>• Pharmacy advised therapy (PAT) – medicines supplied by a registered pharmacist without a prescription from a medical practitioner or dentist.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Antenatal vitamins prescribed during pregnancy – excluding calcium supplements and Omega preparations.</td>
<td>R1 130 per family (subject to the prescribed medicines limit)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Pathology</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Paid at cost or MSR, whichever is the lesser, up to the available limit.</td>
<td>R1 690</td>
<td>R565</td>
<td>R100</td>
</tr>
<tr>
<td>6. Radiology</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>X-rays and mammograms paid at cost or Medical Scheme Rate, whichever is the lesser, up to the available limit.</td>
<td>R2 255 per family per year</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Traditional Plan

<table>
<thead>
<tr>
<th>Services</th>
<th>M</th>
<th>A (max 1)</th>
<th>C (max 2)</th>
</tr>
</thead>
<tbody>
<tr>
<td>7. Supplementary health services* (e.g. chiropody, chiropractic services, speech therapists, biokinetics), paid at cost or Medical Scheme Rate, whichever is the lesser, up to the available limit. * Refer to the previous pages for a full list of services.</td>
<td></td>
<td></td>
<td>R500</td>
</tr>
<tr>
<td>8. Physiotherapy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Paid at cost or Medical Scheme Rate, whichever is the lesser, up to the available limit. Physiotherapy following hospitalisation is covered under the Hospital and Trauma Benefits, provided it is 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 or within a reasonable period of discharge.</td>
<td>R2 675</td>
<td>per family per year</td>
<td></td>
</tr>
<tr>
<td>9. Psychology</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Paid at cost or Medical Scheme Rate, whichever is the lesser, up to the available limit.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. Medical appliances</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not forming an integral part of an operation, e.g. baumanometer, all orthopaedic braces and crutches. These are paid at cost or Medical Scheme Rate, whichever is the lesser, up to the available limit. 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.</td>
<td>R3 500</td>
<td>per family per year. The frequency of the benefit will be subject to the Scheme’s clinical protocols.</td>
<td></td>
</tr>
<tr>
<td>11. Wheelchair and associated appliances</td>
<td></td>
<td></td>
<td>R10 000</td>
</tr>
<tr>
<td>Can be purchased or hired and will be paid for, subject to approval by the Scheme before acquisition.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12. Hearing aids</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• These are paid at cost or Medical Scheme Rate, whichever is the lesser, up to the available limit.</td>
<td></td>
<td></td>
<td>R27 870</td>
</tr>
<tr>
<td>• 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.</td>
<td></td>
<td></td>
<td>R19 080</td>
</tr>
<tr>
<td>• The cost of batteries is excluded.</td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

### Savings Plan

<table>
<thead>
<tr>
<th>Services</th>
<th>M</th>
<th>A (max 1)</th>
<th>C (max 2)</th>
</tr>
</thead>
<tbody>
<tr>
<td>13. Optical benefits</td>
<td></td>
<td>R2 135</td>
<td>R1 430 R355</td>
</tr>
<tr>
<td>• Eye test unlimited (payable from the Optical benefit limit and, once exceeded, payable from Overall Annual Limit)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Lenses, contact lenses and fittings paid at cost or Medical Scheme Rate, whichever is the lesser, up to the available limit.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Frames</td>
<td></td>
<td>R805 per beneficiary every 24 months (subject to the Optical benefits limit)</td>
<td></td>
</tr>
<tr>
<td>14. Maternity benefits</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Paid at cost or Medical Scheme Rate, whichever is the lesser, up to the available limit.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Antenatal visits: R2 455 per family per year.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Ultrasound scans: 2 x two-dimensional scans per family per year.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Antenatal classes: R1 270 per family per year.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15. Wellness Benefit</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Any medical expenses not covered under the Wellness Benefit (such as any consultation costs, which are excluded from this benefit) will be paid from the appropriate Everyday Services Benefit.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Mammogram</td>
<td></td>
<td>Limited to 1 test per female beneficiary over the age of 50 per benefit year.</td>
<td></td>
</tr>
<tr>
<td>• Pap smear (tariff code 4566)</td>
<td></td>
<td>Limited to 1 test per female beneficiary per benefit year.</td>
<td></td>
</tr>
<tr>
<td>• Prostate Specific Antigen</td>
<td></td>
<td>Limited to 1 test per male beneficiary over the age of 50 per benefit year.</td>
<td></td>
</tr>
<tr>
<td>• Colorectal screening</td>
<td></td>
<td>Limited to 1 test per beneficiary over the age of 50 per benefit year.</td>
<td></td>
</tr>
</tbody>
</table>

The Savings Plan consist of a personal medical savings account that provides an upfront (for the entire year) rand value amount, from which your Everyday Services Benefits claims such as doctors, specialists, optometrists and prescription medication are paid. You also qualify for additional maternity benefits, as well as Hospital and Trauma Benefits and Prescribed Minimum Benefits. Approximately 21.3% of your monthly contribution is allocated upfront (for the entire year) to a personal medical savings account. This is then used to cover your Everyday Services Benefits at cost.
How much savings will be allocated for the year?

The annual amount available to pay for Everyday Services Benefits is 12 x your monthly allocation. The 2015 annual amount to pay for Everyday Services Benefits will be calculated and allocated as follows:

- 21.3% of your monthly contributions x 3 (1 January 2015 to 31 March 2015) plus
- 21.3% of your monthly contributions x 9 (1 April 2015 to 31 December 2015)
- Contributions are payable for the first two child dependants.
- The total amounts to your 12 months’ allocation as indicated in the table below.

<table>
<thead>
<tr>
<th>Monthly Income</th>
<th>Member</th>
<th>Per Adult</th>
<th>One Child Dependant only</th>
<th>Two or more Child Dependents</th>
</tr>
</thead>
<tbody>
<tr>
<td>R0 - R6 000</td>
<td>R3 684</td>
<td>R3 174</td>
<td>R1 125</td>
<td>R2 250</td>
</tr>
<tr>
<td>R6 001+</td>
<td>R4 026</td>
<td>R3 945</td>
<td>R1 338</td>
<td>R2 676</td>
</tr>
</tbody>
</table>

Your Everyday Services treatments will be reimbursed automatically at cost from your personal medical savings account until there are no more funds available. If you have insufficient funds available in your personal medical savings account, you will need to pay any difference at the point of sale or service.

Any balance remaining in your personal medical savings account at the end of the benefit year will be carried forward to the following year.

Members who have a positive cash balance in their Savings Plan account earn interest on your Savings Plan account at the same rate that the Scheme is currently earning interest on these monies.

The total costs directly attributable to the management of your Savings Plan account, investments and administration of the bank account and investments, such as bank costs and investment management fees, will be set off against the interest allocation to members with positive cash balances. A monthly statement will be provided by the Scheme detailing the monthly transactions.

If you leave the Scheme during the benefit year, your benefits will be pro-rated. You will therefore be liable for any benefit paid by the Scheme that is more than the pro-rated amount to which you are entitled to. Please note that it is your responsibility to settle this amount before leaving the employ of the company.

For example, if you terminate your employment and membership of the Scheme in June, you will only have contributed 6 months towards the savings benefit. You may, however, have used more than 6 months’ allocation and a debt would therefore be owing to the Scheme. The annual allocation for a single member in the highest income band on the Savings Plan for savings is R4 026. If you have utilised your full savings allocation by the end of June, you will owe the Scheme 6 months of savings contributions.

Savings Plan Additional Benefits

<table>
<thead>
<tr>
<th>Item</th>
<th>Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Maternity Benefits</td>
<td>• Antenatal visits: R2 455 per family per year;</td>
</tr>
<tr>
<td></td>
<td>• Ultrasound scans: 2 x two-dimensional scans per family per year;</td>
</tr>
<tr>
<td></td>
<td>• Antenatal classes: R1 270 per family per year.</td>
</tr>
<tr>
<td>2. Wellness Benefit</td>
<td>• Mammogram: Limited to 1 test per female beneficiary over the age of 50 per benefit year.</td>
</tr>
<tr>
<td></td>
<td>• Pap smear (tariff code 4566): Limited to 1 test per female beneficiary per benefit year.</td>
</tr>
<tr>
<td></td>
<td>• Prostate Specific Antigen: Limited to 1 test per male beneficiary over the age of 50 per benefit year.</td>
</tr>
<tr>
<td></td>
<td>• Colorectal screening: Limited to 1 test per beneficiary over the age of 50 per benefit year.</td>
</tr>
</tbody>
</table>

The Hospital Plan offers Hospital and Trauma Benefits, but does not offer Everyday Services Benefits. You do, however, qualify for the pharmacy-based Wellness Benefit (covering a prescribed list of annual check-ups and preventative health screening tests subject to the use of the selected Nedgroup Network pharmacy), which will be covered by the Scheme.

You are also covered for those services that fall under Prescribed Minimum Benefits where treatment is received from your DSP, but there is no cover for the other Scheme approved chronic conditions.

No personal medical savings account allocation is available on this Plan.
MORE ABOUT YOUR MEDICAL SCHEME

Who administers my medical scheme?
The Scheme is administered by Medscheme Holdings (PTY) LTD and the Traditional Plus Plan is administered by ONECARE. Where there is a different administrative process to follow and where contact details differ for the Plans, these are clearly indicated in the relevant sections of the member guide.

When does the benefit year start?
The Scheme’s benefit year runs from 1 January to 31 December of each year. This means that if you join the Scheme from 1 January, you are entitled to the full allocation of benefits and limits. However, if you join the Scheme during a benefit year, you are only entitled to a month appropriate proportion of the benefits and limits. If any of the benefits or contributions changes during the year, the Board of Trustees will notify you accordingly.

What is the difference between medical scheme rates and private provider rates?
• Medical scheme rates (MSR) are the rates determined by the Board of Trustees. MSR are generally lower than private provider rates.
• Private provider rates (PPR) are private rates charged by the service providers.

As PPR are substantially higher than MSR, patients generally have to make a co-payment (this is where the difference comes in), unless you are on the Platinum Plan (which provides cover at 3 x MSR for Everyday Services Benefit claims) or the Savings Plan (which pays 100% of cost for Everyday Services Benefit claims).

If you visit a practitioner who charges more than the rates covered by your chosen Plan, you will have to settle the difference directly with your practitioner. This does not apply to members of the Savings Plan, as any shortfall will be paid from their personal medical savings account, if they have funds available.

What services are not covered by the Scheme?
There are certain services and procedures not covered by the Scheme, and these are known as exclusions. These exclusions apply in respect of all benefits other than the Prescribed Minimum Benefits. Unless otherwise authorised by the Scheme, no benefits will be granted in respect of any expenses or charges resulting from any of these services. A full list of excluded services and procedures is available from the Scheme upon request, but the following is given as an overview:
• All costs incurred for the treatment of conditions or injuries for which any other party may be liable
• Any wilful or self-inflicted injury or any injury that can be claimed from another source (such as a personal accident policy, the Road Accident Fund, Compensation for Occupational Injuries and Diseases Act, etc.) (Please refer to page 85 for more information.)
• Injuries resulting from professional sport
• Investigations, operations or treatments for cosmetic purposes, artificial insemination, impotence or erectile dysfunction
• Examinations for insurance, employment, visas, pilot and driver’s licences
• Holidays for recuperative purposes
• Experimental treatments
• The purchase of:
  - patent medicines, vitamins and proprietary preparations;
  - applicators, toiletries and beauty preparations;
  - bandages, cotton wool and similar aids;
  - patented foods, including baby foods;

Please note:
The Scheme pays only up to the benefit limit, as stated for each Plan, for both Hospital and Trauma Benefits and Everyday Services Benefits. The Scheme will therefore not pay the difference, even if you have not used up your annual sub-limit for a particular benefit.

What services are not covered by the Scheme?

- [List of excluded services and procedures]

- [Please note:]
  - [Explanation of limitations and exclusions]

- [Full list available from the Scheme upon request]

IN THIS SECTION:
MORE ABOUT YOUR MEDICAL SCHEME
- Who administers my medical scheme?
- When does the benefit year start?
- What is the difference between medical scheme rates and private provider rates?
- What services are not covered by the Scheme?
- tonics, slimming preparations and drugs as advertised to the public;
- household and biochemical remedies;
- sunglasses and domestic remedies; and
- exercise equipment.

Unregistered medicines (i.e. those not approved by the Medicines Control Council)

Orthodontic treatment for persons over the age of 21, excluding services required after trauma.

Who can be a member of the Scheme?
All permanent employees of Nedbank Group Limited and Mutual & Federal must belong to the Nedgroup Medical Aid Scheme as a condition of employment, unless they are dependants on their spouse’s or partner’s medical scheme.

As an employee, you qualify to become a member of the Scheme if you fall into one of the following categories and are not a beneficiary of another medical scheme:

- Employees - Permanent staff.
- Married employees or partner - If you are married or in a committed relationship, you may either join the Nedgroup Medical Aid Scheme or your spouse’s or partner’s medical scheme.
- Retirees/pensioners - A member of the Scheme who retires and continues to belong to the Scheme is called a continuation member. Retirees who were not members of the Nedgroup Medical Aid Scheme prior to retirement do not qualify for membership after retirement. Retirees who join the Nedgroup Medical Aid Scheme after retirement do not qualify to join the scheme again at a later stage.
- Widow/widower and dependants of a deceased member - Unless they join another medical scheme, this group of dependants is entitled to apply to become continuation members of the
Who is regarded as a dependant of the member?
The following people qualify as dependants:

• **Spouse** - Your spouse to whom you are legally married and who is not a member of another medical scheme. Documentation required: A copy of the marriage certificate or ID.

• **Spouse(s) in polygamous and traditional marriages** - Your spouse(s) to whom you are married in terms of any law or custom and who is not a member of another medical scheme. Documentation required: A marriage certificate, suitable other certificate or an affidavit (available from your respective HR Consultant).

• **Ex-spouse** - Your ex-spouse for whose medical expenses you are responsible in terms of a divorce settlement. Documentation required: A copy of the relevant portion of the divorce agreement.

• **Same-sex or other partner** - A person with whom you have a committed and serious relationship, similar to a marriage, based on objective criteria of mutual dependency and a shared and common household, irrespective of the gender of either party. Documentation required: An affidavit (available from your respective HR Consultant).

• **Children, adopted children, stepchildren and children placed in the care and custody of a member, spouse or partner by virtue of a court order** - You or your spouse’s partner’s child who is dependent on you, until the child turns 23. After the child turns 23, you will need to provide proof of the child’s financial dependency on you. When your child marries, he/she will no longer qualify to continue their registration as your dependant and you are obligated to advise the Scheme of this change of marital status. The child's membership of the Scheme will terminate with effect from the end of the month in which he/she is married. There are two categories of dependency:
  - A child who is financially dependent on you (you must submit financial proof of this dependency).
  - A child who is incapable of earning an income owing to mental or physical disabilities, or any similar cause (you must submit medical proof).
  - Any other member of the member’s immediate family in respect of whom you are liable for family care and support, and who is dependent on you and not a member or registered dependent of a member of another medical scheme.

Please note:
When you, as a member, apply to add a dependant to the Scheme, you will need to provide proof of your relationship to the dependant, and of the dependant’s financial dependence on you.

You should register a new dependant (e.g. spouse, new-born baby, adopted child or parent) within 30 days after they become eligible to join the Scheme as a dependant, otherwise a waiting period may apply.

You can obtain application forms for membership from your respective Benefit or HR Consultant.

It is your responsibility to ensure that the correct contributions are deducted from your salary or, if you are a retiree, that the correct amount is deducted via debit order or any other payment method. The Scheme has implemented a credit policy to ensure that arrear debt is managed appropriately.

How are waiting periods applied?
No waiting period will apply for new employees who join the Scheme within 30 days of first becoming an employee.

No waiting period will apply for an employee who undergoes a life-changing event and applies to join the Scheme within 30 days of the life-changing event taking place. A life-changing event is defined as divorce, marriage, retrenchment, spouse’s or partner’s change of employment or death. Proof of the life-changing event must be supplied.

Waiting periods will apply when members join the Scheme or dependants are registered in the following instances:

• Members who were on their spouse’s medical scheme and who voluntarily resigned to join the Nedgroup Medical Aid Scheme, other than when they first qualified to become a member.

• Dependants who were not registered at the time that they first qualified to be registered as dependants on the Scheme.

Depending on previous medical scheme membership or registration as a dependant, the waiting period to be applied may be a three-month general waiting period or a twelve-month condition-specific waiting period, or both.

Waiting periods will apply as follows:

• If you have never been a member or dependant of a medical scheme or were not covered for a period of more than 90 days immediately before applying to the Scheme, the Scheme may impose the general waiting period and the condition-specific waiting period (if the beneficiary suffers from a pre-existing condition). The waiting periods will also apply to Prescribed Minimum Benefits.

• If you have been a member or dependant of a medical scheme for less than 24 months and you apply for membership or registration as a dependant within three months of termination from the previous medical scheme (other than due to a change of employment), a condition-specific waiting period will apply. If the beneficiary suffers from a pre-existing condition, the Scheme may also impose any unexpired balances imposed by the previous scheme. The beneficiary will be entitled to Prescribed Minimum Benefits.

• If you have been a beneficiary of a medical scheme for more than 24 months and apply for membership or registration as a dependent within three months of termination from the previous medical scheme (other than due to a change of employment), the general waiting period will apply. You will be entitled to Prescribed Minimum Benefits.

What do I need to do if my dependants/membership details change?
If you are an employee, you must notify your respective HR/Benefit Consultant and if you are a retiree, you must notify Medscheme or the Pension Fund administrator, of the following:

• a change in your marital status;

• the birth of an infant or adoption of a child;

• the death of any of your dependants;

• your child becoming independent/self-supporting; or if the child marries;
• your child registering as a dependant or a member of another scheme;
• change in banking details (refunds will only be done to the member’s bank account).

What you need to do:
• Obtain a Change in Membership Details form from your HR/Benefit Consultant (or from Medscheme, if you are a retiree).
• Include the necessary documentation such as birth certificate, registration certificate issued by the hospital or death certificate.

Return the completed form and documentation to Medscheme.

Once these changes have been processed, your monthly contributions and benefits will be adjusted accordingly.

Although your membership details may change during the benefit year, you may not change Plans until the beginning of the following benefit year.

What will happen when my Scheme membership comes to an end?
You are entitled to benefits until the last day of the month in which you terminate your membership.

• No contributions are payable when a member terminates their employment on or before the 10th day of such month and benefits will continue until the end of such month. We are confirming that the system does allow for this rule.
• Contributions are payable for the full month when a member terminates their employment on or after the 11th day of such month and benefits will continue until the end of such month.

If your membership of the Scheme ends, for example if you resign, are retrenched, die or transfer to your spouse’s medical scheme, the following will happen:
• Any amounts that have been paid by the Scheme, but which exceed the benefits to which you are entitled, will be recovered from you (or your estate).
• The money in your personal medical savings account (if applicable) will be used by the Scheme to settle your share of any outstanding claims.
• If there is no money in your personal medical savings account, only the benefit amount will be paid to the service provider. You (or your estate) will be responsible for settling the balance with the service provider.

As Everyday Services Benefits under the Savings Plan are pro-rated, it is possible that (should you have selected the Savings Plan) you may have a shortfall if you terminate your membership during the benefit year. In this case, you will be responsible for settling the balance with the Scheme.

What will happen to my personal medical savings account balance?
If you leave the Scheme or transfer to a Plan that does not permit personal medical savings, then your personal medical savings account balance will be refunded to you. If you leave the Scheme and join another medical scheme that permits personal medical savings, then your personal medical savings balance must be transferred to the new Scheme.

The refund or transfer of personal medical savings account balances will take place six months after you leave or transfer. This period allows any outstanding claims to be settled against your personal medical savings account balance. The Scheme will recover any outstanding amounts from you directly if your personal medical savings balance is insufficient or if the balance has already been paid out.

Membership of more than one medical scheme
Section 28 of the Medical Schemes Act No. 131 of 1998 prohibits any person from being a member or dependant of more than one medical scheme. It is unlawful for any person to claim or accept benefits from more than one medical scheme. The medical scheme industry monitors for duplicate membership and should the Nedgroup Medical Aid Scheme become aware of any duplicate membership for a dependant, your dependant’s membership will be automatically terminated to the date prior to the start of their membership on the other medical scheme. Any authorisation or claim paid after the date of their membership on the new medical scheme will be reversed by Nedgroup Medical Aid Scheme and must be submitted to the new medical scheme for processing.
How do I submit a claim?

You do not need to complete a claim form – simply submit all invoices directly to the Scheme. Remember to keep a copy for your records.

1. Before submitting your claim, check that the following information appears on the account:
   - The name of the Scheme
   - Your membership number
   - Surname and initials of member
   - The patient’s first name(s) as it appears on your membership card, together with the date of birth
   - The name and practice number of the service provider (e.g. doctor or pharmacy)
   - ICD10 code
   - A pre-authorisation number on hospital accounts or related accounts
   - Date of service or treatment
   - Amount claimed and tariff code
   - Name, quantity and price for each supply of medicine (where relevant)

   If any of the above information does not appear on the account, it may lead to a delay in the processing of your account. Please request another account from your service provider.

2. Check that the account details are correct and that you have been charged the correct amount.

3. If you have already paid the account, clearly write “Account Paid” on the account and attach the receipt.

4. Keep a copy for your records.

5. Submit your claim (see below for details).

6. Your claim will be settled within 30 days of receipt and, in the case of a pre-paid account, the refund will be generated to you.

Where to submit your claim

<table>
<thead>
<tr>
<th>Hospital Plan, Savings Plan, Traditional Plan and Platinum Plan</th>
<th>Traditional Plus Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Via internal mail: Nedgroup Medical Aid Scheme</td>
<td>Via internal mail: ONECARE Health</td>
</tr>
<tr>
<td>36 Merriman Avenue, 2nd Floor, Vereeniging</td>
<td>10 Mill street, Newlands</td>
</tr>
<tr>
<td>Via the post office: Nedgroup Medical Aid Scheme</td>
<td>Via the post office:</td>
</tr>
<tr>
<td>PO Box 74, Vereeniging, 1930</td>
<td>ONECARE Health</td>
</tr>
<tr>
<td>Via fax: 0860 111 784</td>
<td>P O Box 44991, Claremont, 7735</td>
</tr>
<tr>
<td>Via scan: <a href="mailto:claims@medscheme.co.za">claims@medscheme.co.za</a></td>
<td>Via fax: 021 673 1811</td>
</tr>
<tr>
<td></td>
<td>Via scan: <a href="mailto:nedgroupclaims@onecarehealth.co.za">nedgroupclaims@onecarehealth.co.za</a></td>
</tr>
</tbody>
</table>

If you are faxing or scanning claims

To ensure that claims are promptly processed, please consider the following:

- Check legibility (if the scan is illegible, the administrators will be unable to process the claim. If the contact details are not legible, the member can also not be notified of the concerns.)
- Place your name and contact number on the claim.
- Use the scan facility, the fax facility or normal postage services (but please do not submit the same claim using various methods, as duplicate claims may also lead to delays).
- For audits, the administrator is required to retain legible copies of all member claims.
- Check the size of the email and zip the attachment (if necessary) to ensure that the size of the email is smaller than 2MB. Emails larger than 2MB will not be received by the server.

How can service providers submit claims electronically?

Most service providers submit claims electronically. These claims are then paid directly by the Scheme to the service provider, subject to available limits.
If your service provider uses this facility, ask them for a copy of the claim for your records and check that the services and amounts charged are in fact correct. You do not need to submit a copy, unless you notice on your member statement that the claim has not been processed after a reasonable time. Remember, it remains the member’s responsibility to ensure that claims have been submitted within a period of four months after treatment has been obtained and paid and you are encouraged to review your monthly claims advice/remittance statements.

If the Scheme amends any of the benefits offered, please note that claims submitted after these amendments will be paid according to the rules that existed at the date of the service and not the rules that exist at the date when the claims are submitted or received.

**HINTS:**

Check whether your doctor has submitted the claim on your behalf.

You must submit your claim as soon as possible after receiving the service. If your claim is received later than four months after the date of service, the claim will be considered stale and will not be paid by the Scheme. For example, if you visit the dentist on 20 April, the administrator must receive the claim before 20 August of the same year.

Remember to keep all your claims advices, payment advices and personal medical savings account statements for your records.

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**How can I see my claims online?**

<table>
<thead>
<tr>
<th>Hospital Plan, Savings Plan, Traditional Plan and Platinum Plan</th>
<th>Traditional Plus Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Members may register on Medscheme’s website and access the following self-help facilities of Medscheme on <a href="http://www.medscheme.co.za">www.medscheme.co.za</a>:</td>
<td>Members may register on ONECARE’s website and access the following self-help facilities of ONECARE on <a href="http://www.carecross.co.za">www.carecross.co.za</a>:</td>
</tr>
<tr>
<td><strong>Registration information</strong>&lt;br&gt;The process to register will only take a few minutes and in future you will have direct access to your medical scheme information.&lt;br&gt;1. Go to <a href="http://www.medscheme.co.za">www.medscheme.co.za</a>&lt;br&gt;2. Click on the <strong>I am a…</strong> tab on the top right-hand corner of the Homepage.&lt;br&gt;3. Click on the appropriate option: <strong>Member</strong>.&lt;br&gt;4. Click on <strong>Register</strong>.&lt;br&gt;5. Click on the appropriate registration option: I <strong>would like to register as a Member</strong>.&lt;br&gt;6. Enter your <strong>membership number</strong>.&lt;br&gt;7. Click on <strong>Validate Code</strong> once your details have been entered.&lt;br&gt;8. Select a <strong>beneficiary</strong> to register.&lt;br&gt;9. Choose a <strong>username</strong>. Your username has to be longer than 8 characters.&lt;br&gt;10. Type in your <strong>email address</strong>.&lt;br&gt;11. Choose a <strong>Password</strong>. Your password must be 8 characters and is case sensitive. No “&amp;” signs allowed.&lt;br&gt;12. Click on <strong>Create Account</strong>.&lt;br&gt;13. You will shortly thereafter receive an e-mail from <a href="mailto:webquery@medscheme.co.za">webquery@medscheme.co.za</a>. Click on the <strong>Activate</strong> link in the e-mail. It will direct you to the login section of the member zone of the site.&lt;br&gt;14. You will now be able to login and use the website functionality with your username and password.</td>
<td><strong>Registration information</strong>&lt;br&gt;The process to register will only take a few minutes and in future you will have direct access to your medical scheme information.&lt;br&gt;1. Go to <a href="http://www.carecross.co.za/SC_nedgroup">www.carecross.co.za/SC_nedgroup</a>&lt;br&gt;2. Click on Login.&lt;br&gt;3. Click on Register.&lt;br&gt;4. Click on the <strong>I agree</strong> for the Terms and Conditions.&lt;br&gt;5. Click on the appropriate registration option: Members.&lt;br&gt;6. Complete the form to register as an online user and click on Register Member.&lt;br&gt;7. CareCross will generate a username and password for you and an activation option will be emailed or SMS ed to you.&lt;br&gt;8. You will be required to activate your profile and then login and use the website functionality with your username and password.</td>
</tr>
</tbody>
</table>

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**Whom should I contact if I have any queries about claims?**

<table>
<thead>
<tr>
<th>Hospital Plan, Savings Plan, Traditional Plan and Platinum Plan</th>
<th>Traditional Plus Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Queries</strong>&lt;br&gt;If you have any queries regarding claims, you should contact Medscheme at 0860 100 080.</td>
<td><strong>Queries</strong>&lt;br&gt;If you have any queries regarding claims, you should contact ONECARE Health at 0860 103 491.</td>
</tr>
</tbody>
</table>
What medical scheme cover will I have while outside South Africa on holiday or on business?

If you are injured or become ill while outside South Africa on holiday or business, you will be responsible for settling the account. You may claim the cost back from the Scheme when you return. However, if your account is in a foreign language, this must be fully translated and detailed.

The reimbursement will be paid according to the equivalent Nedgroup Medical Aid Scheme benefits and will be refunded in South African rands, subject to the exchange rate on the date of treatment. If you are intending to travel abroad, it is wise to take out additional medical cover. Your travel agent will be able to assist you with this or you can purchase this cover online. If you have purchased your travel tickets with your credit card, please check with your bank whether travel cover is included.

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.

ER24 is contracted by the Scheme to arrange for appropriate emergency medical services for our members. The direct number is +27 102 053 038 to access emergency medical assistance during your stay in any of the countries covered outside our borders. For emergency medical services within the borders of South Africa, you may contact them at 0861 633 911 or 084 124.

What rules apply if I have been involved in a motor car accident?

In certain circumstances, you may not be covered by the Scheme for injuries resulting from a motor vehicle accident, as these medical expenses can be claimed from a third party.

If you are involved in a motor vehicle accident, you should consult an attorney to find out whether you have a claim against the Road Accident Fund.

If you have a valid claim, your attorney must submit an indemnity letter to the Scheme, in which case the Scheme will pay for your medical costs up to the available benefits. This will be done on the undertaking that the Scheme will be reimbursed once the claim is paid by the third party, i.e. the Road Accident Fund. (Alexander Forbes is contracted by the Scheme to identify Road Accident Fund Claims and to liaise with your attorney and the Road Accident Fund to recover monies paid on your behalf for past medical expenses related to the accident.) You should always inform the Scheme when you claim from another source.

If the attorney determines that there is no claim against the Road Accident Fund, the Scheme will pay for the medical costs that were incurred as per the Scheme Rules.

How can I claim in terms of the Compensation for Occupational Injuries and Diseases Act?

In certain circumstances, you may not be covered by the Scheme for injuries resulting from an accident sustained in the workplace, as these medical expenses can be claimed from a third party. Claims in terms of the Compensation for Occupational Injuries and Diseases Act are not covered by the Scheme.

Forms for the Compensation for Occupational Injuries and Diseases Act should be completed by the treating hospital or medical practitioner and the relevant employer, and then submitted to the Commissioner of Occupational Injuries and Diseases.

The Scheme will not pay any benefits until the Commissioner rules that the injury does not fall under the Compensation for Occupational Injuries and Diseases Act.

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The Scheme will not pay any benefits until the Commissioner rules that the injury does not fall under the Compensation for Occupational Injuries and Diseases Act.
If you are still not satisfied, please escalate to the office of the Principal Officer:

Nicole Jones  
Email: nicolejon@nedbank.co.za | Tel: (021) 412 3587

Julia le Roux  
Email: julial@nedbank.co.za | Tel: (021) 412 3814

What can I do if I have a complaint against my medical scheme?

The Registrar of Medical Schemes is the regulator of the medical scheme industry. Any member or any person who is aggrieved with the conduct of a medical scheme, health professionals, private hospital or nurse, can submit a complaint to the Registrar’s Office. However, the Registrar requires that members FIRST try to resolve any complaints with their medical scheme, before they contact the Registrar.

Once you have tried and failed to resolve a complaint with the Scheme, you may contact the Registrar to make a complaint. Complaints can be submitted through fax, e-mail or in person at the Registrar’s office. The Registrar’s contact details are as follows:

**Council for Medical Schemes**

Block A Eco Glades 2 Office Park, 420 Witch-Hazel Street, Ecopark, CENTURION, 0157  
Website address: www.medicalschemes.com – (on the landing page there is a quick links toolbar; click on the “How to lodge a complaint” link for further information.)  
Telephone no.: (012) 431 0500  
Fax no.: (012) 431 0608  
Customer Care Share call no.: 0861 123 267  
E-mail address: complaints@medicalschemes.com

• The Registrar’s Office will send a written acknowledgement of a complaint within 3 working days of its receipt, providing the name, reference number and contact details of the person who will be dealing with the complaint.

• In terms of Section 47 of the Medical Schemes Act, a written complaint received in relation to any matter provided for in this Act will be referred to the medical scheme. The medical scheme is obliged to provide a written response to the Registrar’s Office within 30 days.

• The Registrar’s Office shall within 4 days of receiving the complaint from the administrator, analyse the complaint and refer a complaint to the medical scheme for comments.

• Upon receipt of the response from the medical scheme, the Registrar’s Office will analyse the response in order to make a decision or ruling. Decisions / rulings will be made within 120 days of the date of referral of a complaint and communicated to the parties.

**The Registrar’s Ruling and appeal to Council**

• Section 49 of the Act makes provision for any party who is aggrieved with the decision of the Registrar to appeal such a decision. This appeal is at no cost to either of the parties.

• An appeal must be lodged within 30 days of the date of the decision. The operation of the decision shall be suspended pending review of the matter by the Council’s Appeals Committee.

• The secretariat of the Appeals Committee will inform all parties involved of the date and time of the hearing. This notice should be provided no less than 14 days before the date of the hearing.

• The parties may appear before the Committee and tender evidence or submit written arguments or explanations in person or through a representative.

• The Appeals Committee may after the hearing confirm or vary the decision concerned or rescind it and give another decision as they deem just.

**The Section 50 Appeals process**

• Any party that is aggrieved with the decision of the Appeals Committee may appeal to the Appeal Board.

• The aggrieved party has 60 days within which to appeal the decision and must submit written arguments or explanation of the grounds of his or her appeal.

• The Appeal Board shall determine the date, time and venue for the hearing and all parties will be notified in writing.

• Appeal Board shall be heard in public unless the chairperson decides otherwise.

• The Appeal Board shall have the powers which the High Court has to summon witnesses, to cause an oath or affirmation to be administered by them, to examine them, and to call for the production of books, documents and objects.

• The decisions of the Appeal Board are in writing and a copy thereof shall be furnished to the parties. A prescribed fee of R2000 is payable for Section 50 Appeals.
How can I keep my medical costs low?

- Negotiate with your doctor to charge the recommended tariff or to give you a discount, if he or she has opted out of charging medical scheme rates.
- Talk to your doctor about prescribed medicines. An alternative generic medicine may be as effective, and cost you much less. If you are too shy to approach the doctor, the dispensing pharmacist can do this for you.
- Try to avoid all unnecessary treatments. This is wasteful and costly to you and the Scheme.
- 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, please arrange for the hospital admission after 12pm. That way the Scheme will only pay for the afternoon (i.e. a half-day).

What do I do if I suspect fraudulent activity against the Scheme?

Unnecessary and fraudulent expenses are funded by you, the member, through increased contributions. You can contribute towards the fight against fraud by carefully and regularly checking your claims transactions and making sure that you have not been involved in a fraud scam without your knowledge.

Examples of fraud scams discovered by the Scheme have been:

- A service provider putting in a claim for services that were never rendered.
- A service provider performing a procedure or giving treatment that is excluded by the Scheme rules, and then charging for it under a different code.
- A pharmacy providing generic medicine, but charging for the more expensive brand name.

If you suspect that a service provider, colleague or any other person or organisation may be engaged in fraudulent activities against the Scheme, please contact the Fraud Hotline on 0800 112 811. This hotline is managed by an independent company, Tip-Offs Anonymous, and you can choose to remain anonymous. You can also email fraud@medscheme.co.za to report your suspicions.

When do I get my tax certificate from the Scheme and how can I request a copy of the tax certificate?

The medical scheme will e-mail the tax certificate to you in May of each year.

You may e-mail nedgroup.enquiries@medscheme.co.za to request a copy or if you are on the Traditional Plus Plan, email nedgroup@onecarehealth.co.za. Alternatively, log on to the secure website at www.medscheme.co.za and download your tax certificate or make use of the member self-help service.

Where can I obtain a membership certificate?

You may e-mail nedgroup.enquiries@medscheme.co.za.

How can I replace or get additional medical scheme membership cards?

Contact your Benefit or HR consultant or e-mail nedgroup.enquiries@medscheme.co.za.

As a retiree, why am I entitled to maternity benefits when the Scheme could rather increase my other benefits?

Maternity benefits are part of the Prescribed Minimum Benefits (PMB) that must by law (Medical Schemes Act, 1998) be made available to all members by the Scheme, irrespective of age. That is why you will find maternity benefits offered on all our Plans. It is therefore not permissible to remove this benefit from retirees’ benefits and ‘credit’ them with other, more age-related benefits.

In accordance with the Medical Scheme Act, all members registered on the same Plan must be provided the same benefit package. No differentiation of benefits is allowed based on age, gender or income.
## JARGON GUIDE

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual limit</td>
<td>The maximum amount of cover that you have for medical expenses during a benefit year.</td>
</tr>
<tr>
<td>Benefit year</td>
<td>The period for which benefits and allocations apply, in this case 1 January to 31 December. Should you join the Scheme during a benefit year, you are only entitled to a month appropriate portion of the benefits and limits specified for that year.</td>
</tr>
<tr>
<td>Child dependant</td>
<td>A member’s dependent child, including a stepchild or legally adopted child, who is under the age of 23 years.</td>
</tr>
<tr>
<td>Everyday Services Benefits</td>
<td>These benefits cover medical treatment that you receive out of hospital or as an outpatient at a hospital.</td>
</tr>
<tr>
<td>Designated service provider (DSP)</td>
<td>Appointed by the Scheme to provide certain specified medical services to members, e.g. a group of service providers or a state facility.</td>
</tr>
<tr>
<td>Hospital &amp; Trauma Benefits</td>
<td>These generally cover the major medical expenses that you would incur when undergoing surgery or while admitted in hospital.</td>
</tr>
<tr>
<td>ICD10 code</td>
<td>International Classification of Diseases (ICD)10 coding is a system that classifies diseases and the complications connected to these diseases according to a specific category.</td>
</tr>
<tr>
<td>Medical protocols</td>
<td>A set of pre-approved treatments authorised for PMB and other conditions to be followed by service providers.</td>
</tr>
<tr>
<td>Medical scheme rates (MSR)</td>
<td>The rate determined by the Board of Trustees.</td>
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<tr>
<td>Medicine formularies</td>
<td>A list of approved medicines that may be used by a dispensing doctor or pharmacist for treatment.</td>
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<tr>
<td>Medicine price (SEP)</td>
<td>Single exit price plus dispensing fee.</td>
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<tr>
<td>Personal Medical savings account</td>
<td>A savings account to accumulate funds for future approved medical needs (Savings Plan only).</td>
</tr>
<tr>
<td>Pre-authorisation</td>
<td>The process whereby a member advises the Scheme of his/her or a dependant’s admission to hospital. Penalties are payable if you do not pre-authorise.</td>
</tr>
<tr>
<td>Prescribed Minimum Benefits (PMB)</td>
<td>The unlimited benefit to which all members are entitled for treatment related to the conditions specified in the Medical Schemes Act, provided this treatment is obtained at a DSP and subject to the Scheme’s treatment protocols and formularies.</td>
</tr>
<tr>
<td>Private Provider Rates (PPR)</td>
<td>The rates charged by private providers.</td>
</tr>
<tr>
<td>Shortfall</td>
<td>Any amount paid by the Scheme on your behalf that exceeds the amount to which you are entitled.</td>
</tr>
<tr>
<td>Sub-limit</td>
<td>The maximum amount of cover you have available for specified medical expenses during a benefit year.</td>
</tr>
<tr>
<td>Treatment Plan</td>
<td>A summary of benefits that will be covered in terms of your PMB related condition.</td>
</tr>
<tr>
<td>Waiting period</td>
<td>The period during which you will not be covered for any medical expenses incurred, even though you will be making contributions to the Scheme.</td>
</tr>
<tr>
<td>Condition-specific waiting period:</td>
<td>A period during which a beneficiary is not entitled to claim benefits in respect of a condition for which medical advice, diagnosis, care or treatment was recommended or received within the 12-month period ending on the date on which an application for membership was made.</td>
</tr>
<tr>
<td>General waiting period:</td>
<td>A three-month period during which a beneficiary is not entitled to claim any benefits.</td>
</tr>
</tbody>
</table>