MALCOR
MEDICAL AID SCHEME
Administered by Discovery

MALCOR MEDICAL AID SCHEME | 2025

BENEFIT GUIDE

CONTENTS

A HEALTHY APPROACH TO

QUALITY AND CARE IN 2025

Malcor Medical Aid Scheme provides excellent healthcare benefits that would truly make a difference in the lives of you and your loved ones. You have complete peace of mind that your healthcare is in good hands at every stage of your health journey.

We have designed this benefit guide to provide you with a summary of information on how to get the most out of the Scheme's benefits. To see what we have in store for you in 2025, you can also access the guide on the homepage of the website **www.malcormedicalaid.co.za**.

ABOUT THIS BENEFIT GUIDE

This booklet serves as a guide to the Malcor Medical Aid Scheme. It consists of information about your membership and benefits. This Benefit Guide is merely a summary of the benefits and features of the Malcor Medical Aid Scheme plans and is subject to the Rules of the Malcor Medical Aid Scheme. The Rules of the Scheme will apply in all circumstances. Members who require further information should contact their personnel departments or the Scheme at **0860 100 698**.

This brochure provides you with a summary of the benefits and features of the Malcor Medical Aid Scheme, pending approval from the Council for Medical Schemes. The Malcor Medical Aid Scheme is a closed Scheme, and is administered by Discovery Health (Pty) Ltd.

This brochure gives you a brief outline of the benefits Malcor Medical Aid Scheme offers. This does not replace the Scheme Rules. The registered Scheme Rules are legally binding and always take precedence.

Detailed benefit documents may be obtained from www.malcormedicalaid.co.za > Find a document if you are registered as an online user. Please share this information with your dependants who are your beneficiary members of the Malcor Medical Aid Scheme.

WHO CAN JOIN THE MALCOR MEDICAL AID SCHEME?

The Malcor Medical Aid Scheme is a restricted-access medical scheme for a number of associated employer groups. An employer is defined as 'any company or organisation that was previously a subsidiary or an associated company of Malbak Limited at the time of the latter's dissolution in 1996, or has subsequently been acquired by such companies or organisations'. Employers currently making use of the Malcor Medical Aid Scheme include, but are not limited to, CFAO Motors South Africa formerly known as Unitrans Automotive, Defy Appliances (Pty) Ltd, Aspen Holdings (Pty) Ltd and Omnia Holdings Limited.

Membership is available to all employees of approved employers subject, in certain cases, to the satisfactory outcome of a medical examination.

WHO MAY JOIN AS YOUR DEPENDANT?

- Your spouse or partner in a committed and serious relationship similar to marriage, including mutual dependency and both partners living in a shared and common household.
- Your children can be added as dependants on your health plan. Your child needs to be financially dependent on you to qualify for cover as an adult dependant. They may be students, or are mentally or physically disabled.
- You have 30 days in which to register a new spouse. We count the 30 days from the date of marriage.
- You have 60 days in which to register a newborn baby. We count the 60 days from the date of birth.

GENERAL GUIDELINES

ON THE MALCOR MEDICAL AID SCHEME

Members and their dependants are entitled to benefits from the date their membership commences as reflected on their membership cards.

There are certain limitations and exclusions applicable to all members. To avoid incurring personal liability for medical treatment, members should, if in any doubt, refer to the Scheme's Rules or contact the Scheme for clarification prior to agreeing to such treatment.

The Scheme is, according to the Medical Schemes Act, allowed to apply a Late-Joiner Penalty (LJP) to an applicant or to the dependant of an applicant who fits the definition of a late-joiner. The LJP fee is a percentage increase in a member's contribution. It is a lifetime penalty that is not be removed, even when members move from one registered South African medical scheme to another.

It is recommended that members who are about to embark on any costly treatment that does not require specific preauthorisation, such as orthodontic treatment, submit quotations to the Scheme to obtain information about the extent to which the Scheme will cover the proposed treatment.

PLAN D members might be required to preauthorise all benefits BEFORE consulting with service providers. You may confirm benefits by calling Enablemed on 0860 002 402.

Annual limits are apportioned according to the period of membership in relation to the benefit year i.e. 1 January to 31 December. Thus your benefit limits will be prorated if you join during the benefit year.

FOUR INNOVATIVE COVER PLANS

Plan A

A traditional, fully comprehensive plan designed for those seeking complete healthcare cover

Excellent out-of-hospital limits

All in-hospital costs are covered at 100% of the Scheme Rate

Plan B

A traditional, fully comprehensive plan designed for those seeking decent healthcare cover

Good out-of-hospital limits

All in-hospital costs are covered at 100% of the Scheme Rate

Plan C

A traditional, fully comprehensive plan designed for those seeking basic healthcare cover

Limited out-of-hospital cover

All in-hospital costs are covered at 100% of the Scheme Rate

Plan D

Low-cost, network option administered by Enablemed

Choice of own GP and access to private hospitals

Chronic medicine is covered as set out in the Prescribed Minimum Benefit guidelines and includes chronic illnesses that are on the Chronic Disease List.

PREAUTHORISATION FOR HOSPITALISATION

You must call the Malcor Medical Aid Scheme on 0860 100 698 to get preauthorisation for all your hospital treatment, except in the case of an emergency.

You will be given an authorisation number if your treatment is approved. In the case of an emergency where you are unable to phone the Malcor Medical Aid Scheme to obtain authorisation in advance, you or a family member must call the Scheme within three days from the date of admission.

PREAUTHORISATION IS ALSO REQUIRED FOR THE FOLLOWING TREATMENT

- Oncology and radiotherapy
- Hospice
- Sterilisation
- Infertility treatments
- Step-down and rehabilitation facilities in the private sector
- Specialised dentistry in hospital
- Registered nursing services
- Super antibiotics
- Biologicals.

DAY SURGERY NETWORK FOR CERTAIN PROCEDURES OR OPERATIONS

Certain procedures must be performed at one of the Scheme's Day-Surgery Network facilities. You will find details of the Day Surgery facilities near you on the website at **www.malcormedicalaid.co.za.**

You must have the listed procedures done at one of these accredited Day Surgery Network facilities as they are the Designated Service Providers for the Scheme.

If you do not go to one of the Scheme's designated facilities, a R6,650 deductible will apply to the facility account.

Ear, nose and throat procedures

- Tonsillectomy and/or adenoidectomy
- Repair nasal turbinates, nasal septum
- Simple procedures for nose bleed (extensive cautery)
- Scopes, nasal endoscopy (laryngoscopy)
- Middle ear procedures (mastoidectomy, myringoplasty, myringotomy and/ grommets)
- Sinus lavage

Orthopaedic procedures

- Tendon and/or ligament repair, muscle debridement, fascia procedures (tenotomy, tenodesis. tenolysis, repair/reconstruction, capsulotomy, capsulectomy, synovectomy, excision tendon sheath lesion, fasciotomy, fasciectomy)
- Repair of bunion toe deformity
- Arthroscopy, arthrotomy (shoulder, elbow, knee, ankle, hand, wrist, foot, temporomandibular joint), arthrodesis (hand, wrist, foot)
- Treatment of simple closed fractures and or dislocations, removal of pins, and plates, subject to individual case review
- Minor joint arthroplasty (intercarpal, carpometacarpal and metacarpophalangeal, interphalangeal joint arthroplasty)

Gastrointestinal procedures

- Gastrointestinal scopes (oesophagoscopy, gastroscopy, colonoscopy, sigmoidoscopy, proctoscopy, anoscopy)
- Anorectal procedures (treatment of haemorrhoids, fissure, fistula)

Urological procedures

- Cystoscopy
- Male genital procedures (circumcision, repair of penis, exploration of testes and scrotum, orchiectomy, epididymectomy, excision hydrocoele, excision varicocele vasectomy)

Gynaecological procedures

- Colposcopy with large loop excision of the transformation
- Diagnostic Dilatation and Curettage
- Endometrial ablation
- Diagnostic Hysteroscopy
- Examination under anaesthesia
- Diagnostic laparoscopy
- Simple vulval and introitus procedures: simple hymenotomy, partial hymenectomy, simple vulvectomy, excision bartholin's gland cyst
- Vaginal, cervix and oviduct procedures: excision vaginal septum, cyst or tumour, tubal ligation or occlusion, uterine cervix cerclage, removal cerclage suture
- Suction curettage
- Uterine evacuation and curettage

Eye procedure

- Cataract surgery
- Treatment of glaucoma
- Other eye procedures: (removal of foreign body, conjunctival surgery (repair laceration, pterygium), glaucoma surgery, probing and repair of tear ducts, vitrectomy, retinal surgery, eyelid surgery, strabismus repair)
- Corneal transplant

Ganglionectomy

Simple superficial lymphadenectomy

Approved breast procedures

- Mastectomy for gynecomastia
- Lumpectomy (fibroadenoma)

Skin procedures

- Debridement
- Simple repair of superficial wounds
- Remove of lesions (dependent on site and diameter)

Biopsies

- Skin, soft tissue, muscle bone, lymph, eye, mouth, throat, breast, cervix, valva, prostate, penis, testes, subcutaneous tissue

Removal of foreign body

- Subcutaneous tissue, muscle, external auditory, canal under general anaesthesia

Simple hernia procedures

- Umbilical hernia repair
- Inguinal hernia repair

Nerve procedures

- Neuroplasty median nerve, ulnar nerve, digital, nerve of hand or foot.

HELPING YOU

GET THE MOST OUT OF YOUR COVER

MAKE THE FULL COVER CHOICE

We offer members the choice to be covered in full for hospitalisation, specialists (in-hospital), chronic medicine and GP consultations. Look out for the Full Cover Choice stamp in this benefit guide. It shows you when to use our range of online tools that guide you to full cover.

Remember that your claims are still subject to the overall annual limit. We have payment arrangements with certain GPs. These GPs agree to join the Discovery Health GP Network to which you have access.

We will refer to the networks and payment arrangements throughout the Benefit Guide.

MEMBERS ON THE MALCOR MEDICAL AID SCHEME MAY HAVE A CO–PAYMENT FOR IN-AND OUT-OF-HOSPITAL SPECIALIST COVER

If you are treated by a specialist out-of-hospital, the Malcor Medical Aid Scheme will cover up to 120% of the Scheme Rate for Plan A and 100% of the Scheme Rate for Plan B and C. Please log in to the Malcor Medical Aid Scheme website at www.malcormedicalaid.co.za > Doctor visits > Find a healthcare professional to find your nearest in-hospital network specialist at a DSP hospital for full cover. The Malcor Medical Aid Scheme has selected the following hospitals as the Scheme's in-hospital Designated Service Provider (DSP) or 'network':

- National
  All MediClinic hospitals
- Kwazulu-Natal
  Busamed Gateway
  Busamed Hillcrest
- East London
  Life East-London
- Gqeberha
  Life St George's

The Scheme will cover up to 100% of the Scheme Rate if you are treated in a hospital outside of the network.

WHEN YOU NEED TO GO TO THE DOCTOR

Our Medical and Provider Search Advisor (MaPS) tool helps you find a healthcare professional with whom we have an agreement. These healthcare professionals have agreed to only charge you the Scheme Rate and we pay them in full.

Log in to www.malcormedicalaid.co.za and click on Doctor visits > Find a healthcare professional. You will be able to search for providers by geographical location or speciality. Each provider shown on the MaPS tool is shown with a tag to indicate whether or not they are a network doctor.

GP NETWORK DOCTORS ARE PAID DIRECTLY IN FULL

When you see a GP in the GP Network, their consultation cost will be paid in full. If you choose to usea GP that is not in the network, the Scheme will reimburse your consultation at the Scheme Rate.

Please log in to the Malcor Medical Aid Scheme website at www.malcormedicalaid.co.za > Doctor visits > Find a healthcare professional to find your nearest participating GP.

COMPREHENSIVE MATERNITY AND POST-BIRTH BENEFITS

Members on **Plan A and Plan B** will have access to comprehensive maternity and post-birth risk benefits. Members will be further supported through access to 24/7 support, advice and guidance. These benefits do not affect members' day-to-day benefits and are funded from the risk benefit at the Scheme Rate. The benefit must be activated by the member by dialing 0860 100 698.

Benefits during Pregnancy

- Antenatal Consultations: 12 visits to a GP, gynaecologist or midwife
- Ultrasound Scans & Prenatal Screening: Up to 2 ultrasound scans, 1 nuchal translucency or Non-Invasive Prenatal Test (NIPT) or down syndrome screening test covered
- Blood Tests: Defined list of tests per pregnancy
- Pre- or postnatal Classes or Consultation with a nurse: Up to 5 pre-or post natal classes or consultations with a registered nurse
- Private Ward Cover: up to Scheme rate p/day (Plan A only)
- Essential registered devices: up to R4,370 (Plan A) R2,140 (Plan B) e.g. breast pumps and smart thermometers.

Post-birth Benefits

- Post natal classes or consultation with a nurse: 5 pre-or post natal classes or consultations with a registered nurse
- GP & Specialist Consultations: Up to 2 visits with a GP, paediatrician or ENT for baby
- Six Week Consultation: 1 six week post-birth consultation with a GP or gynaecologist
- Nutrition Assessment: 1 nutrition assessment with a dietician
- Mental Health: 2 mental health consultations with a GP, gynaecologist or psychologist
- Lactation Consultation: 1 lactation consultation with a registered nurse or lactation specialist.

COVER FOR GOING TO CASUALTY

If you are admitted to hospital from casualty, we will cover the costs of the casualty visit from your Hospital Benefit, as long as we preauthorise your hospital admission. If an admission occurs after hours, you must apply for authorisation on the next available working day. If you go to a casualty or emergency room and you are not admitted to hospital, the Scheme will pay the claims from your out-of-hospital benefits. Some casualties charge a facility fee, which we do not cover.

PATIENT MANAGEMENT PROGRAMMES
AND CHRONIC ILLNESS COVER

The Scheme will fund approved medicine on the medicine list or medicine with the same active ingredient as the approved medicine list up to the Maximum Medical Aid Price (MMAP). Medicine not on the medicine list will not be approved from the Chronic Illness Benefit (CIB) and will be funded from the Acute Medicine limit or by yourself. There are further Additional Disease List conditions that are covered for members on Malcor Plan A.

ADVANCED ILLNESS BENEFIT

Members with cancer have access to a comprehensive quality care programme. This programme offers unlimited cover for approved care at home.

COVER FOR CHRONIC MEDICINES

The following guidelines apply to chronic medication covered by the Scheme

The Chronic Illness Benefit covers approved medicine for the 27 Prescribed Minimum Benefit (PMB) Chronic Disease List (CDL) conditions, including HIV and AIDS. The Scheme will fund approved medicine on the medicine list or medicine with the same active ingredient as the approved medicine up to the Maximum Medical Aid Price (MMAP). Medicine not on the medicine list will not be approved from the Chronic Illness Benefit (CIB) and will be funded from the Acute Medicine limit or by yourself.

If your condition is approved by the Chronic Illness Benefit, it will cover certain procedures, tests and consultations for the diagnosis and ongoing management of the 27 Prescribed Minimum Benefits (PMBs) Chronic Disease List CDL conditions (including HIV and AIDS) in line with Prescribed Minimum Benefits.

Chronic Disease List (CDL) conditions (all plans)

All members qualify for chronic medication for the following 27 conditions on the Chronic Disease List (CDL) that the Medical Schemes Act (No 131 of 1998) defines as Prescribed Minimum Benefits:

- Addison's Disease
- Asthma
- Bipolar Mood Disorder
- Bronchiectasis
- Cardiac Failure
- Cardiomyopathy
- Chronic Obstructive Pulmonary Disease
- Chronic Renal Disease
- Coronary Artery Disease
- Crohn's Disease
- Diabetes Insipidus
- Diabetes Mellitus Type 1
- Diabetes Mellitus Type 2
- Dysrythmia
- Epilepsy
- Glaucoma
- Haemophilia
- HIV/AIDS
- Hyperlipidaemia
- Hypertension
- Hypothyroidism
- Multiple Sclerosis
- Parkinson's Disease
- Rheumatoid Arthritis
- Schizophrenia
- Systemic Lupus Erythematosus
- Ulcerative Colitis.

Additional Disease List (ADL) available to Plan A members only		
▪ Acne	▪ Chronic Hepatitis	▪ Narcolepsy
▪ Allergic Rhinitis	▪ Cystic Fibrosis	▪ Obsessive Compulsive Disorder
▪ Ankylosing Spondylitis	▪ Depression	▪ Osteoarthritis
▪ Arthritis	▪ Gastro-oesophageal Reflux Disease	▪ Osteoporosis
▪ Attention Deficit and Hyperactivity Disorder (ADHD)	▪ Motor Neurone Disease	▪ Paget's Disease
▪ Barret's Oesophagus	▪ Myasthenia Gravis	▪ Psoriasis
		▪ Psoriatic Arthritis.

You must apply for chronic cover by completing a Chronic Illness Benefit application form with your doctor and submit it for review. The application form is available at **www.malcormedicalaid.co.za > Find a document**. Alternatively, you can call **0860 100 698** or your healthcare professional can call **0860 44 55 66** for assistance. For a condition to be covered from the Chronic Illness Benefit, there are certain benefit entry criteria that the member needs to meet. If necessary, you or your doctor may have to supply additional information or copies of certain documents to finalise your application. If you leave out any information or do not provide the medical tests or documents needed with the application, cover will only start from when we receive the outstanding information.

COVER FOR DIABETES

Diabetes Cardiometabolic Care Programme

Are you living with diabetes?

We will help you to manage your diabetes and the many challenges that comes from living with this condition through our Diabetes Cardiometabolic Care (DCC) Programme. We encourage you to join this programme as it brings together a team of health professionals to ensure you get high-quality coordinated healthcare and improved outcomes.

You also have access to various tools and extra benefits to monitor and manage your condition, as well as dedicated care navigators to help with all your diabetes-related needs.

How to join the Diabetes Cardiometabolic Care Programme

If you are registered on the Chronic Illness Benefit for diabetes, you automatically have access to the Diabetes Cardiometabolic Care Programme through your chosen Premier Plus GP.

If you are not yet registered, ask your doctor to help you get started. Detailed information about this programme will be shared with you once registered.

Check if your doctor is on our network

To check if your regular doctor is on our network, you can:

- Visit **www.malcormedicalaid.co.za**
- Choose **Find a healthcare provider** on the Discovery app
- Call **0860 100 698**
- Email: **Members_DCP@malcormedicalaid.co.za**

Your doctor will work with you to manage your condition

Your Diabetes Cardiometabolic Care Programme is based on international and locally accepted clinical and lifestyle guidelines.

Through the programme, you and your doctor (who must be on our Premier Plus GP network) can:

- Agree on key goals
- Track your progress on a personalised dashboard on HealthID (a system for doctors)
- Generate your Diabetes Management Score to help identify which areas to focus on to stabilise your condition and improve your overall health.

If you visit a doctor who is not part of the Premier Plus GP Network, you may have to pay part of the cost.

If you have any questions

Call **0860 100 698** or email **Members_DCP@malcormedicalaid.co.za**

Remember, if left untreated, diabetes may result in serious complications. We are here to help you navigate the journey.

Continuous Glucose Monitoring (CGM) Benefit

If you are registered on the Chronic Illness Benefit (CIB) for Type I diabetes, you will have access to a list of Continuous Glucose Monitoring (GCM) sensors, if you are enrolled onto the Diabetes Cardiometabolic Care Programme via your Premier Plus GP. These devices enable you to measure your glucose levels more frequently, helping you to better manage your condition and understand causes of variability. Use of a CGM device will give you insight into the effect your diet, medication and daily activities have on your glucose levels. CGM sensors meeting the criteria set out above will fund from your overall annual limit, up to a monthly limit.

The devices used with the CGM sensors for qualifying members will fund from your external medical appliances limit and overall out-of-hospital limit.

COVER FOR HIV AND AIDS

HIVCare Programme

For members living with HIV and AIDS, the HIVCare Programme provides comprehensive disease management. We take the utmost care to protect the right to privacy and confidentiality of our members.

Malcor members are encouraged to enrol in the HIVCare Programme by calling the Malcor Medical Aid Scheme on **0860 100 698**.

The case managers will assist you and guide you with your treatment plan and benefits. Members or dependants who are HIV positive but have not yet enrolled are encouraged to do so. Your health and medical treatment are of the utmost importance.

HIV Prophylactics

If you, as a Malcor member, need HIV prophylactics to prevent HIV infection from mother-to-child transmission, occupational and traumatic exposure to HIV or sexual assault, please call Malcor Medical Aid Scheme immediately on **0860 100 698** as treatment must start as soon as possible.

This treatment is paid for by the Malcor Medical Aid Scheme at Scheme Rate.

Mental Health Care Programme

Mental health disorders are among the leading causes of ill-health and disability worldwide. A focus on enhanced support for mental wellbeing is important in all facets of society including individuals, families and workplaces.

Mental Health Care Programme (out of hospital)

All members with a history of depression have access to a Mental Health Care Programme designed to offer those diagnosed with acute or episodic major depression, optimal care in a coordinated network to ensure the best outcomes.

To enroll you onto the programme, a GP in the Premier Plus GP network or a psychologist in the Mental Health Care Programme Network will perform a PHQ-9 assessment to confirm depression severity. Qualifying members will then gain access to the programme that runs over a 6-month period but can be extended to 12 months by your enrolling provider where clinically appropriate.

Additional benefits available on the Mental Health Care Programme for qualifying members:

- One extended consultation with your Premier Plus GP annually
- Two standard consultations with your enrolling Premier Plus provider
- Funding for antidepressant medicine on the formulary if prescribed by your Premier Plus GP
- Additional psychotherapy sessions with your psychologist on the Mental Health Care Programme Network payable up to a limit of R3,486.

Mental Health Relapse Prevention Programme

A team of care coordinators including psychiatric nurses and registered counsellors will proactively reach out to members who are identified with a high probability of a psychiatric admission.

Members enrolled on the Relapse Prevention Programme, in addition to the support and education provided by the care coordinator, will have access to an additional basket of outpatient care in order ensure that their condition can be effectively managed in the outpatient setting.

The relapse prevention basket of care includes:

- Two psychiatrist visits
- Six counselling sessions (psychologist, social worker, occupational therapist or registered counsellor).

Should the care coordinator identify that the member is struggling, the treating doctor will also be alerted.

HOME CARE NURSING

Members have access to quality home-based care delivered by Discovery Home Care. This benefit gives members access to certain treatment that can be provided in a home environment, making it possible to receive care without being admitted to hospital. Preauthorisation is required.

Service	What it involves
IV Infusion	The administration of IV clinical therapy for stable patients where a hospital admission is not required.
Wound care	Wound care for venous ulcer, diabetic foot ulcers, pressure sore and other moderate to severe wounds if patient's condition is stable and hospital admission is not required.
Post-natal care	This service offers home visits for healthy mothers, and their babies, if they choose to be discharged a day early from hospital. This service includes three day visits by a midwife, within a six-week postnatal period.

Cover for Hospital at Home

Hospital at Home Benefit Experience has shown that hospital-level care can be delivered safely in a home-setting for a range of clinically appropriate conditions. Members will have access to funding for select low acuity medical conditions, as well as a range of clinically appropriate services and procedures to safely manage any referred medical and post-operative admission.

To access this benefit, your treating specialist must identify you as a member with an illness that can be treated at home and will first consult with you to confirm if you are digitally engaged and that your home environment is suitable to receive care at home. It remains your choice to be treated in hospital even if you qualify for a Hospital at Home admission.

Admissions to Hospital at Home are subject to preauthorisation in lieu of hospitalisation. The pre-authorisation enables risk-based funding for approved remote monitoring devices and healthcare services for patients who meet the clinical and benefit criteria.

While receiving care at home, members have 24/7 access to an in person and a virtual care team. This real-time connection ensures that patients can always reach a clinician if they have questions or concerns. Family members are kept up to date on the patient's progress, either during the home visits, or through a virtual consultation. Depending on a patient's specific needs, consultations with allied healthcare professionals may be incorporated into their personalised care plan.

Programme Enrolment

All treating physicians will be made aware of the programme.

Treating providers, in conjunction with Discovery Health's in-hospital case managers will identify members and inform them of the programme based on clear criteria.

Programme Funding

All services offered as part of the Hospital at Home programme fund from the overall annual limit for in-hospital expenses where there is a valid preauthorisation in lieu of hospitalisation.

This unlocks risk-based funding for approved devices and healthcare services for those who meet the clinical and benefit criteria.

Patient specific eligibility criteria applies for use of certain services, as determined by the treating care team.

Devices

Qualifying members will have funding for a defined list of registered devices funded up to 100% of the Scheme Rate, with a limit of R4,500 per person per year.

The applicable registered remote monitoring devices will be delivered directly to qualifying members by the nurse on their first visit.

TYPICAL HOSPITAL AT HOME MEMBER JOURNEY ILLUSTRATED BELOW.

CLINICAL ASSESSMENT AND REFERRAL

STEP 01

PATIENT PRESENTS AT CASUALTY OR DOCTOR'S PRACTICE

A 60-year-old, patient presents at casualty with an acute cough, pleuritic chest pain and fever

- Doctor diagnoses patient with community acquired pneumonia and discusses Hospital at Home as an option for treatment
- The patient confirms that they have a suitable home environment to receive care at home, and are digitally engaged

STEP 02

DOCTOR REFERRAL

- The doctor completes the Hospital at Home application form and emails through to the Scheme
- The doctor also shares the patient's personalised treatment plan which indicates that intravenous infusion (IV), oral medication and remote monitoring is required with a Biofourmis device

ADMISSION TO THE PATIENT'S HOME

STEP 03

TRANSPORT

The patient travels home or is transported by ambulance or medical taxi service

STEP 04

CARE COORDINATION AND HOME SET-UP

A HomeCare nurse meets the patient at home, where they are:

- Informed of their treatment plan
- Set up and instructed on relevant devices and apps
- Provided with medicine
- Set up with an IV

ADMISSION TO THE PATIENT'S HOME

STEP 05

LIVE MONITORING

The patient's condition is monitored 24/7 through a secure dashboard by their treating healthcare provider, their HomeCare nurse and a team of clinicians in the ER Consulting clinical command centre

STEP 06

HEALTHCARE PROFESSIONAL CONSULTATIONS

- The patient receives daily visits from their treating HomeCare nurse and conducts daily online consultations with their physician to track their progress
- As part of their treatment plan, the patient also receives daily treatment from a physiotherapist

DISCHARGE

STEP 07

CLINICAL SERVICES

Blood samples are taken to track how the patient is responding to treatment and the patient's treating doctor receives a notification when the results are shared from the lab

STEP 08

DISCHARGE

- The patient is responding well to treatment and is discharged from Hospital at Home
- The HomeCare nurse assists with:
  - Delivery of take-home medicine
  - Discharge planning services

Oncology Programme

If you are diagnosed with cancer, you must register on the Malcor Medical Aid Scheme's Oncology Programme. The Malcor Medical Aid Scheme's Oncology Programme follows the ICON or SAOC protocols and guidelines. Oncology limits will apply for non-PMB treatment.

Please register by calling **0860 100 698**.

Readmission Prevention Benefit

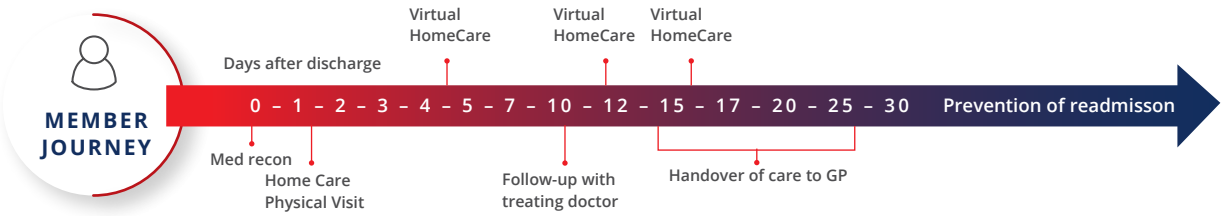
The focus of this benefit is to decrease the readmission rates by ensuring that patients discharged from acute care do not suffer a relapse or deterioration that may require readmission to hospital for unplanned reasons. The benefit is targeted at four conditions currently: acute myocardial infarction/ischaemic heart disease, pneumonia, heart failure and Chronic Obstructive Pulmonary Disease (COPD). Predictive modelling will identify those members who are deemed at highest risk of being readmitted for these conditions and the benefit will be available to them.

The benefit has three components:

- Weekly coaching sessions via WhatsApp/Email/call over a period of four weeks
- A GP follow-up consultation funded from risk; and
- A medicine reconciliation at the point of discharge performed by the treating doctor.

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

The typical member journey of a member eligible for the the Readmission Prevention Benefit is illustrated below.



Virtual House Calls

Virtual House Call by GPs is an initiative whereby GPs on the Scheme GP or Premier Plus GP Network will proactively reach out to their "at risk" members who might be inappropriately rationing care. The aim of this benefits is to prevent disease exacerbations and serious admissions. The Scheme will fund one virtual house call per annum for members who are registered for a condition on the Chronic Illness Benefit (CIB) excluding oncology.

World Health Organisation (WHO) global outbreak benefit

Baskets of care which includes in-hospital and out-of-hospital management and supportive treatment of global World Health Organisation recognised disease outbreaks, subject to Prescribed Minimum Benefit guidelines or as otherwise legislated.

SCREENING BENEFIT

Members on Plan A, Plan B and Plan C will have access to a Screening Benefit. This benefit includes funding of selected screening tests to better manage your health. By paying these tests from your Screening Benefit that funds from the Overall annual in-hospital benefit, your existing radiology and pathology benefits will last longer.

Screening test consisting of

- Blood glucose
- Blood pressure
- Cholesterol
- Body Mass Index

Colorectal cancer/bowel screening

- One faecal occult or faecal immunochemical test (FOBT/FIT) per male and female beneficiary
- Every two years
- Must be between 45 and 75 years old
- Includes the cost of one colonoscopy for at risk members or those with a positive faecal occult test

Mammogram

- One mammogram per female beneficiary 40 years or older.
- Every two years
- One mammogram for at-risk females under 40 years, frequency will be determined based on clinical guidelines
- Further mammograms are funded from the radiology benefit. Limits may apply.

Pap smear

- One Pap smear per female beneficiary over 18 years
- Every three years
- Further Pap smears are funded from the pathology benefit. Limits may apply.

Prostate-specific antigen test

- One prostate-specific antigen test per male beneficiary
- Once per annum
- Further prostate-specific antigen tests are funded from the pathology benefit. Limits may apply.

HIV test

- Unlimited HIV test per male and female beneficiary

Bone density test

- One bone density test per male and female beneficiary over the age of 50 years
- Once per annum
- Further bone density tests are funded from the radiology benefit. Limits may apply.

MEDICINE
BENEFIT

	Type of medicine	Obtained from	Prescribed by	Paid from
In-hospital	Medicines given to you while you are in-hospital (you are an admitted patient)	H		In-Hospital Benefit
In-hospital	Medicines given to you when you leave the hospital (you are being discharged as a patient). Medicine is billed by the hospital directly – you are not handed a script to collect from the pharmacy	H		Hospital Benefit
In-hospital	Medicines given to you when you leave the hospital (you are being discharged as a patient). Medicine is not billed by the hospital directly – you are handed a script to collect from the pharmacy	H		Seven day supply: paid from your Acute Medicine Benefit
Out-of-hospital	Prescribed acute (schedule 0-6)			Acute Medicine Benefit
Out-of-hospital	Approved prescribed chronic (must be registered on the Chronic Illness Benefit)	or		Chronic Illness Benefit
Out-of-hospital	Pharmacy prescribed or self-prescribed (schedule 0, 1 or 2)		or	Acute Medicine Benefit (up to the over-the-counter medicine sub-limit)
Out-of-hospital	Approved vitamins (HIV, Oncology, Pre-natal only)	or		Acute Medicine Benefit or Managed Care Programme risk
Out-of-hospital	Prescribed vitamins Iron, single and multivitamins with a NAPPI code, only when prescribed by a physician. Limited to R80 and/or 500ml/60 tablets per script. Tonics, mineral supplements and baby food is not covered.			Acute Medicine Benefit

H Hospital Pharmacy Doctor Self

MEDICAL BENEFIT

DESIGNATED SERVICE PROVIDER (DSP) PHARMACY NETWORK FOR ONCOLOGY AND ONCOLOGY-RELATED MEDICINE

The DSP Pharmacy Network must be used to obtain your oncology medicines. A 20% co-payment applies when using a pharmacy outside of the oncology DSP Pharmacy Network.

There are primarily two service settings catered for within the DSP arrangement: those providing medication administered in-rooms; and for medication scripted and dispensed through a retail pharmacy.

For medicines administered in-rooms:

Treatment administered in the doctor's rooms, such as injectable and infusional chemotherapy, should be obtained from a courier pharmacy that is contracted as a DSP.

The in-room treatment services are provided through a network of courier pharmacies. Usually, the treating oncologist will have an arrangement in place with a courier pharmacy to dispense and deliver treatment to their practice (treatment facility). The following courier pharmacies (providing oncology specific services) are included in the DSP network offering:

- Dis-Chem's Oncology Courier Pharmacy
- Medipost Pharmacy
- Qestmed
- Olsens Pharmacy
- Southern Rx

Certain providers dispensing, bill the Scheme directly for treatment done in rooms and these practices would be exempt from the DSP arrangement. It would also not apply to chemotherapy administered in-hospital.

For medicines scripted and dispensed at a retail pharmacy

Oncology and oncology-related medicine (like supportive medicine, oral chemotherapy and hormonal therapy) is usually scripted by the treating doctor for the member to obtain from their local retail or courier pharmacy. The DSP arrangement for scripted and dispensed medication will be covered in full at the following pharmacies:

- Dis-Chem's Oncology Courier Pharmacy
- Medipost Pharmacy
- Qestmed
- Olsen's Pharmacy
- Southern Rx

VISIT

www.malcormedicalaid.co.za > Medicine for more information.

Over-the-counter medicines (OTC)

Pharmacists can prescribe and dispense schedule 0, 1 and 2 medicines for the treatment of minor ailments such as dysmenorrhoea, headaches, sinusitis, abdominal colic, stomach cramps, dyspepsia, heartburn, constipation, diarrhoea, muscular pain, coughs and colds, flu, sprains, insect bites, rashes, itchy skin, hayfever, nausea and vomiting, migraines, worms, vaginitis, anti-fungal and anti-viral conditions. These costs will be paid by the Scheme and deducted off the relevant plan-specific acute medicine OTC sub-limit.

GENERAL GUIDELINES: THE SCHEME APPLIES THE FOLLOWING GUIDELINES IN RESPECT OF MEDICINE BENEFITS ON PLANS A, B AND C:

Generic medication

Generic medicines are produced once patents of original drugs have expired. They have the same active ingredients as the original medicines. They may, however, be in a different form from the original drug and will not be in the same packaging.

By using generics, members can use less of their Acute Medicine Benefit each time they claim. However, members are still assured of quality because all generic medicines sold in South Africa must be approved by the Medicines Control Council.

Maximum medical aid price (MMAP®)

The Scheme covers the cost of medication up to the recommended MMAP®. This price represents the lowest average price available in the marketplace for a particular classification of drug. This price is in most cases the lowest average generic price as well.

Members are fully responsible for the difference between the actual price charged for medication and the related MMAP® level. For this reason members are urged to ask their doctors to prescribe generic medication wherever possible.

If there is no generic alternative on the MMAP list, the full cost of the original drug will be paid by the Scheme.

Medicine price structure

Current legislation regulates the pricing of all medication and the Scheme will cover medication up to a maximum of this Single Exit Price, subject to MMAP®. Legislation also allows for a dispensing fee to be charged and this is covered by the Scheme up to the amount charged by the Scheme's DSP, being Dis-Chem.

Medication preferred provider

Dis-Chem have been appointed as the Scheme's Designated Service Provider (DSP) for all medication requirements. Dis-Chem have offered the Scheme a beneficial dispensing fee structure. Should a member choose to obtain their medication from a provider who is unable to match this dispensing fee arrangement, they will be personally liable for any resultant excess.

EX GRATIA
BENEFIT

WHAT IS EX GRATIA?

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

The Board of Trustees may in its absolute discretion increase the amount payable in terms of the Rules of the Scheme as an Ex-Gratia award. As Ex Gratia awards are not registered benefits, but are awarded at the discretion of the Board of Trustees.

Ex Gratia requests are considered on an individual basis and any decision made will in no way set a precedent or determine future policy. Decisions taken by the Board is final and are not subject to appeal or dispute.

A discretionary benefit which a medical aid scheme may consider to fund in addition to the benefits as per the registered Rules of a medical scheme. Schemes are not obliged to make provision there for in the rules and members have no statutory rights there to.

PRESCRIBED MINIMUM BENEFITS (PMBs) AND DESIGNATED SERVICE PROVIDERS (DSPs)

WHAT IS A PMB?

Prescribed Minimum Benefits are prescribed by law as a minimum benefit package to which each medical scheme member is entitled. The Regulations to the Medical Schemes Act of 1998 require that medical schemes need to provide cover for certain conditions even when scheme exclusions or waiting periods apply, or when the member has reached the limit for a benefit.

HOW PMB CLAIMS ARE PAID

Your cover depends on whether you choose to use the Malcor Medical Aid Scheme's Designated Service Providers (DSPs) or not.

The Malcor Medical Aid Scheme has selected MediClinic facilities Busamed Gateway, Busamed Hillcrest (in KZN), Life East London (East London) and Life St George's (Gqeberha) as the Scheme's in-hospital Designated Service Provider (DSP) or 'network'. The latest list of hospitals and other service providers is available at **www.malcormedicalaid.co.za > Doctor visits > Find a healthcare professional**

WHAT WE COVER AS A PRESCRIBED MINIMUM BENEFIT

The Prescribed Minimum Benefits make provision for the cover of the diagnosis, treatment and ongoing care of:

- 271 diagnoses and their associated treatment
- 27 chronic conditions
- Emergency treatment.

REMEMBER

Your hospital admission is subject to approval and preauthorisation. If you need to be admitted for emergency medical treatment, please arrange for authorisation 72 hours after your admission or have a family member contact us to arrange this.

Out-of-hospital PMB cover is subject to approval and preauthorisation. The application form can be downloaded from **www.malcormedicalaid.co.za > Find a document** or by calling the Scheme on **0860 100 698.**

BENEFIT TIP

If you choose to use the Malcor Medical Aid Scheme's DSPs, the Scheme will pay your medical expenses in full, from your Hospital Benefit. If you choose not to use a DSP, the Scheme will pay for medical expenses incurred while you are admitted to hospital at up to the Scheme Rate. You will be responsible for the balance as a co-payment.

COVER

FOR EMERGENCIES

YOUR HEALTH BENEFITS ALSO INCLUDE COVER FOR MEDICAL EMERGENCIES IN SOUTH AFRICA.

Emergencies in South Africa

In an emergency, call Discovery **911** on **0860 999 911** – this number is displayed on your membership card for easy reference.

Cover while travelling overseas

If you require emergency medical services while overseas, that would normally be covered by the Malcor Medical Aid Scheme, you can claim the reimbursement of the cost of these services back from the Malcor Medical Aid Scheme on your return. The Malcor Medical Aid Scheme will refund you at the Malcor Rate that would have been paid if emergency medical services had been obtained in South Africa.

Please download the international claim form from the website and send it to us with the detailed claim so that we can review the claims for payment.

Malcor Medical Aid Scheme Emergency service

Cover is provided for emergency medical evacuations. The Discovery Medicopters, supported by ground staff, provide medical support and air evacuation in extreme critical cases. The emergency helicopters operate from Johannesburg, Cape Town and Durban.

Motor vehicle accidents

The member must inform the Scheme about the accident as soon as ossible. Discovery Health will assist with the Road Accident Fund claim in the following ways:

- Discovery Health will refer the member to a Discovery Health approved attorney who will assist the member with their claim against the Road Accident Fund (the member may however make use of their own attorney).
- If the member uses one of Discovery Health's approved attorneys, those attorneys will analyse the member's accident (at no cost to the member) to determine whether the member has a valid claim.
- If the member chooses to use their own attorney, the member should ask their attorney to contact the Scheme in order to assist the member's attorneys with the accident-related accounts and any fee-related queries which the attorneys may have.

The Scheme will pay for accident-related healthcare expenses in accordance with the rules of the Scheme and the member's plan type.

If the Road Accident Fund pays for medical expenses which were also paid by the Scheme, the Scheme must be reimbursed in accordance with the amount paid by the Road Accident Fund.

ADVANCED TECHNOLOGY

AND CONVENIENCE

WHEN YOU'RE AT THE DOCTOR – HEALTH ID

HealthID, Discovery Health's application for healthcare professionals, is the first of its kind in South Africa. Many doctors in the network will be able to access your health records with your consent. Remember that member confidentiality will be protected at all times and your information can only be accessed with your consent.

MANAGING DIABETES DIGITALLY

The Malcor Medical Aid Scheme will fund a telemetric glucometer for all members registered for diabetes. These devices provide an efficient and simple user interface for capturing blood glucose readings and insulin levels, and for logging exercise and meals – all in real time.

The data captured through this device integrates seamlessly with HealthID (an application that doctors can download) to access members' information remotely and identify risks in a timely manner.

These benefits allow doctors to spend less time downloading data and more time focusing on the health of patients, making diabetes management easier for members of the Malcor Medical Aid Scheme. These benefits are provided through Dis-Chem pharmacies and will be funded subject to your external medical appliances limit and overall out-of-hospital limit.

Online bookings:

You can conveniently use the Discovery app to make real time online bookings. You can download the Discovery app by going to the Apple AppStore or Google Play.

YOUR HEALTH

PLAN AT YOUR FINGERTIPS

Managing your health plan online and on the Discovery app puts you fully in touch with your health plan no matter where you are. If your mobile device is with you, so is your plan (available for Plans A, B and C).

APP

Electronic membership card

View your electronic membership card with your membership number.

Submit and track your claims

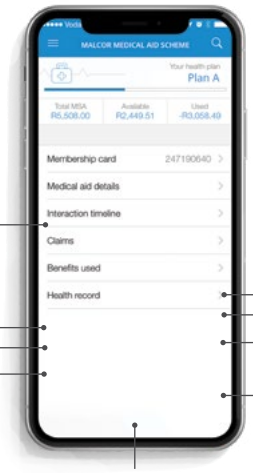
Submit claims by taking a photo of your claim using your smartphone camera and submit. You can also view a detailed claims history.

Track your day-to-day medical spend and benefits

Access important benefit information about your specific plan. You can also keep track of your available benefits.

Access your health records

View a full medical record of all doctor visits, health metrics, past medicine, hospital visits and dates of X-rays or blood tests. It is all stored in an organised timeline that is easy and convenient to use.



Give consent to your doctor accessing your medical records

Give consent to your doctor to get access to your medical records on HealthID. This information will help your doctor understand your medical history and assist you during a consultation.

Find a healthcare provider

Find your closest healthcare provider who we have a payment arrangement with such as pharmacies and hospitals, specialists or GPs and be covered in full.

Request a document

Need a copy of your membership certificate, latest tax certificate or other important medical scheme documents? Request it on our app and it will be emailed directly to you.

Access the procedure library

View information on hospital procedures in our comprehensive series of medical procedure guides. You can also view a list of your approved planned hospital admissions.

Update your emergency details

Update your blood type, allergies and emergency contact information.

DESKTOP

A website that responds to your device

Our website has been designed to work on a variety of different digital devices – your computer, your tablet and your cellphone. No matter what size the screen, the information will always be customised to your particular device making it easy to read.

Keeping track of your benefits

You can keep track of your available benefits online. You can access all important benefit information about your plan.

Keeping track of your claims

We have securely stored information about your claims. You can submit your claim online, view your claims statement, do a claims search if you are looking for a specific claim, see a summary of your hospital claims and even view your claims transaction history.

Accessing important documents

We have securely stored documents so that they are available when you need them most. Whether you are looking for your tax certificate, membership certificate or simply looking for an application form, we have them all stored on our website.

Finding a healthcare professional

You can use our Medical and Provider Search tool to find a healthcare professional. You can also find one who we cover in full so that you don't have a co-payment on your consultation. You can even filter your search by speciality and area and the results will be tailored to your requirements.

Download now:

Download on the App Store

ANDROID APP ON Google play

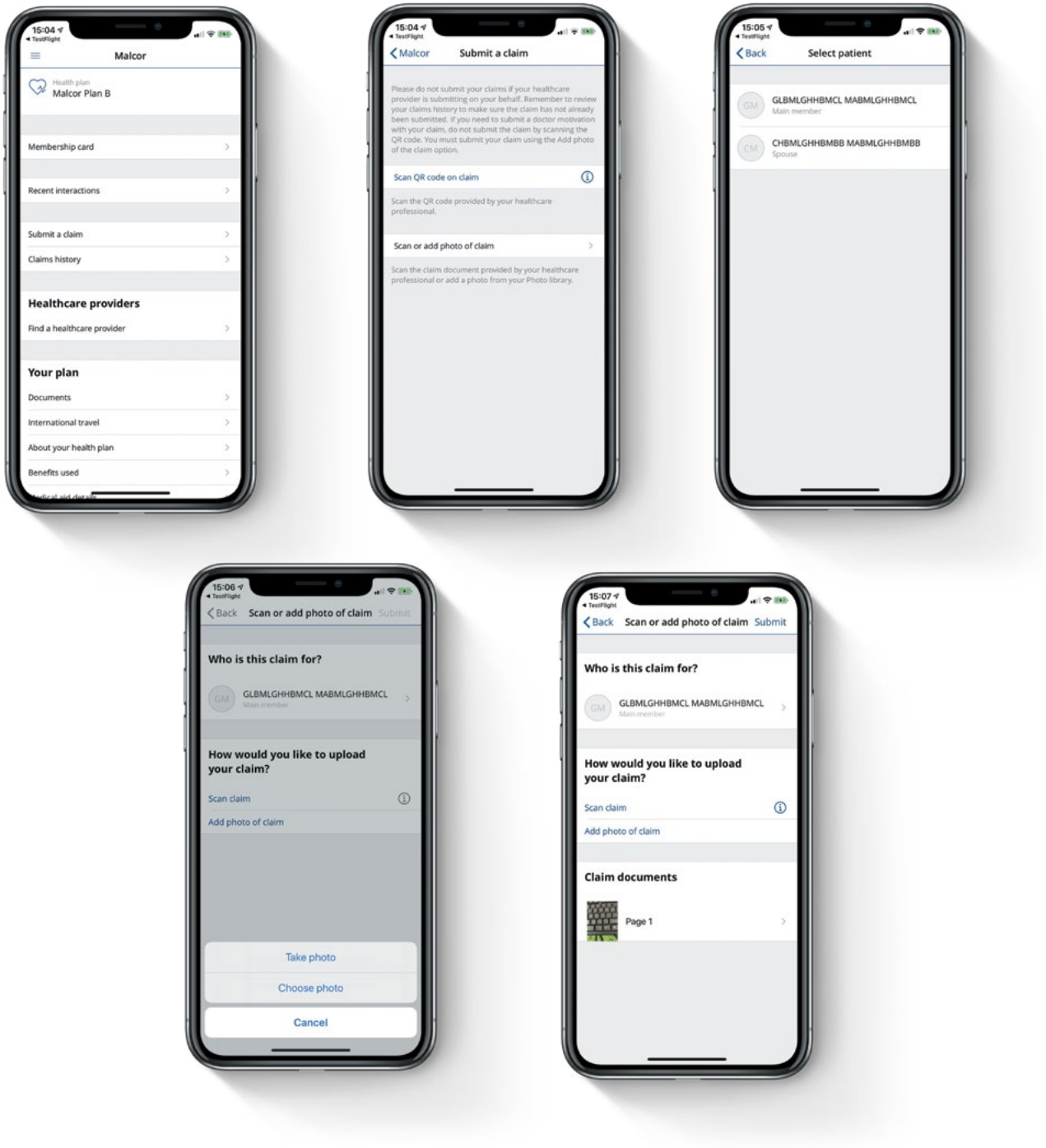
SUBMIT YOUR CLAIMS ON YOUR SMARTPHONE APP IN 3 EASY STEPS:

Download the Discovery app from the App Store or Google Play and log in

Select Submit a claim from the menu

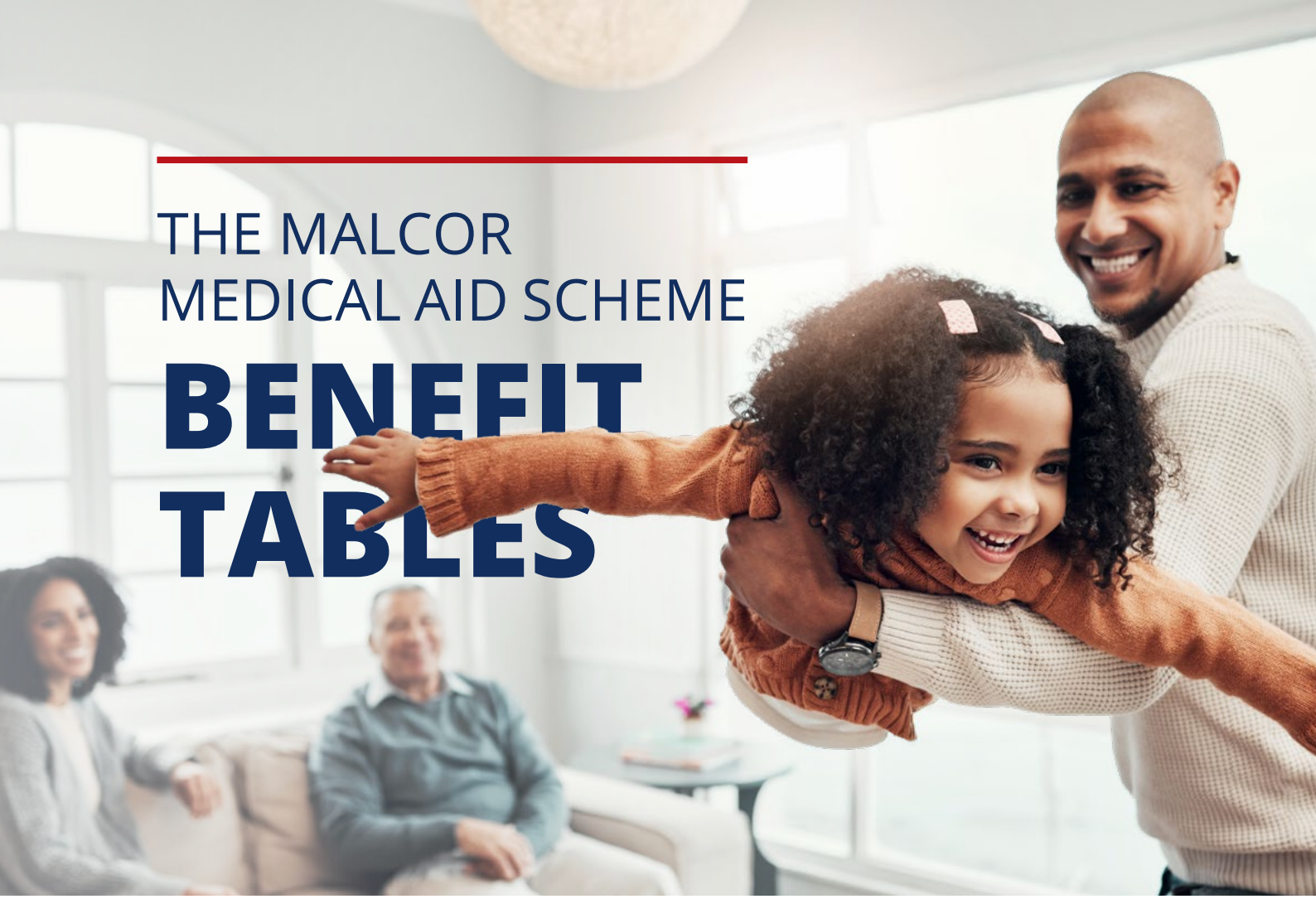
Take a photo of the claim and immediately upload it or use your phone to scan the QR code*

*If the claim has a QR code, simply scan the QR code from within the Discovery app.



THE MALCOR MEDICAL AID SCHEME

BENEFIT TABLES



HOSPITAL BENEFITS: PLANS A, B AND C

Benefit limits are prorated if a member joins the Malcor Medical Aid Scheme during the year unless otherwise stated. Preauthorisation is required before admission, except in the case of an emergency.

		Plan A	Plan B	Plan C
Healthcare service	**Basis of cover**	**Annual limits**	**Annual limits**	**Annual limits**
Statutory Prescribed Minimum Benefits	Services rendered by public hospitals/DSP at 100% of cost or agreed rate or 100% of the Scheme Rate in a private hospital where the beneficiary voluntarily elects another service provider	Unlimited	Unlimited	Unlimited
	Where PMB performed in a private hospital involuntarily such procedure will be paid at 100% of cost			
	All Prescribed Minimum Benefits are paid according to the regulations.			
Overall annual limit for in-hospital expenses	100% of the Scheme Rate funded from overall annual in-hospital benefit Preauthorisation required	Unlimited	Unlimited	R1,000,000 per family per annum

		Plan A	Plan B	Plan C
Healthcare service	**Basis of cover**	**Annual limits**	**Annual limits**	**Annual limits**
Day Surgery Network for certain procedures or operations **(refer to "Day Surgery Network for certain procedures or operations" elsewhere in this Benefit Guide for the list of procedures)**	100% of the Scheme Rate funded from overall annual in-hospital benefit Day-Surgery Network applies as DSP Preauthorisation required Subject to protocols and clinical entry criteria	Unlimited for listed procedures A R6,650 deductible will apply for voluntary use of a non-DSP Day Surgery Network	Unlimited for listed procedures A R6,650 deductible will apply for voluntary use of a non-DSP Day Surgery Network	Overall annual in-hospital limit A R6,650 deductible will apply for voluntary use of a non-DSP Day Surgery Network
Health at Home Home-based healthcare for clinically appropriate chronic and acute treatment and conditions that can be treated at home	100% of the Scheme Rate funded from overall annual in-hospital benefit Preferred Provider Network applies (where applicable) Preauhorisation required Subject to the treatment meeting the treatment guidelines and clinical and benefit entry criteria	Basket of care as set by the Scheme	Basket of care as set by the Scheme	Basket of care as set by the Scheme
Home Care Nursing for IV Infusion, wound care and post-natal care	100% of the Scheme Rate funded from overall annual in-hospital benefit Discovery Home Care is the DSP Preauthorisation required Subject to protocols and clinical entry criteria	Unlimited No benefit out of DSP	Unlimited No benefit out of DSP	Overall annual in-hospital limit No benefit out of DSP
Home-monitoring devices A defined list of registered devices clinically appropriate for chronic and/or acute conditions	100% of the Scheme Rate funded from overall annual in-hospital benefit Preauhorisation required for the device Subject to clinical protocols and benefit entry criteria	R4,500 per beneficiary per year	R4,500 per beneficiary per year	R4,500 per beneficiary per year
Accommodation, materials, theatre fees	100% of the Scheme Rate funded from overall annual in-hospital benefit Preauthorisation required	Unlimited	Unlimited	Overall annual in-hospital limit
Blood transfusions	100% of the Scheme Rate funded from overall annual in-hospital benefit	Unlimited	Unlimited	Overall annual in-hospital limit
Ambulance (local emergency evacuation)	100% of the Scheme Rate funded from overall annual in-hospital benefit DSP applies	Unlimited	Unlimited	Overall annual in-hospital limit
Specialists	100% of the Scheme Rate funded from overall annual in-hospital benefit Specialist Network applies as DSP Preauthorisation required	Unlimited	Unlimited	Overall annual in-hospital limit
GP	100% of the Scheme Rate funded from overall annual in-hospital benefit GP Network applies as DSP Preauthorisation required	Unlimited	Unlimited	Overall annual in-hospital limit

		Plan A	Plan B	Plan C
Healthcare service	**Basis of cover**	**Annual limits**	**Annual limits**	**Annual limits**
Virtual House Call Virtual GP House Call Consultation (initiated by a network GP) via telephone, DrConnect or another virtual platform (to be claimed with code VDHC by provider)	For all registered Chronic Illness Benefit (CIB) conditions (excluding oncology) 100% of the Scheme Rate funded from overall annual in-hospital benefit DSP for GPs: GP Network or Premier Plus GP Network	One Virtual House Call per annum per beneficiary	One Virtual House Call per annum per beneficiary	One Virtual House Call per annum per beneficiary
Comprehensive Maternity benefits Antenatal consultations, Antenatal classes, Ultrasound scans and prenatal screening, Blood tests, Private ward, Essential registered devices	100% of the Scheme Rate funded from overall annual in-hospital benefit	Antenatal consultations are limited to 12 visits. Pre or post natal classes are limited to 5 consultations with a registered nurse. A limit of 2 ultrasound scans and one nuchal translucency or NIPT or down syndrome screening test are covered. Blood tests are limited to a defined basket. Private ward cover up to Scheme Rate per day. Cover on essential registered devices is limited to R4,370	Antenatal consultations are limited to 12 visits. Pre or post natal classes are limited to 5 consultations with a registered nurse. A limit of 2 ultrasound scans and one nuchal translucency or NIPT or down syndrome screening test are covered. Blood tests are limited to a defined basket. No benefit for private ward cover. Cover on essential registered devices is limited to R2,140	Refer to Maternity Out-of-hospital benefits
Post-birth benefits GP and specialist visits, Post natal consultations, Six week post-birth consultation, Nutrition assessment, Mental health consultation, Lactation consultation	100% of the Scheme Rate funded from overall annual in-hospital benefit	Consultations with a GP, paediatrician or an ENT is limited to 2 visits for your baby. Pre or post natal classes are limited to 5 consultations with a registered nurse. A limit of one six-week post-birth consultation with a GP, midwife or gynaecologist is covered. A limit of one nutrition assessment with a dietician is covered. Mental health consultations with a GP, gynaecologist or psychologist is limited to 2 visits. A limit of one lactation consultation with a nurse or lactation specialist is covered	Consultations with a GP, paediatrician or an ENT is limited to 2 visits for your baby. Pre or post natal classes are limited to 5 consultations with a registered nurse. A limit of one six-week post-birth consultation with a GP, midwife or gynaecologist is covered. A limit of one nutrition assessment with a dietician is covered. Mental health consultations a GP, gynaecologist or psychologist is limited to 2 visits. A limit of one lactation consultation with a nurse or lactation specialist is covered	Refer to Maternity out-of-hospital benefits

		Plan A	Plan B	Plan C
Healthcare service	**Basis of cover**	**Annual limits**	**Annual limits**	**Annual limits**
Organ transplants	100% of the Scheme Rate funded from overall annual in-hospital benefit. PMB at cost Preauthorisation required	Unlimited	Unlimited	Overall annual in-hospital limit
Internal prosthesis (hip, knee, shoulder joints,artificial eyes, intraocular lenses, defibrillators, pacemakers, stents, spinal items, etc.)	100% of the Scheme Rate funded from overall annual in-hospital benefit Preauthorisation required Sub-limits: Hip Knee Pacemakers Stents	R137,710 per beneficiary per annum R68,855 R68,855 R68,855 R30,630	R93,655 per beneficiary per annum R46,815 R46,815 R46,815 R26,760	R50,610 per beneficiary per annum No sub-limits. Subject to overall internal prothesis limit.
Cardiac stents (limited to the internal prosthesis sub-limit for stents for Plan A and Plan B. For Plan C it is subject to the internal prosthesis sub-limit)	100% of the Scheme Rate funded from overall annual in-hospital benefit Preauthorisation required	3 stents per beneficiary per annum	3 stents per beneficiary per annum	3 stents per beneficiary per annum
Bone-anchored hearing aid	100% of the Scheme Rate funded from overall annual in-hospital benefit Preauthorisation required	Subject to internal prosthesis limit	Subject to internal prosthesis limit	Subject to internal prosthesis limit
Spinal prosthesis	100% of the Scheme Rate funded from overall annual in-hospital benefit Preauthorisation required	Subject to internal prosthesis limit	Subject to internal prosthesis limit	Subject to internal prosthesis limit
External medical items (HALO traction, embolytic stockings, certain back braces)	100% of the Scheme Rate funded from overall annual in-hospital benefit Preauthorisation required	Unlimited	Unlimited	Overall annual in-hospital limit
Pathology	100% of the Scheme Rate funded from overall annual in-hospital benefit Preauthorisation required	Unlimited	Unlimited	Overall annual in-hospital limit
Radiology	100% of the Scheme Rate funded from overall annual in-hospital benefit Preauthorisation required	Unlimited	Unlimited	Overall annual in-hospital limit
Endoscopies	100% of the Scheme Rate funded from overall annual in-hospital benefit Preauthorisation required	Unlimited	Unlimited	Overall annual in-hospital limit
Specialised radiology (MRI, CT scans, PET scans, nuclear medicine studies, angiograms, arthrograms)	100% of the Scheme Rate Preauthorisation required	Unlimited Overall annual in-hospital limit regardless of setting (out of hospital or in hospital)	Unlimited Overall annual in-hospital limit regardless of setting (out of hospital or in hospital)	Out-of-hospital: Overall annual out-of-hospital limit In-hospital: Overall annual in-hospital limit
Dentistry (maxilla-facial procedures)	100% of the Scheme Rate funded from overall annual in-hospital benefit Preauthorisation required Conservative dentistry and specialised dentistry not covered in-hospital unless preauthorised	Unlimited	Unlimited	Overall annual in-hospital limit

		Plan A	Plan B	Plan C
Healthcare service	**Basis of cover**	**Annual limits**	**Annual limits**	**Annual limits**
In theatre dentistry – Children under the age of 12 years	100% of the Scheme Rate funded from overall annual in-hospital benefit Preauthorisation required	Unlimited	Unlimited	Overall annual in-hospital limit
Ophthalmologic procedures (corneal crosslinking included)	100% of the Scheme Rate funded from overall annual in-hospital benefit Preauthorisation required	Unlimited	Unlimited	Overall annual in-hospital limit
Mental health	100% of the Scheme Rate funded from overall annual in-hospital benefit Preauthorisation required	21 days per beneficiary per annum	21 days per beneficiary per annum	21 days per beneficiary per annum
Drug and alcohol rehabilitation	100% of the Scheme Rate funded from overall annual in-hospital benefit DSP applies Preauthorisation required	21 days per beneficiary per annum	21 days per beneficiary per annum	21 days per beneficiary per annum
Detoxification for substance dependency	100% of the Scheme Rate funded from overall annual in-hospital benefit DSP applies Preauthorisation required	Three days per beneficiary per approved event, subject to rehabilitation days being available.	Three days per beneficiary per approved event, subject to rehabilitation days being available.	Three days per beneficiary per approved event, subject to rehabilitation days being available.
Allied professionals (acousticians, biokineticists, chiropractors, dietitians, nursing providers, occupational therapists, physiotherapists, podiatrists, psychologists, psychometrics, social workers, speech and hearing therapists)	100% of the Scheme Rate funded from overall annual in-hospital benefit Preauthorisation required	Unlimited	Unlimited	Overall annual in-hospital limit
Private nursing, step down, sub-acute physical rehabilitation	100% of the Scheme Rate funded from overall annual in-hospital benefit Preauthorisation required	Unlimited	Unlimited	Overall annual in-hospital limit
Renal dialysis	100% of the Scheme Rate funded from overall annual in-hospital benefit DSP applies	Unlimited	Unlimited	Overall annual in-hospital limit
Medication supplied in-hospital	100% of the Scheme Rate funded from overall annual in-hospital benefit Preauthorisation required	Unlimited	Unlimited	Overall annual in-hospital limit

		Plan A	Plan B	Plan C
Healthcare service	**Basis of cover**	**Annual limits**	**Annual limits**	**Annual limits**
To-take-out (TTO) medication	100% of the Scheme Rate funded from overall annual in-hospital benefit Preauthorisation required	Limited to seven days if billed on the hospital account	Limited to seven days if billed on the hospital account	Limited to seven days if billed on the hospital account
International travel	100% of claim funded from the overall annual in-hospital benefit Preauthorisation required	R500,000 per beneficiary per journey, 90 days from departure date	R500,000 per beneficiary per journey, 90 days from departure date	R500,000 per beneficiary per journey, 90 days from departure date
Home oxygen	100% of the Scheme Rate funded from overall annual in-hospital benefit DSP applies Preauthorisation required	Unlimited	Unlimited	Overall annual in-hospital limit
HIV and AIDS-related treatment	100% of the Scheme Rate funded from overall-annual in-hospital benefit PMB criteria apply	Unlimited	Unlimited	Overall annual out-of-hospital limit. Approved PMB's will fund through the limit
Post-exposure HIV prophylaxis following occupational exposure, traumatic exposure or sexual assault	100% of Scheme Rate PMB criteria apply	Unlimited	Unlimited	Overall annual out-of-hospital limit. Approved PMB's will fund through the limit
HIV prophylaxis to prevent mother-to-child transmission	100% of Scheme Rate PMB criteria apply	Unlimited	Unlimited	Overall annual out-of-hospital limit. Approved PMB's will fund through the limit
Prescribed antiretroviral medication for HIV/AIDS and medication to treat opportunistic infections such as tuberculosis and pneumonia	100% of Scheme Rate PMB criteria apply	Unlimited	Unlimited	Overall annual out-of-hospital limit. Approved PMB's will fund through the limit
Oncology treatment and medication	100% of the Scheme Rate or reference price, whichever is applicable, funded from the oncology limit. Subject to ICON and SAOC guidelines and preauthorisation by Scheme Oncology Pharmacy DSP applies – 20% co-payment out-of-network. Wigs are covered from the overall out-of-hospital benefits, subject to the external medical items limit.	R500,000 per family per annum	R300,000 per family per annum	R200,000 per family per annum
Pre-Advanced Illness Benefit: member support programme (Pre-advanced Illness Benefit Care team enrolls member on AIB)	100% of the Scheme Rate funded from overall annual in-hospital benefit	1 x Social worker visit (as per Counselling network) 1 x GP visit (palliative trained GP)	1 x Social worker visit (as per Counselling network) 1 x GP visit (palliative trained GP)	1 x Social worker visit (as per Counselling network) 1 x GP visit (palliative trained GP)

		Plan A	Plan B	Plan C
Healthcare service	**Basis of cover**	**Annual limits**	**Annual limits**	**Annual limits**
Advanced Illness Benefit (end-of-life care at home)	100% of the Scheme Rate funded from the overall annual in-hospital benefit DSP applies	Unlimited	Unlimited	Unlimited
Stem cell transplants	100% of the Scheme Rate funded from overall annual in-hospital benefit	R500,000 per family per annum (part of the Oncology Benefit)	R300,000 per family per annum (part of the Oncology Benefit)	R200,000 per family per annum (part of the Oncology Benefit)

OUT-OF-HOSPITAL BENEFITS: PLANS A, B AND C

		Plan A	Plan B	Plan C
Healthcare service	**Basis of cover**	**Annual limits**	**Annual limits**	**Annual limits**
Overall annual limit for out-of-hospital expenses	100% of the Scheme Rate funded from overall annual out-of-hospital benefit	R139,040 per family per annum	R82,950 per family per annum	Annual limit per family based on number of dependants: M – R10,255 M1 – R18,440 M2 – R22,535 M3 – R26,700 M4+ – R30,715
GPs and homeopaths	100% of the Scheme Rate funded from overall annual out-of-hospital benefit DSP for GPs: GP Network	Overall annual out-of-hospital benefit limit	Annual limit per family based on number of dependants: M – 6 visits M1 – 12 visits M2 – 16 visits M3 – 20 visits M4+ – 24 visits When the limit is reached, claims are funded at 50% of the Scheme Rate from the overall out-of-hospital benefit.	Overall annual out-of-hospital benefit limit
Specialists (cardiologist, paediatrician, gynaecologist, specialist physician, oncologist, etc.)	Plan A: 120% of the Scheme Rate funded from overall annual out-of-hospital benefit (excluding dental specialists and anesthetist funded at 100% of the Scheme Rate). Plans B and C: 100% of the Scheme Rate funded from overall annual out-of-hospital benefit	Annual limit per family based on number of dependants: M – 7 visits M1 – 12 visits M2 – 17 visits M3 – 24 visits M4+ – 26 visits	Annual limit per family based on number of dependants: M – 4 visits M1 – 8 visits M2 – 11 visits M3 – 14 visits M4+ – 17 visits	Overall annual out-of-hospital benefit limit
Maternity consultations (gynaecologist and GPs)	100% of the Scheme Rate funded from overall annual out-of-hospital benefit	Refer to the Comprehensive Maternity and Post birth benefit	Refer to the Comprehensive Maternity and Post birth benefit	Overall annual out-of-hospital benefit limit
Endoscopies	100% of the Scheme Rate funded from overall annual out-of-hospital benefit if not preauthorised	Overall annual out-of-hospital benefit limit	Overall annual out-of-hospital benefit limit	Overall annual out-of-hospital benefit limit
External medical items (walking sticks, commodes, bed pans, toilet seat raisers, crutches, glucometers, foot orthotics, shoe innersoles, wigs for specific conditions etc)	100% of cost funded from overall annual out-of-hospital benefit	R4,865 per family per annum	R 3,055 per family per annum	Overall annual out-of-hospital benefit limit
Continuous Glucose Monitoring devices (transmitters and readers): Freestyle Libre (Abbot), MediLink and Enlite (Medtronic) and Dexcom G6 (Ethitec) devices (or as amended from time to time)	100% of the Scheme Rate funded from overall annual out-of-hospital benefit Only for beneficiaries approved and registered on the Chronic Illness Benefit (CIB) for Type I Diabetes and, enrolled onto the Diabetes Cardiometabolic Care (DCC) Programme via your Premier Plus GP Subject to protocols and clinical entry criteria	Limited to 1 per annum per qualifying beneficiary Subject to available External Medical Items limit	Limited to 1 per annum per qualifying beneficiary Subject to available External Medical Items limit	Limited to 1 per annum per qualifying beneficiary Subject to available External Medical Items limit

		Plan A	Plan B	Plan C
Healthcare service	**Basis of cover**	**Annual limits**	**Annual limits**	**Annual limits**
Continuous Glucose Monitoring sensors for use with Freestyle Libre (Abbot), MediLink and Enlite (Medtronic) and Dexcom G6 (Ethitec) devices (or as amended from time to time)	100% of the Scheme Rate funded from overall annual in-hospital benefit Only for beneficiaries approved and registered on the Chronic Illness Benefit (CIB) for Type I Diabetes and, enrolled onto the Diabetes Cardiometabolic Care (DCC) Programme via your Premier Plus GP If obtained from a non-network provider, funding will be from the available acute medication benefit and limit	Monthly limit: Adults: R1,634 Children under 18: R1,634	Monthly limit: Adults: R817 Children under 18: R1,634	Monthly limit: Adults: R817 Children under 18: R1,634
Walkers	100% of cost funded from overall annual out-of-hospital benefit	R800 per family per annum	R510 per family per annum	Overall annual out-of-hospital benefit limit
Wheelchairs (including buggies and carts)	100% of cost funded from overall annual out-of-hospital benefit	R4,770 per family per annum	R3,010 per family per annum	Overall annual out-of-hospital benefit limit
Hearing aids	100% of cost funded from overall annual out-of-hospital benefit	R24,320 per family per annum	R 16,700 per family per annum	Overall annual out-of-hospital benefit limit
Pathology	100% of the Scheme Rate funded from overall annual out-of-hospital benefit. When the limit is reached, claims are funded at 80% of the Scheme Rate from the overall annual out-of-hospital benefit for Plan A and at 65% for Plan B Point of care pathology testing is subject to meeting the Scheme's Treatment guidelines and Managed Health Care criteria.	Annual limit per family based on number of dependants: M – R4,475 M1 – R7,235 M2 – R9,320 M3 – R11,930 M4+ – R13,445	Annual limit per family based on number of dependants: M – R1,885 M1 – R3,300 M2 – R4,230 M3 – R5,185 M4+ – R6,120	Overall annual out-of-hospital benefit limit
Radiology	100% of the Scheme Rate funded from overall annual out-of-hospital benefit. When the limit is reached, claims are funded at 80% of the Scheme Rate from the overall annual out-of-hospital benefit for Plan A and 65% for Plan B	Annual limit per family based on number of dependants: M – R4,475 M1 – R7,235 M2 – R9,320 M3 – R11,930 M4+ – R13,445	Annual limit per family based on number of dependants: M – R1,885 M1 – R3,300 M2 – R4,230 M3 – R5,185 M4+ – R6,120	Overall annual out-of-hospital benefit limit
Pregnancy scans	100% of the Scheme Rate funded from overall annual out-of-hospital benefit. When the limit is reached, claims are funded at 80% of the Scheme Rate for Plan A and 65% for Plan B from the overall annual out-of-hospital benefit Claims accumulate to the out-of-hospital radiology limit	Refer to the Comprehensive Maternity and Post birth benefit	Refer to the Comprehensive Maternity and Post birth benefit	Overall annual out-of-hospital benefit limit
Dentistry (conservative dentistry and specialised dentistry, inclusive of osseo-integrated implants as well as related sinus lift and bone graph procedures)	100% of the Scheme Rate funded from overall annual out-of-hospital benefit	Annual limit per family based on number of dependants: M – R12,930 M1 – R21,535 M2 – R28,000 M3 – R34,365 M4+ – R40,930	Annual limit per family based on number of dependants: M – R5,710 M1 – R9,515 M2 – R12,355 M3 – R15,210 M4+ – R16,160	Overall annual out-of-hospital benefit limit

		Plan A	Plan B	Plan C
Healthcare service	**Basis of cover**	**Annual limits**	**Annual limits**	**Annual limits**
Dental therapy	100% of the Scheme Rate funded from overall annual out-of-hospital benefit	R1,644 per family per annum	R1,085 per family per annum	Overall annual out-of-hospital benefit limit
Radial Keratotomy and Excimer laser treatment (performed in hospital or out-of-hospital setting)	100% of the Scheme Rate funded from overall annual out-of-hospital benefit	R21,690 per beneficiary per annum	No benefit	No benefit
Optical benefits (spectacles, contact lenses, frames and all add-ons)	100% of the Scheme Rate funded from overall annual out-of-hospital benefit Optometry Network applies: members will receive discounts as negotiated (discount applies to frames, eyeglass lenses and add-on components but excludes contact lenses and professional services)	Annual limit per family based on dependants: M – R6,200 M1+ – R12,405	Annual limit per family based on dependants: M – R2,900 M1+ – R6,535	Overall annual out-of-hospital benefit limit
Eye tests	100% of the Scheme Rate funded from overall annual out-of-hospital benefit	One test per beneficiary per annum	One test per beneficiary per annum	One test per beneficiary per annum
Allied professionals (acousticians, biokineticists, chiropractors, dietitians, nursing providers, occupational therapists, physiotherapists, podiatrists, psychologists, psychometrics, social workers, speech and hearing therapists)	100% of the Scheme Rate funded from overall annual out-of-hospital benefit, subject to the Allied Professionals limit	R20,925 per family per annum	R13,275 per family per annum	Overall annual out-of-hospital benefit limit
Mental health (psychologists and counsellor)	100% of the Scheme Rate funded from overall annual out-of-hospital benefit, subject to the Allied Professionals limit and PMBs	Refer to the Allied professionals out-of-hospital benefit limit. PMBs: 15 consultations per beneficiaries per annum	Refer to the Allied professionals out-of-hospital benefit limit. PMBs: 15 consultations per beneficiaries per annum	Refer to the Allied professionals out-of-hospital benefit limit. PMBs: 15 consultations per beneficiaries per annum
Mental Health Care Programme: enhanced out-patient care (for qualifying members with Major Depression or Episodic Depression within the last 12 months who are enrolled onto the programme)	100% of the Scheme Rate funded from the outpatient Mental Health Care Programme benefit. Programme duration is between 6 and 12-months. DSP: Premier Plus GP Network or a psychologist in the Mental Health Care Programme Network	One extended consultation per annum Two standard consultations per annum Funding of antidepressant medicine Additional psychotherapy clinically approved	One extended consultation per annum Two standard consultations per annum Funding of antidepressant medicine Additional psychotherapy clinically approved	One extended consultation per annum Two standard consultations per annum Funding of antidepressant medicine Additional psychotherapy clinically approved
Mental Health Care: Relapse Prevention Programme (In addition to existing mental health benefits and PMBs)	100% of the Scheme Rate funded from the outpatient Mental Health Care Programme benefit.	2 psychiatric visits 6 counselling sessions Care coordination services	2 psychiatric visits 6 counselling sessions Care coordination services	2 psychiatric visits 6 counselling sessions Care coordination services
Drug and alcohol rehabilitation, detox and substance abuse	No benefit	No benefit	No benefit	No benefit

Healthcare service	Basis of cover	Plan A Annual limits	Plan B Annual limits	Plan C Annual limits
Acute medication (includes homeopathic medication, vaccines*, pharmacy assisted treatment, TTO obtained at a pharmacy and over-the-counter medication)	100% of the Malcor Medication Rate funded from overall annual out-of-hospital benefit DSP applies *Vaccines and immunisation to be funded based on State EPI vaccines	Annual limit per family based on number of dependants: M – R17,045 M1 – R24,365 M2 – R31,665 M3 – R41,430 M4+ – R46,300	Annual limit per family based on number of dependants: M – R8,140 M1 – R11,615 M2 – R15,100 M3 – R19,760 M4+ – R22,100	Overall annual out-of-hospital benefit limit
	Over-the-counter sub limits	M – R3,180 M1+ – R9,540	M – R2,120 M1+ – R6,360	No sub-limit. Subject to overall annual out-of-hospital benefit limit
Chronic Illness Benefit	CHRONIC DISEASE LIST			
	Maximum Medical Aid Price (MMAP) Subject to medicine list (formulary). DSP applies Subject to review and approval by CIB based on benefit entry criteria	Funded from the overall annual in-hospital benefit	Funded from the overall annual in-hospital benefit	Funded from the overall annual out-of-hospital benefit limit
	ADDITIONAL DISEASE LIST			
	Maximum Medical Aid Price (MMAP) Subject to medicine list (formulary). DSP applies Subject to review and approval by CIB based on benefit entry criteria	Funded from the overall annual in-hospital benefit	No benefit	No benefit
Contraceptives	ORAL CONTRACEPTIVES			
	100% of the Malcor Medication Rate funded from the overall annual out-of-hospital benefit, subject to the acute medicine limit DSP applies	R195 per beneficiary per month	R195 per beneficiary per month	R190 per beneficiary per month
	MIRENA DEVICE			
	100% of the Scheme Rate funded from the overall annual out-of-hospital benefit Subject to the acute medicine limit DSP applies	One every 5 years	One every 5 years	One every 5 years
	ASSOCIATED GYNAECOLOGY COSTS FOR INSERTION AND REMOVAL IN THE DOCTOR'S ROOMS			
	Plan A: 120% of the Scheme Rate funded from the overall annual out-of-hospital benefit Plan B and C: 100% of the Scheme Rate funded from the overall annual out-of-hospital benefit	Subject to the specialist annual limit per family	Subject to the specialist annual limit per family	Overall annual out-of-hospital benefit
	ASSOCIATED GYNAECOLOGY COSTS FOR MIRENA INSERTION AND REMOVAL IN THEATRE			
	100% of the Scheme Rate Subject to preauthorised and benefit entry criteria	Overall annual out-of-hospital benefit limit	Overall annual out-of-hospital benefit limit	Overall annual out-of-hospital benefit limit

		Plan A	Plan B	Plan C
Healthcare service	Basis of cover	Annual limits	Annual limits	Annual limits
	IMPLANON NXT			
	100% of the Scheme Rate funded from the overall annual out-of-hospital benefit Subject to the acute medicine limit DSP applies	One every 3 years	One every 3 years	One every 3 years
	ASSOCIATED GYNAECOLOGY COST FOR IMPLANON NXT IMPLANT OR REMOVAL			
	Plan A: 120% of the Scheme Rate funded from the overall annual out-of-hospital benefit Plan B and C: 100% of the Scheme Rate funded from the overall annual out-of-hospital benefit Subject to the specialist annual limit per family	Subject to the specialist annual limit per family	Subject to the specialist annual limit per family	Overall annual out-of-hospital benefit
Musculo-skeletal topical agents (Topical Analgesic Agents)	100% of the Malcor Medication Rate funded from overall annual out-of-hospital benefit, subject to the acute medicine limit DSP applies	65g per fill, limited to two fills per beneficiary per annum	65g per fill, limited to two fills per beneficiary per annum	65g per fill, limited to two fills per annum
Screening for Adults: Mammogram Pap smears Prostate HIV Colorectal cancer Bone density	100% of the Scheme Rate funded from the Screening Benefit funded from the overall annual in-hospital benefit	1 x Mammogram for female beneficiaries from 40 years+ and, at-risk females under 40 years, every 2-years 1 x Pap smear for female beneficiaries over 18 years, every 3-years 1 x Prostate antigen test for male beneficiaries, once per annum Unlimited HIV test per beneficiary per annum	1 x Mammogram for female beneficiaries from 40 years+ and, at-risk females under 40 years, every 2-years 1 x Pap smear for female beneficiaries over 18 years, every 3-years 1 x Prostate antigen test for male beneficiaries, once per annum Unlimited HIV test per beneficiary per annum	1 x Mammogram for female beneficiaries from 40 years+ and, at-risk females under 40 years, every 2-years 1 x Pap smear for female beneficiaries over 18 years, every 3-years 1 x Prostate antigen test for male beneficiaries, once per annum Unlimited HIV test per beneficiary per annum

		Plan A	Plan B	Plan C
Healthcare service	**Basis of cover**	**Annual limits**	**Annual limits**	**Annual limits**
		1 x Colorectal cancer faecal occult blood test (FOBT) or faecal immunochemical test (FIT)) for all beneficiaries between ages 45 and 75, every 2-years. 1 x Colonoscopy for members with a positive faecal occult test (FOBT) 1 x Bone density testing for all beneficiaries over the age of 50 year once per annum	1 x Colorectal cancer faecal occult blood test (FOBT) or faecal immunochemical test (FIT)) for all beneficiaries between ages 45 and 75, every 2-years. 1 x Colonoscopy for members with a positive faecal occult test (FOBT) 1 x Bone density testing for all beneficiaries over the age of 50 year once per annum)	1 x Colorectal cancer faecal occult blood test (FOBT) or faecal immunochemical test (FIT)) for all beneficiaries between ages 45 and 75, every 2-years. 1 x Colonoscopy for members with a positive faecal occult test (FOBT) 1 x Bone density testing for all beneficiaries over the age of 50 year once per annum
Screening Benefit Dis-Chem WellScreen	100% of the Scheme Rate funded from the overall annual out-of-hospital benefit	Combined benefit of two screening tests per beneficiary per annum*	Combined benefit of one screening test per beneficiary per annum**	Combined benefit of one screening test per beneficiary per annum**
Screening Benefit	100% of the Scheme Rate funded from overall annual out-of-hospital benefit	Combined benefit of two screening tests per beneficiary per annum*	Combined benefit of one screening test per beneficiary per annum**	Combined benefit of one screening test per beneficiary per annum**
Annual health check (blood glucose test, blood pressure test, cholesterol test and Body Mass Index (BMI))	Annual health check to be carried out at the Wellness network pharmacy/ provider			
Screening Benefit – Children's screening check. Applies to children between the ages of two years and 18 years (Body Mass Index and counselling, where appropriate, hearing screening, dental screening and milestone tracking for children under the age of eight)	100% of the Scheme Rate funded from overall annual out-of-hospital benefit Children's screening tests to be carried out at a network pharmacy/ provider	One test per qualifying child per annum	One test per qualifying child per annum	One test per qualifying child per annum

* Member may claim for a maximum of two screening tests per annum and may choose to use either the Dis-Chem WellScreen test or the Health Check or both.

** Member may claim for a maximum of one screening test per annum and may choose to use either the Dis-Chem WellScreen test or the Health Check.

WORLD HEALTH ORGANISATION (WHO) GLOBAL OUTBREAK BENEFIT

		Plan A	Plan B	Plan C
Healthcare service	**Basis of cover**	**Annual limits**	**Annual limits**	**Annual limits**
World Health Organisation (WHO) Global Outbreak Benefit	Baskets of care which includes in-hospital and out-of-hospital management and supportive treatment of global World Health Organisation recognised disease outbreaks DSP applies where applicable	Subject to Prescribed Minimum Benefit guidelines or as otherwise legislated	Subject to Prescribed Minimum Benefit guidelines or as otherwise legislated	Subject to Prescribed Minimum Benefit guidelines or as otherwise legislated

THE MALCOR MEDICAL AID SCHEME

BENEFIT TABLES

HOSPITAL BENEFITS: PLAN D

Benefit limits are prorated if a member joins the Malcor Medical Aid Scheme during the year unless otherwise stated. Preauthorisation required, except in the case of an emergency. In all instances, Prescribed Minimum Benefits (PMBs) are paid at cost and are unlimited.

Service	Benefits/Annual limits	Benefit requirements/ conditions
Overall annual limit	No annual limit	Subject to protocols and sub-limits not being exceeded
Statutory Prescribed Minimum Benefit services rendered by public hospitals payable at 100% of cost	No annual limit	
Emergency medical cover while travelling outside of South Africa	100% of SA tariff rates payable in RSA currency	

	Service	Benefits	Annual limits	Benefit requirements/ conditions
1. HOSPITALISATION AND ASSOCIATED COSTS – PROVINCIAL AND PRIVATE				
Items 1.01 – 1.21: All admissions to hospitals and services listed below must be preauthorised by the Designated Service Provider. Tel: 0860 00 24 02. The Scheme will pay the costs of Prescribed Minimum Benefits in full for the involuntary use of a non-Designated Service Provider and 100% of the Scheme Rate for services obtained from a Designated Service Provider.				
	Overall annual limit	R640,000 per family per annum	Subject to sub-limits not being exceeded	
1.01	**Accommodation, theatre fees medicines, intensive care**	100% of Managed Care Rate	Subject to PMBs as prescribed	Medicine dispensed on discharge limited to a five-day supply
1.02	**Surgical procedures in hospital** including GP and specialist consultations	100% of Managed Care Rate Hip Arthroscopy not covered	Subject to PMBs as prescribed Private wards not covered	
1.03	**Diagnostic investigations** e.g. Radiology, Pathology, MRI/ CAT scans etc.	100% of Managed Care Rate	Authorisation must be obtained prior to the examination or within 24 hours in case of an emergency Limited to R13,133 per family per annum	Subject to clinical protocols and PMBs as prescribed MRI and CT Scans must be authorised by the Scheme, or the Managed Health Care Organisation

Service		Benefits	Annual limits	Benefit requirements/ conditions
1. HOSPITALISATION AND ASSOCIATED COSTS – PROVINCIAL AND PRIVATE				
Items 1.01 – 1.21: All admissions to hospitals and services listed below must be preauthorised by the Designated Service Provider. Tel: 0860 00 24 02. The Scheme will pay the costs of Prescribed Minimum Benefits in full for the involuntary use of a non-Designated Service Provider and 100% of the Scheme Rate for services obtained from a Designated Service Provider.				
1.04	**Blood transfusions**	100% of cost		
1.05	**Oncology treatment**	100% of Managed Care Rate Subject to ICON protocols	Limit of 294,000 per family per annum	Subject to PMBs as prescribed
1.06	**Accommodation for confinements** Note: Waiting period may be applied, subject to the rights of interchangeability	100% of Managed Care Rate	NVD – Limited to two days Caesar – Limited to three days Limited to two sonars per confinement	Subject to PMBs as prescribed
1.07	**Psychiatric treatment and clinical psychology**	No benefit		Subject to PMBs as prescribed Drug and alcohol treatment at SANCA affiliated facilities only
1.08	**Organ transplants**	100% of Managed Care Rate	Limited to R141,000 per family per annum Cornea transplants: only locally harvested corneas will be covered	Subject to PMBs as prescribed and preauthorisation. Only locally harvested corneas will be covered
1.09	**Renal dialysis**	100% of Managed Care Rate		Subject to PMBs as prescribed.
1.10	**Dental hospitalisation**	No benefit		
1.11	**Sterilisation/vasectomy**	No benefit		(Revisions excluded)
1.12	**Internal prosthesis**	100% of cost	Limited to R30,600per case per annum Cardiac stents – one per lesion, maximum three lesions Aphakic Lenses – R6,120 per lens	Subject to PMBs as prescribed and preauthorisation Cardiac stents are reimbursed at the cost of bare metal stents (BMS) and not drug eluting stents (DES). (Revisions excluded)
1.13	**Physiotherapy**	100% of Managed Care Rate		Subject to PMBs as prescribed and preauthorisation
1.14	**Step down facilities** Instead of hospitalisation	100% of Managed Care Rate	Limited to a maximum of two weeks per person per annum	Subject to PMBs as prescribed and preauthorisation
1.15	**Private nursing** Instead of hospitalisation	100% of Managed Care Rate	Limited to a maximum of two weeks per person per annum	Subject to PMBs as prescribed and preauthorisation
1.16	**Rehabilitation facilities**	100% of Managed Care Rate	Limited to a maximum of two weeks per person per annum	Subject to PMBs as prescribed and preauthorisation
1.17	**Circumcision** In- and out-of-hospital	100% of Managed Care Rate	Limited to R1,600 per person per annum	
1.18	**Hyperbaric Oxygen Therapy**	No benefit		
1.19	**Back surgery**	100% of Managed Care Rate	Refer to the limit as per item 1.12	Subject to PMBs as prescribed and preauthorisation Subject to back treatment protocols as per DBC
1.20	**Stereotactic Radiosurgery**	No benefit		
1.21	**Laparoscopic Procedures**	No benefit		Subject to PMBs as prescribed and preauthorisation

OUT-OF-HOSPITAL BENEFITS: PLAN D

Benefit limits are prorated if a member joins the Malcor Medical Aid Scheme during the year unless otherwise stated. In all instances, PMBs are paid at cost and are unlimited.

Service		Benefits	Annual limits	Benefit requirements/ conditions
2. GENERAL PRACTITIONERS AND SPECIALISTS				
2.01	**Consultations**			
	General Practitioners	100% of Managed Care Rate	No annual limit	Subject to member's choice of nominated GP
	Specialists	100% of Managed Care Rate	Limited to four visits per family per annum	Subject to referral from nominated GP
	Outpatient facilities	100% of Managed Care Rate	Two visits per family per annum	
2.02	**Antenatal care** Included in sub limits for consultations and medication	100% of Managed Care Rate	Limited to two sonars per pregnancy	Note: waiting periods may apply subject to the rights of interchangeability
2.03	**Diagnostic investigations**			Subject to PMBs as prescribed
	Pathology	100% of Managed Care Rate	Limited to R1,300 per person per annum	
	Radiology	100% of Managed Care Rate	Limited to R1,300 per person per annum	
	MRI/Cat Scans	No benefits		
3. MEDICINES				
3.01	**Acute medicines** (including homeopathic medicine)	100% of Designated Service Provider reference price	Unlimited subject to medicine dispensed by the nominated GP and medicine formulary	
3.02	**PMB Chronic Disease List (CDL) medicines**	100% of Designated Service Provider reference price	Unlimited, but subject to Designated Service Providers' treatment protocols and medicine formulary	PMBs subject to registration and preauthorisation of the medicine with the Scheme's Preferred Provider Tel: 0860 00 24 02
3.03	**Other chronic (non-CDL) medicines**	100% of Designated Service Provider reference price	Unlimited, but subject to Designated Services Providers' treatment protocols and medicine formulary	Non-CDL PMBs subject to registration and preauthorisation of the medicine with the Scheme's Preferred Provider, Tel: 0860 00 24 02
3.04	**Pharmacy Advised Treatment (PAT)** Over the counter medication. In consultation with pharmacist, restricted to schedule 0, 1 and 2 medicines	100% of Managed Care Rate	R490 per family per annum at R165 per event	
4. OPTICAL BENEFITS				
Contact the Designated Service Provider for availability of contracted optometrists. Tel: 0860 00 24 02				
4.01	**Spectacle lenses** In Network Benefits	100% of cost	Limited to R1,330 per person payable every 24 months	Subject to using the Scheme's Designated Service Provider
4.02	**Spectacle lenses** Out of Network Benefits Applicable to members who choose to utilise a non-Preferred Provider Network Optometrists	Included in limit 4.01 above		
4.03	**Contact lenses** In and Out of Network	No benefit		

Service		Benefits	Annual limits	Benefit requirements/ conditions
4.04	**Frames** In and Out of Network	Included in limit 4.01 above		
4.05	**Eye tests** In and out of Network	Included in limit 4.01 above		
5. DENTISTRY				
5.01	**Conservative dentistry** (e.g. fillings, extractions and X-rays)	100% of Managed Care Rate	Subject to overall annual limit	preauthorisation required from Designated Service Provider Tel: **0860 10 49 25**
5.02	**Specialised dentistry** (e.g. crowns, bridge-work, dentures, orthodontics and periodontics)	No benefit		
5.03	**Maxillo facial and oral surgery** (consultations, surgical procedures and operations)	No benefit		
6. ALTERNATIVE SERVICES				
6.01	**Chiropractic, homeopathy, podiatry and naturopathy**	No benefit		
7. REMEDIAL AND OTHER THERAPIES				
7.01	**Audiology, dietitians, hearing aid acousticians, occupational therapy, orthoptics, social workers and speech therapy**	No benefit		
8. APPLIANCES				
8.01	**Appliances** (e.g. hearing aids, wheelchairs, calipers etc.)	No benefit		Subject to PMBs as prescribed
9. EXTERNAL PROSTHESIS				
9.01	**External prosthesis** (e.g. artificial limbs, eyes, etc.)	No benefit	Subject to overall annual limit	Subject to PMBs as prescribed preauthorisation required from Designated Service Provider Tel: 0860 10 49 25
10. PHYSIOTHERAPY (out of hospital)				
10.01	**Physiotherapy** (out-of-hospital)	No benefit		Subject to PMBs as prescribed
11. OTHER BENEFITS				
11.01	**Ambulance services** **LifeMed 0861 086 911** (air/road ambulance and emergency services)	100% of Cost		Non-emergency: Subject to preauthorisation beforehand. Failure to do this could result in the member being liable for the costs incurred Emergency: Subject to authorisation within 72 hours after the emergency Inter-hospital transfers: must be done by the Designated Service Provider only
11.02	**HIV/AIDS and sexually transmitted diseases**	100% of Managed Care Rate	Hospitalisation payable as a PMB.	Subject to Regulation 8(3) Subject to treatment protocols, medicine formulary and registration of chronic medicine by the member's nominated GP
11.03	**Infertility**	100% of Cost	Subject to PMBs as prescribed	

REPORTING FRAUD OR MALPRACTICE

Be part of the solution and not the problem. Report any fraudulent or unethical practice to us and take an active role in combating crime.

KEY INFORMATION

The Scheme pays the applicable Malcor Rate directly to providers as standard practice. If medical providers charge in excess of Malcor Rates, the member will then have to settle the balance with the relevant provider.

Should a member pay a provider directly and submit his claim with proof of receipt, the Scheme will refund the Malcor Rate to the member.

NB! All medical aid refunds are done electronically and members are urged to ensure their banking details with the Scheme are always updated.

IMPORTANT TIPS WHEN CLAIMING

When claiming from the Scheme for your medical costs, whether these are hospital, chronic or out-of-hospital, these steps apply:

- When sending claims, please make sure the following details are clear:
  - Your membership number
  - The service date
  - Your doctor's details and practice number
  - The amount charged
  - The relevant consultation, procedure or NAPPI codes and diagnostic (ICD-10) codes
  - The name and birth date of the dependant for whom the service performed
  - If paid, attach your receipt or make sure the claim says 'paid'.
- Check with your healthcare providers if they have sent your claims to us to avoid duplicates.
- Send your claims within four months of the date of service, otherwise they will be treated as expired and will not be paid.
- Always remember to keep copies of your claims for your records.
- To see the status of your claim, you can go to **www.malcormedicalaid.co.za**

IMPORTANT NOTES

1. Healthcare practices must be appropriately registered with the Board of Healthcare Funders (BHF) and must have a valid practice number in order for claims to be considered.
2. The Scheme Rate is set by the Scheme for reimbursement or it is the rate agreed between the Scheme and the provider. Discovery Health has been mandated to negotiate certain rates on behalf of the Scheme.

Fraud hotline (anonymous)

To report any crime related activity, call anonymously on the toll-free number 0800 004 500. This is a totally independent, professional hotline service.

HOW TO CLAIM

Email

You can email your claim to **claims@malcormedicalaid.co.za**

You can scan and email your Plan D claim to **claims@enablemed.com**

Post

You can post your claims to the following address:

PO Box 8012
Greenstone
1616

USING THE MOBILE APP

You can take a picture or scan your claim using the mobile App. For step by step instructions on how to do this refer to page 27 of this Benefit Guide. This functionality is only available to Plans A, B and C.

CLAIM DROP-OFF BOXES

You can drop your claims in the Discovery Health claims drop-off boxes situated around the country, in convenient places such as pharmacies and medical practices, as well as most Virgin Active or Planet Fitness gyms.

The Malcor Medical Aid Scheme claims boxes will remain in place at the various employer groups and you may continue to use these.

CLAIM QUERIES

For any claim queries, call the Scheme on **0860 100 698** or email **service@malcormedicalaid.co.za**. Note this email address should not be used to submit your claims.

CHANGING PLANS

Members have freedom of choice between the four plans. Members may change plans with effect from January each year. Members may request a plan change at the end of the year when the year-end communication is sent out by the Scheme.

GENERAL EXCLUSIONS

1. PRESCRIBED MINIMUM BENEFITS

The Scheme shall pay in full, without any co-payment or use of deductibles, the diagnosis, treatment and care costs of the Prescribed Minimum Benefits as per Regulation 8 of the Act. Furthermore, where a protocol or formulary drug preferred by the Scheme has been ineffective or would cause harm to a beneficiary, the Scheme will fund the cost of the appropriate substitution treatment without a penalty to the beneficiary as required by Regulation 15H and 15I of the Act.

2. LIMITATIONS AND RESTRICTIONS OF BENEFITS

Unless otherwise decided by the Trustees, the following limitations and restrictions will be applied to the application of benefits:

2.1. The Scheme may require a second opinion in respect of proposed treatment or medication which may result in a claim for benefits and for that purpose the relevant beneficiary shall consult a dental or medical practitioner nominated by the Scheme and at the cost of the Scheme.

2.2. In cases where a specialist is consulted without the recommendation of a general practitioner, the benefit allowed by the Scheme may, at its discretion, be limited to the amount that would have been paid to the general practitioner for the same service.

2.3. Unless otherwise decided by the Scheme, benefits in respect of medicines obtained on a prescription are limited to one month's supply (or to the nearest broken pack) for every such prescription or repeat thereof.

2.4. If the Scheme does not have funding guidelines or protocols in respect of benefits for services and supplies referred to in Annexure B, beneficiaries will only qualify for benefits in respect of those services and supplies if the Scheme or its managed healthcare organisation acknowledges them as medically necessary, and then subject to such conditions as the Scheme or its managed healthcare organisation may impose.

2.5. The Scheme reserves the right not to pay for any new technology. Coverage of new technology will be assessed by the Scheme with due consideration given to:

2.5.1. medical necessity

2.5.2. clinical evidence of its use in clinical medicine including outcome studies

2.5.3. its cost-effectiveness

2.5.4. its affordability

2.5.5. its value relative to existing services or supplies;

2.5.6. its safety.

2.6. New technology is defined as any clinical intervention of a novel nature as well as those with which the Scheme has not had previous experience.

2.7. The Scheme reserves the right to impose and apply exclusions and limits to the benefits that will be paid for medicines/procedures/interventions which have been accepted into the practice of clinical medicine through a process of health technology.

2.8. Benefits in respect of the cost of emergency medical treatment whilst abroad are covered at the applicable Malcor Rate using the then prevailing exchange rate into RSA currency.

3. BENEFITS EXCLUDED

General exclusions mentioned in this paragraph are not affected by medicines or treatment approved and authorised in terms of any Scheme approved managed healthcare programme. Expenses incurred in connection with any of the following will not be paid by the Scheme:

3.1. all costs that exceed the maximum allowed for benefits to which the member is entitled in terms of the rules

3.2. all costs for operations, medicines, and procedures for cosmetic purposes or for non-clinical reasons

3.3. if, in the opinion of the medical advisor, the healthcare service in respect of which a claim is made is not appropriate and necessary for any aspect of the management of the medical condition

3.4. all costs for treatment, if the efficacy and safety of such treatment cannot be proved

3.5. purchase of the following:

- homemade remedies; and
- alternative medicines.

3.6. beneficiaries admitted during the course of a financial year are entitled to the benefits set out in the relevant benefit option chosen, with the maximum benefits being adjusted in proportion to the period of membership calculated from the date of admission to the end of the particular financial year

3.7. all costs for services rendered by:

3.7.1. persons not registered with a recognised professional body constituted in terms of an Act of Parliament; or

3.7.2. any institution, nursing home or similar institution, not registered in terms of the applicable law

3.8. abdominoplasties (including the repair of divarication of the abdominal muscles)

3.9. accommodation and services provided in a geriatric hospital, old age home, frail care facility, or the like

3.10. acupuncture

3.11. anabolic steroids, immunostimulants (except for immunoglobulin and growth hormones, which are subject to preauthorisation by the relevant managed healthcare programme)

3.12. ante and postnatal exercises

3.13. appointments which a beneficiary fails to keep

3.14. appliances, devices and procedures not scientifically proven or appropriate

3.15. aromatherapy

3.16. autopsies

3.17. ayurvedics

3.18. leg rests, back rests and chair sets

3.19. bandages and dressings (except medicated dressings subject to authorisation by the relevant managed healthcare programme)

3.20. beds and mattresses

3.21. bilateral gynaecomastia in beneficiaries under the age of 18 years (in beneficiaries over 18 years Scheme protocols will apply)

3.22. blepharoplasties

3.23. breast augmentation

3.24. breast reconstruction (unless necessitated by preauthorised surgical mastectomy, traumatic mastectomy or congenital unilateral absence of a breast which is subject to Scheme protocols)

3.25. breast reductions

3.26. nasal surgery done by a plastic surgeon, nasal cautery (procedure code 1069) if done with other intranasal procedures

3.27. external cardiac assistive devices

3.28. coloured or cosmetic effect contact lenses, and contact lens accessories and contact lens solutions

3.29. cosmetic preparations, emollients, moisturisers, medicated or otherwise, soaps, scrubs and other cleansers, sunscreen and sun tanning preparations, medicated shampoos and conditioners, not including coal tar products and the treatment of lice infestation, scabies and other microbial infections

3.30. dental procedures or devices which are not regarded by the relevant managed healthcare programme as clinically essential or clinically desirable; and costs for

3.30.1. anaesthetics in respect of dental services, except where approved by the Scheme's dental advisor

3.30.2. general anaesthetics, conscious analog-sedation and hospitalisation for dental work except in the case of patients under the age of 12 years and bony impaction of third molars.

3.31. labial frenectomies in respect of beneficiaries under the age of 12 years

3.32. orthodontic treatment over the age of 21 years

3.33. use of high impact acrylic and precious metal in dentures or the cost of precious metal as an alternative to semi-precious or non-precious metal in dental prosthesis

3.34. osseo-integrated tooth implants in a hospital setting, (including related sinus lift or bone graft procedures) except where approved by the Scheme's dental advisor

3.35. diagnostic kits, agents and appliances except for diabetic accessories

3.36. sleep therapy

3.37. treatment for erectile dysfunction and loss of libido

3.38. tonics, evening primrose oil, fish liver oils, nutritional supplements, minerals and food and nutritional supplements including baby food and special milk preparations unless usage is specifically recommended by a Scheme approved managed healthcare programme of which the beneficiary is a member or allowed by Scheme (benefit is confined to single and multivitamins and iron prescribed by a doctor and vitamins for members receiving authorised HIV and/or Oncology treatment and/or vitamins for women that are pregnant)

3.39. gender reassignment treatment

3.40. genioplasties

3.41. oral appliances and the ligation of temporal artery and its branches for the treatment of headaches

3.42. hirsutism

3.43. holidays for recuperative purposes

3.44. humidifiers

3.45. hyperbaric oxygen therapy

3.46. infertility treatment

3.47. ionisers and air purifiers

3.48. iridology

3.49. surrogate pregnancy

3.50. keloid surgery, except for burns and functional impairment deemed by the Scheme to be medically necessary

3.51. laxatives

3.52. medication in connection with substance abuse treatment unless specifically authorised by the relevant managed healthcare programme

3.53. medicines not included in a prescription from a medical practitioner or other healthcare professional who is legally entitled to prescribe such medicines

3.54. medicine not approved by the Medicine Control Council or other statutory body empowered to approve/register medicine

3.55. MRI, CT scans and PET scans ordered by a non-accredited general practitioner

3.56. obesity treatment

3.57. orthopaedic shoes and boots

3.58. osteopathy

3.59. otoplasties

3.60. pain relieving machines, e.g. TENS, APS machines

3.61. refractive eye surgery/excimer laser treatment except on Plan A

3.62. reflexology

3.63. revision of scars

3.64. rhinoplasties

3.65. smoking cessation treatment and anti-smoking preparations

3.66. stethoscopes

3.67. sphygmomanometers/blood pressure monitors

3.68. sunglasses

3.69. travelling expenses

3.70. uvulopalatalpharyngoplasty (UPPP) and laser – assisted uvuloplatoplasty (LAUP)

3.71. pharmacy service and facility fees

3.72. services rendered during any waiting periods that are imposed on a member or any dependant joining the Scheme

3.73. all claims where ICD10 codes are missing on the related account or are, invalid or incomplete

3.74. Rhizotomy and/or facet joint injections of the spine, except where approved by the Scheme's medical advisor.

CONTACT US

HOW TO CONTACT THE SCHEME (PLAN A, B AND C)

For any queries, call the Scheme on **0860 100 698** or visit the Scheme's website **www.malcormedicalaid.co.za.**
Visit the Discovery Store at the following places:

Sandton

1 Discovery Place, Sandton
Telephone: 011 529 4483
Opening hours:
Monday – Friday: 08:00 – 17:00
Saturday: 08:00 – 15:00
Sunday: Closed
Public holidays: Closed

Pretoria

Menlyn Maine Central Square, Shop 35, Corner of Dallas Ave and Aramist Ave, Menlyn
Telephone: 012 676 4221 | 012 676 4222
Opening hours:
Monday – Saturday: 09:00 – 18:00
Sunday and public holidays: 09:00 – 14:00

Durban

Shop 7, 16 Chartwell Drive,
Granada Square, Umhlanga
Telephone: 031 576 7308 | 031 576 7276
Opening hours:
Monday – Friday: 08:00 – 17:00
Saturday: 09:00 – 14:00

Sunday and public holidays: 09:00 – 14:00

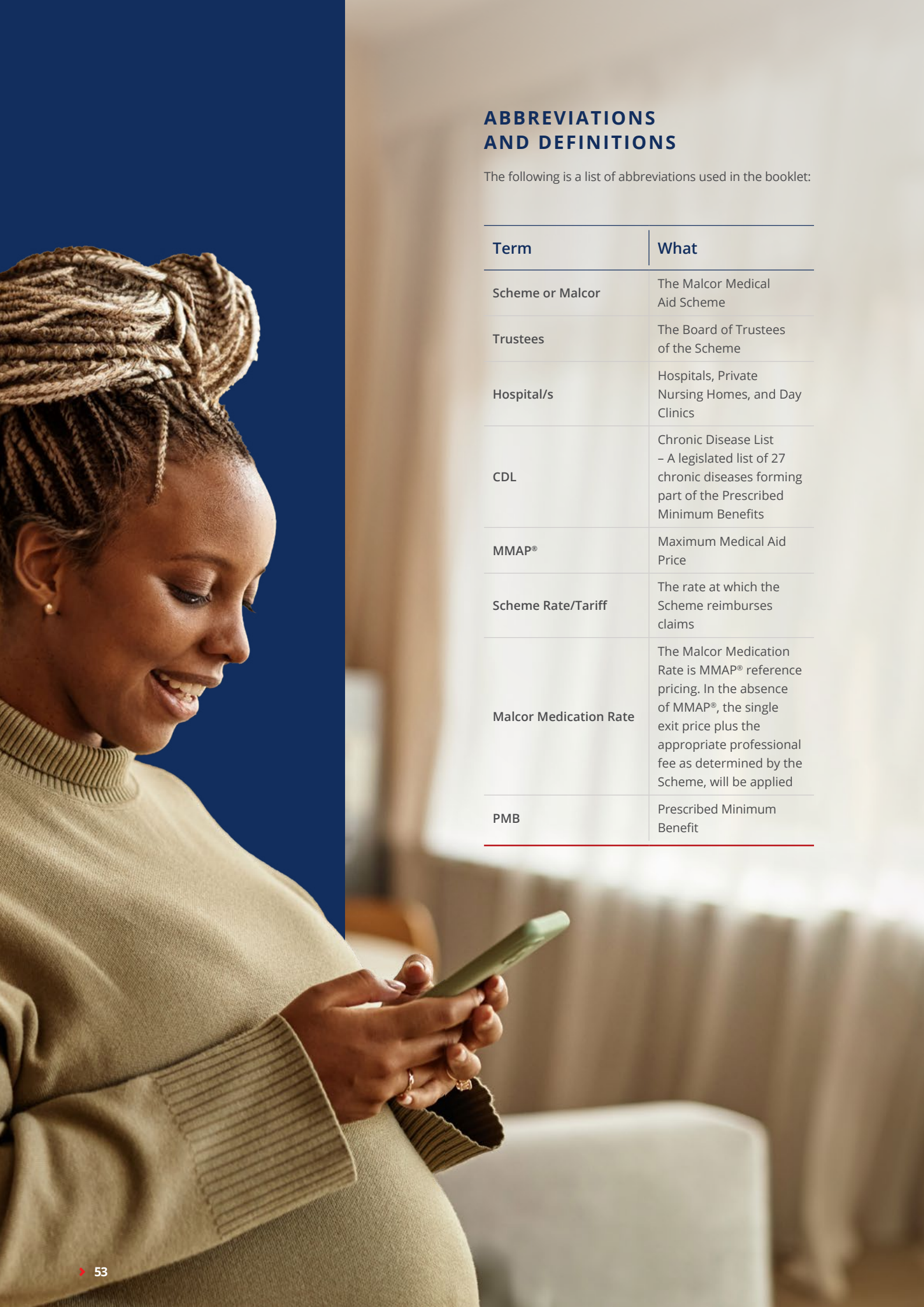
Cape Town

Sable Park, Bridgeways Precinct,
Century City 7446
Telephone: 021 527 1262
Opening hours:
Monday – Friday: 08:00 – 17:00
Saturdays: 08:00 – 13:00
Public Holidays: 08:00 – 13:00
Sundays: Closed

The Point shopping centre,
76 Regent Road, Sea Point
Telephone: 021 527 1073
Opening hours:
Monday – Friday: 09:00 – 18:00
Saturday and Sundays : 09:00 – 14:00
Public holidays: Closed

How to contact enablemed (plan D)

24 hour preauthorisations: 0860 002 402
Dentistry: 0860 104 925
24 hour medical emergency: 0861 086 911



ABBREVIATIONS AND DEFINITIONS

The following is a list of abbreviations used in the booklet:

Term	What
Scheme or Malcor	The Malcor Medical Aid Scheme
Trustees	The Board of Trustees of the Scheme
Hospital/s	Hospitals, Private Nursing Homes, and Day Clinics
CDL	Chronic Disease List – A legislated list of 27 chronic diseases forming part of the Prescribed Minimum Benefits
MMAP®	Maximum Medical Aid Price
Scheme Rate/Tariff	The rate at which the Scheme reimburses claims
Malcor Medication Rate	The Malcor Medication Rate is MMAP® reference pricing. In the absence of MMAP®, the single exit price plus the appropriate professional fee as determined by the Scheme, will be applied
PMB	Prescribed Minimum Benefit

THE COUNCIL FOR MEDICAL SCHEMES

FOR YOU, FOR HEALTH, FOR LIFE.

What?

The Council for Medical Schemes (CMS) is a statutory body established in terms of the Medical Schemes Act 131 of 1998 to provide regulatory oversight to the medical scheme industry. The CMS' vision is to promote vibrant and affordable healthcare cover for all.

Why?

It is our mission to regulate the medical schemes industry in a fair and transparent manner.

- We protect the public, informing them about their rights, obligations and other matters, in respect of medical schemes;
- We ensure that complaints raised by members of the public are handled appropriately and speedily;
- We ensure that all entities conducting the business of medical schemes, and other regulated entities, comply with the Medical Schemes Act;
- We ensure the improved management and governance of medical schemes;
- We advise the Minister of Health of appropriate regulatory and policy interventions that will assist in attaining national health policy objectives; and
- We collaborate with other entities in executing our regulatory mandate.

Who?

The CMS governs the medical schemes industry and therefore your complaint should be related to your medical scheme. Any beneficiary or any person who is aggrieved with the conduct of a medical scheme can submit a complaint.

It is however very important to note that a prospective complainant should always first seek to resolve complaints through the complaints mechanisms in place at the respective medical scheme before approaching the CMS for assistance.

You can contact your scheme by phone or if not satisfied with the outcome, in writing to the Principal Officer of the scheme, giving her/him full details of your complaint. If you are not satisfied with the response from your Principal Officer, you can ask the matter to be referred to the Disputes Committee of your scheme.

If you are not satisfied with the decision of the Disputes Committee, you can appeal against the decision within 3 months of the date of the decision to the CMS. The appeal should be in the form of an affidavit directed to the CMS. We are for you.

When?

When you need us! The CMS protects and informs the public about their medical scheme rights and obligations, ensuring that complaints raised are handled appropriately and speedily.

We are for health.

How?

Complaints against your medical scheme can be submitted by letter, fax, email or in person at our Offices from Mondays to Fridays (08:00–17:00). The complaint form is availablefrom **www.medicalschemes.com**

Your complaints should be in writing, detailing the following: Full names, membership number, benefit option, contact details and full details of the complaint with any documents or information that substantiate the complaint.

The CMS' Customer Care Centre and Complaints Adjudication Unit also provides telephonic advice and personal consultations, when necessary.

Our aim is to provide a transparent, equitable, accessible, expeditious, as well as a reasonable and procedurally fair dispute resolution process. The CMS will send a written acknowledgement of a complaint within three working days of its receipt, providing the name, reference number and contact details of the person who will be dealing with a complaint.

In terms of Section 47 of the Medical Schemes Act 131 of 1998, 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 CMS within 30 days.

The CMS shall within four days of receiving the complaint from the scheme or its administrator, analyse the complaint and refer the complaint to the relevant medical scheme for comments.

YOU CAN CONTACT THE CMS

Customer Care Centre

0861 123 267
0861 123 CMS

Reception

Tel: 012 431 0500
Fax: 012 430 7644

General enquiries

Email enquiries: information@medicalschemes.co.za
www.medicalschemes.co.za

Complaints

Fax: (086) 673 2466
Email: complaints@medicalschemes.co.za

Postal address
Private Bag X34
Hatfield
0028

Physical address
Block A, Eco Glades 2 Office Park
420 Witch-Hazel Avenue
Eco Park, Centurion
0157

MALCOR
MEDICAL AID SCHEME
Administered by Discovery

Call Centre 0860 100 698 | service@malcormedicalaid.co.za | www.malcormedicalaid.co.za

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