2019 MEMBER GUIDE

moto HEALTH CARE

taking care of our own

MOTO HEALTH CARE

MOTO HEALTH CARE (MHC) – Join a medical aid created exclusively for the people in the motor industry.

Taking care of our own at every stage of their health journey

Moto Health Care (MHC) is dedicated to serving the healthcare needs of the motor industry. It is managed by a dedicated team of professional people with an average of 20 years' experience in the medical aid environment.

PLEASE NOTE: Product rules, limits, terms and conditions apply. Where there is a discrepancy between the content provided in this member guide, the website and the Scheme rules, the Scheme rules will prevail.

The Scheme rules are available on request. Benefits are subject to approval from the Council for Medical Schemes (CMS).

MHC PLAN RANGE

You can choose from 7 plans that are designed to meet your individual and unique healthcare needs.

Optimum Page 40

Traditional plan. Unlimited cover in any private hospital. Extensive day to day benefits paid from the insured benefits. Cover for additional non PMB conditions, full cover for chronic medicines at any pharmacy as per formulary for all chronic conditions on the disease list (CDL). Free preventative screening benefits and ER made EASY via Health Maximiser.
Unlimited cover for oncology, dialysis, pathology and radiology.

1

Classic + Network Page 37

2

New generation plan with a savings component that assists members in managing their day to day benefits. Unlimited cover in any private hospital for Classic members. Classic Network members can benefit from discounted contributions but need to utilise a designated service provider. Cover for comprehensive pre- and post-natal healthcare services for maternity and early childhood. Additional non PMB conditions are also covered, full cover for chronic medicines on our formulary for all Chronic conditions on the Disease List (CDL) subject to use of a designated service provider. Free preventative screening benefits and ER made EASY via Health Maximiser.

Hospicare + Network Page 34

Targeted at members requiring hospital cover primarily. The extensive in and out of hospital benefits are for PMB conditions only. Hospicare members have unlimited hospital cover at any provider. Hospicare Network members can benefit from discounted contributions but are required to utilise a designated service provider. 26 chronic conditions are covered in full if our pharmacy network provider is used.

3

Custom Page 31

4

Targeted at young and healthy members, this plan is a network option that has an overall annual hospital limit and sub-limits for associated providers. Access to unlimited day to day benefits. Cover for comprehensive pre- and post-natal health services for maternity and early childhood. 25 chronic conditions are covered subject to use of our formulary and designated service provider. This option includes separate cover for Over the Counter medicines (OTC).

Essential Page 28

Entry level option with unlimited cover at any public hospital. GP consultations are unlimited subject to use of a primary care provider. Treatment for 5 chronic conditions can be accessed via our network provider. This option includes cover for optometry and dentistry, and a rich preventative care benefit.

5

Additional Benefits

6

All plans/members have access to:

- Wellbeing programmes via Multiply - page 7
- Patient care programmes for chronic conditions, maternity, oncology and renal care - page 15
- HealthSaver, assisting you to save at your own pace for those unexpected medical costs - page 8
- Health information at your fingertips via the MHC mobile app - page 6
- Wellness days via employer groups - page 8

TABLE OF CONTENTS

ENHANCING BENEFITS, WITHOUT COMPROMISING AFFORDABILITY

You get comprehensive cover inclusive of many value adding products such as the MHC mobile app, preventative care benefits, a maternity programme tailored for all expectant parents, patient care programmes and wellness days, to name a few.

CONNECT WITH US

Information at your fingertips

Taking care of our own is a key component of our value proposition which is why you benefit from state-of-the-art technology and services when you join Moto Health Care.

Digital health technology supporting you 24/7

Click on your preferred operating system icon below to download the app or log onto the website www.mhcmf.co.za for more info.

Download on the App Store

ANDROID APP ON Google play

MHC MOBILE APP
KEY FEATURES

- Track your claims and medical expenditure.
- Download key documents – tax/ membership certificates and claims statements.
- Access your digital membership card.
- Submit your enquiry online via the app.
- View your monthly contributions and track your payment history.

- Search for healthcare professionals in our network.
- Designed for GP's, hospitals and pharmacies.
- Search for a specific benefit category and sub category.
- Access dashboards that provide you with an overview of your information in real time.

- Manage your pregnancy and your baby's health.
- Access your electronic health record.
- Understand and manage your health risk.
- View the history of medication dispensed by providers.

PREVENTATIVE CARE
VIA HEALTH MAXIMISER™

We believe in giving you more!

PREVENTATIVE SCREENING IS IMPORTANT TO ENSURE THAT MEDICAL CONDITIONS ARE DETECTED EARLY.

Members on the Classic, Classic Network and Optimum Options have access to:

- Baby immunisations as per Department of Health protocols
- Bone density scans
- Cholesterol tests
- Mammograms
- Prostate antigen blood tests
- Tetanus injections

Preventative medicines applicable to Classic and Classic Network members:

You can get the following paid from your annual savings limit:

- Oral contraception and devices
- Slimming preparations
- Treatment that assists with smoking cessation
- Treatment for sexual dysfunction
- Vitamins

multiply wellness & rewards

THE BENEFITS DON'T JUST ADD UP, THEY MULTIPLY

Multiply
You can benefit from exclusive access to value-added offers outside of Moto Health Care Medical Scheme benefits and rules. Multiply is a wellness and rewards programme that helps you make the right choices so that you can live a better, healthier life and also gives you the money to help you afford it.

Wellness
Multiply's goal is to help you make better life choices. Use Multiply to get more money by doing the things that matter to you – things you already do every day.

Rewards
Multiply rewards you for every move you make to improve your life. Choosing wellness means discounts and cash back with our various partners – Edgars, Pick n Pay, Mango and more – as well as on Momentum products.

INTRODUCING ER MADE EASY

Introducing ER made EASY via Health Maximiser for Classic, Classic Network and Optimum members, ER made EASY is an initiative that offers all beneficiaries, regardless of their age, free emergency medical cover when you need it the most. Each beneficiary will have direct access to a hospital's Emergency Room (ER) for medical treatment in emergency situations.

Up until now, this payment was made from the savings/day-to-day benefit (where applicable). If a Member's savings/day-to-day benefits are exhausted, then the amount will be payable by the Member. With ER made EASY this is no longer the case. Even if the Member doesn't have normal benefits available, the cost of the ER visit will be covered up to a maximum of R1 000. MHC offers one emergency visit per beneficiary per annum, members need to pay upfront for services and, if the incident meets the emergency criteria/protocol, a maximum of R1 000 will be reimbursed.

These emergency circumstances may include:

- Sport injuries
- Playground accidents
- Car accidents
- Assault

COMPLEMENT YOUR COVER WITH HEALTHSAVER

You can use additional complementary products to seamlessly enhance your medical aid. Save for additional medical expenses with HealthSaver. HealthSaver lets you save for additional day-to-day medical expenses, such as co payments, exclusions and more.

Note: All Moto Health Care members qualify for this product which is regulated outside the Scheme benefits and Rules. The cost for this product is excluded from the MHC monthly contribution. Members interested in the product must sign up directly. Refer to contact details.

Essential option members can access the benefits below when referred by a primary care provider:

- Cholesterol tests
- Blood glucose testing
- TB screening
- Blood pressure testing
- Breast examination via ultrasound

These tests and consultations do not affect your day-to-day benefits as they are paid from the Screening and Prevention Benefit.

Wellness days

You can now benefit from the opportunity to be screened for existing and potential health risks at your workplace. Our aim is to help you detect health risks early, so that you can prevent or reduce the impact of a disease.

Screening tests

Before getting tested you will need to fill out a medical history questionnaire, which will give the healthcare professional information about your health risks. The following tests are performed at wellness screening sessions:

Blood pressure check

Weight and height, with body mass index (BMI)

Blood sugar and cholesterol (one finger prick required)

Waist circumference

COUNSELLING AND INFORMATION

If the questionnaire or tests show that you are at risk of health conditions, the healthcare professional will provide counselling and advice on the day of the assessment. Information will be shared on the steps you can take to prevent or reduce your health risks. You will also receive brochures on topics such as smoking, exercise and weight management, and may be contacted by one of our Wellness or Lifestyle Coaches.

WELCOME TO BABY BUMPS

A comprehensive programme designed with the needs of expectant parents, and their support network, in mind. We aim to give you support, education and advice through all stages of your pregnancy, the confinement and post-natal (after birth) period. Welcoming a little one to the family is one of the happiest times of your life. As an MHC member you can rest assured that mom and baby's every healthcare needs are more than taken care of.

Share your happy news with us as soon as your pregnancy has been confirmed.

Register between 12 and 20 weeks of your pregnancy to gain access to these additional benefits. This cover does not affect your day-to-day benefits. Benefits will be activated when your pregnancy profile is created.

DURING YOUR PREGNANCY

Antenatal consultations
You are covered for up to 12 visits at your gynaecologist, GP or midwife based on the plan you choose.

Ultrasound scans
You are covered for up to two 2D ultrasound scans. 3D and 4D scans are paid up to the rate we pay for 2D scans.

Vitamins
Only pregnancy related vitamins are covered

Paediatric visits
Your baby is covered up to two visits. Cover depends on the plan you choose.

How do I access the benefits?
- Members on the Essential and Custom options must visit their network general practitioner for antenatal care.
- Members on the Custom option will be referred to a specialist on the network and Essential option members will be given a letter to visit their nearest state facility.
- All maternity care outside the network must be pre-authorised.
- Members on the Hospicare, Hospicare Network, Classic, Classic Network and Optimum options can visit a specialist of their choice.
- All members need to contact the call centre to obtain pre-authorisation for hospital admission for the birth. Pre-authorisation is subject to designated service provider arrangements if applicable to your plan of choice.

The maternity programme is headed by highly skilled and experienced, registered nursing sisters with additional qualifications in midwifery who will provide you with support, education and advice throughout your pregnancy.

Registering on the programme
Contact the call centre between weeks 12 and 20 of your pregnancy to telephonically enrol on the programme.

A new, revolutionary maternity benefit! BellyBabies provide expert antenatal knowledge and support to expecting parents throughout their pregnancy.

BellyBabies is endorsed by MHC. Members can access these benefits independently and have them paid via the HealthSaver product.

Once members sign up they have access to:

- Online Antenatal Classes
- Postnatal Classes
- Video Consult

For more information, please email BellyBabies at **support@bellybabies.co.za.**

Our Preventative Care benefit covers child immunisations according to the Department of Health Immunisation Schedule.

The Department of Health has added the following vaccines to the schedule:
6 months – Measles vaccine
12 months – Measles vaccine
9 years – HPV vaccine

Download the immunisation schedule from the MHC website, which lists all vaccines for children under the age of 12.

AN IMMUNISED CHILD IS A HEALTHY AND PROTECTED CHILD!

PRESCRIBED MINIMUM BENEFIT CONDITIONS

In terms of the Medical Schemes Act 131 of 1998 and its Regulations, all medical schemes have to cover the costs related to the diagnosis, treatment and care of:

- An emergency medical condition
- A defined list of 270 diagnoses
- A defined list of 25 chronic conditions

TO ACCESS PRESCRIBED MINIMUM BENEFITS, THERE ARE RULES THAT APPLY:

- Your medical condition must qualify for cover and be part of the defined list of Prescribed Minimum Benefit (PMB) conditions.
- The treatment needed must match the treatments in the defined benefits.
- You must use designated service providers (DSPs) in our network if applicable to your plan.

This does not apply in emergencies. However, even in these cases, where appropriate and according to the rules of the Scheme, you may be transferred to a hospital or other service providers in our network once your condition has stabilised.

If your treatment doesn't meet the above criteria, the Scheme can apply co-payments or pay for PMBs at Scheme rates.

You will be responsible for the difference between what the Scheme pays and the actual cost of your treatment.

PMB claims for Custom and Essential options members will be paid at the Scheme rates, as these options are exempt from the PMBs.

WHAT IS AN EMERGENCY?

An emergency medical condition, also referred to as an emergency, is the sudden and, at the time unexpected, onset of a health condition that requires immediate medical and surgical treatment, where failure to provide medical or surgical treatment would result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part or would place the person's life in serious jeopardy. An emergency does not necessarily require a hospital admission. We may ask you for additional information to confirm the emergency. **For emergency assistance, please call 0861 009 353.**

You get extensive cover for chronic conditions

MHC members living with a chronic illness get the best care when they register on the Chronic Care Programme.

The programme grants you free access to treatment for a list of medical conditions under the Prescribed Minimum Benefits (PMBs). The PMBs cover 26 chronic conditions on the Chronic Disease List (CDL). Some of our plans cover conditions that are richer than the PMBs, and cover depends on the plan you choose.

Chronic Illness Benefit

This benefit covers you for a defined list of chronic conditions. You need to apply to have your medicine covered for your chronic condition. Refer to page 24/25 for additional info (process flow).

Medicine cover for the Chronic Disease List (CDL)

You get full cover for approved chronic medicine on our list. For medicine not on our list, you may incur a co-payment. Refer to page 12 for additional information.

Medicine cover for the Additional Disease List

If you on the Optimum plan we cover an additional 28 conditions while the Classic and Classic Network plans cover 10 conditions for medicine on the Additional Disease List (NON-PMB Conditions).

How do we pay for medicine?

We pay for medicine up to the maximum of the Moto Health Care (MHC) rate including the fee for dispensing it.

CHRONIC CONDITIONS COVERED

CONDITIONS COVERED ON THE DISEASE LIST (CDL)

ESSENTIAL OPTION	CUSTOM OPTION	HOSPICARE, HOSPICARE NETWORK, CLASSIC, CLASSIC NETWORK AND OPTIMUM OPTIONS
Asthma	Addison's disease	Addison's disease
Diabetes insipidus	Asthma	Asthma
Hyperlipidaemia	Bronchiectasis	Bipolar mood disorder
Hypertension	Cardiac failure	Bronchiectasis
Hypothyroidism	Cardiomyopathy	Cardiac failure
	Chronic obstructive pulmonary disease	Cardiomyopathy
	Chronic renal disease	Chronic obstructive pulmonary disorder
	Coronary artery disease	Chronic renal disease
	Crohn's disease	Coronary artery disease
	Depression	Crohn's disease
	Diabetes insipidus	Dysrhythmia
	Diabetes mellitus types 1 & 2	Diabetes insipidus
	Dysrhythmias	Diabetes mellitus type 1
	Epilepsy	Diabetes mellitus type 2
	Glaucoma	Epilepsy
	Hyperlipidaemia	Glaucoma
	Hypertension	Haemophilia
	Hypothyroidism	Hyperlipidaemia
	Menopause	Hypertension
	Multiple sclerosis	Hypothyroidism
	Parkinson's disease	Multiple sclerosis
	Rheumatoid arthritis	Parkinson's disease
	Schizophrenia	Rheumatoid arthritis
	Systemic lupus erythematosus	Schizophrenia Systemic
	Ulcerative colitis	Systemic lupus erythematosus
		Ulcerative colitis

ADDITIONAL NON-PMB CHRONIC CONDITIONS COVERED

CLASSIC OPTION CLASSIC NETWORK OPTION	OPTIMUM OPTION
Acne	Acne
Allergic rhinitis	Allergic rhinitis
Ankylosing spondylitis	Ankylosing spondylitis
Depression	Attention-deficit/hyperactivity disorder
Eczema	Cystic fibrosis
Gastro-oesophageal reflux disease	Depression
Gout prophylaxis	Eczema
Osteoporosis	Gastro-oesophageal reflux disease (GORD)
Osteoarthritis	Gout prophylaxis
Psoriasis	Meniere's disease
	Migraine prophylaxis
	Motor neuron disease
	Narcolepsy
	Neurogenic bladder
	Onychomycosis
	Osteoporosis
	Osteoarthritis
	Overactive bladder syndrome
	Paget's disease
	Peptic ulcer disease
	Peripheral arterial disease
	Primary hypogonadism (hormonal levels required)
	Psoriasis
	Psoriatic arthritis
	Renal calculi
	Thrombo- embolic disease
	Tourette syndrome
	Trigeminal neuralgia

Remember: Chronic medicines approved from the additional non-PMB chronic condition benefit on the Classic, Classic Network and Optimum options will be paid subject to an annual limit.

To ensure that you continue to obtain your chronic medication, a new prescription needs to be submitted every six months.

WHERE TO OBTAIN YOUR MEDICATION

The plans listed below have designated service providers (DSPs) for chronic medication.

ESSENTIAL CUSTOM OPTIONS	HOSPICARE OPTION	HOSPICARE NETWORK OPTION	CLASSIC OPTION	CLASSIC NETWORK OPTION
You must use a network pharmacy or allocated GP	Scheme pharmacy network	Medipost	Scheme pharmacy network	Medipost

Avoid a 30% co-payment by using these DSPs.

GETTING THE MOST OUT OF YOUR CHRONIC MEDICATION BENEFITS

DO	OR YOU MAY
If applicable to your option, get your medication from one of our DSP pharmacies who charge special rates (available on online or from our client service team)	Deplete your chronic medication benefit before the end of the year
Enquire about your specific condition's chronic basket (available on www.mhcmf.co.za or telephonically from our Pharmacy Benefit Management team)	Be required to contribute towards your medication cost
Opt for generic versions of your medication as far as possible to stretch every Rand	Deplete your chronic medication benefit before the year ends
Double check that your doctor or pharmacy has registered your chronic condition with the Scheme	Face out-of-pocket expenses
Ensure that your treating doctor includes the ICD10 code on your prescription	Have your medication declined as they do not correlate with your diagnosis
Ensure that you ask about and understand the Reference Pricing and Generic Reference Pricing that may be applied to the medicine product on your prescription	Have unforeseen out-of-pocket expenses

INTEGRATED CARE

To ensure you get high quality coordinated healthcare and the best outcomes, we have care programmes that will assist you in maximising your benefits and help you manage your condition optimally.

These programmes assist our at-risk members to manage their health and benefits better so that they are always able to get the care they need when they need it the most. Members will be assigned to personal wellness coaches that will assist them every step of the way. Wellness coaches will develop a tailor-made care path based on your unique healthcare needs which also include unlocking extra benefits.

WHO WILL BENEFIT FROM THIS PROGRAMME?

- Chronic patients (depending on the severity of your condition) for example members who have been diagnosed with diabetes, hypertension, HIV and cancer.
- Patients with an increased risk of having an adverse health event that may, for example, result in hospitalisation.
- Patients who have had severe in-hospital or other acute health events patients with rare diseases who require constant monitoring.

WHO QUALIFIES FOR THE CARE MANAGEMENT PROGRAMMES

It's important to keep in mind that Integrated Care is a health management programme and not a medical scheme benefit. We have a sophisticated process, based on our advanced managed care principles and protocols, that quickly identifies members who could benefit from the helping hand the programme offers. Once identified, we start helping you to use your specific option's benefits better. In some cases, we'll even unlock extra benefits that assist you to stay as healthy as possible, for as long as possible.

HOW TO REGISTER ON THE PROGRAMME

If you have registered on the Chronic Illness Benefit, you can join the patient care programme especially designed to assist you manage your chronic condition. Partnering with your healthcare practioner, the care programme unlocks additional services according to your unique needs and condition, for example diabetic enrolees have additional benefits for dieticians. Upon registration onto the programme, you will also be allocated to your personal wellness or lifestyle coach depending on your risk profile, these coaches are there to assist and advise you during every step of your healthcare journey.

OUR/YOUR LIFE – HIV CARE PROGRAMME COVERS YOU FOR THE CARE YOU NEED

Special care is taken to ensure your privacy and confidentiality is maintained, including the way in which your medication is delivered.

1. Contact 0860 109 793 or download the registration form from www.mhcmf.co.za
2. Return the completed form via fax to 012 675 3848 or email it to ha@mhcmf.co.za.
3. A care coach from the HIV/Your Life programme will contact you.

ONCOLOGY CARE

If you are diagnosed with cancer, register for the oncology programme as soon as possible. Once we have approved your cancer treatment, you are covered for additional benefits offered by the programme. Benefits include chemotherapy, radiotherapy, visits to the Oncologists and cancer related blood tests.

How do you register on the programme?

1. Your oncologist must email your histology report and treatment plan to oncology@mhcmf.co.za.
2. Your treatment plan will be reviewed and a member of the clinical team will contact your doctor.
3. The oncology management team will call you to discuss the authorised treatment plan.

Note: If your oncology treatment plan changes or additional benefits are required, please ensure that your oncologist notifies the oncology management team.

PALLIATIVE CARE

Holistic home-based end of life care and services are provided via our Palliative care programme, assisting members and their families to cope better. This benefit is subject to Scheme Rules and clinical protocols.

europ assistance
you live we care

EMERGENCY SERVICES

The Scheme has a contract with Europ Assistance to provide emergency medical services to members of the Scheme.

When you call **0861 009 353**, the emergency operations centre will assign an ambulance to the incident.

Emergency medical services include:

- Access to a 24-Hour emergency medical assistance contact centre.
- Assisted by medically trained and registered agents with the HPCSA.
- Immediate dispatch of emergency medical services in order to provide lifesaving assistance.
- Constant monitoring of the incident untill ambulance provider has transferred the member to the hospital.
- Emergency pre-arrival instructions provided by agents e.g. CPR.

EMERGENCY TRANSPORTATION BY AIR OR ROAD AMBULANCE DEPENDING ON THE PLAN YOU CHOOSE.

The procedure you should follow is:

1. Dial **0861 009 353.**
2. Give your name and the telephone number that you are calling from.
3. Provide a brief description of what has happened and how serious the situation is.
4. Provide the address or location of the incident to help paramedics get there.
5. Do not put down the phone until the person on the other side has disconnected the call.

IMPORTANT POINTS:

Please ensure that all your registered dependants are aware of this service.

Inform your child's school that he/she is your dependant on the Scheme and make sure your child and the school is aware of the emergency medical service number.

MEMBERSHIP

WHO CAN JOIN THE SCHEME?

Any person who is employed in the retail motor industry may join the Scheme.

HOW TO APPLY FOR MEMBERSHIP

in FIVE easy steps

ACTIVE EMPLOYEE MEMBERSHIP

STEP 1

Visit your HR Department to obtain a copy of the membership application form

STEP 2

The application form can also be accessed via:

1. www.mhcmf.co.za **OR**
2. The Contact Centre by dialing 0861 000 300

STEP 3

Ensure that all the required documentation is submitted together with the fully completed application form (refer to page 10 of the membership application form for the details)
Remember to complete the inception date

STEP 4

Request your HR to sign and stamp your application form

STEP 5

CONTINUATION MEMBERSHIP

STEP 1

Dial 0861 000 300 to confirm if you meet the requirements for continuation membership on the Scheme

STEP 2

If YES
Complete the continuation form which can be obtained from:

1. www.mhcmf.co.za **OR**
2. The Contact Centre by dialing 0861 000 300

STEP 3

Ensure that all the required documentation is submitted together with the fully completed application form
Remember to complete the inception date

STEP 4

Your bank needs to stamp the debit order instruction on the form

STEP 5

Submit your finalised application form to membership@mhcmf.co.za OR fax to 031 580 0478.
The reference number provided can be used to follow up on the progress of your application.

MEMBERSHIP

CONTINUATION OF MEMBERSHIP

Members who were employed in the motor industry and who leave for one of the following reasons can continue as members of the Scheme:

- when you are retrenched
- when you retire
- if you are unable to work due to ill health
- when you pass away, your surviving spouse and children may continue as beneficiaries
- if you become disabled
- if you resign from a company that offers medical cover on MHC and are employed by another company in the industry which does not offer medical cover on MHC
- if you leave the industry to start your own business

Make sure MHC has your latest contact details on record to ensure that you receive the latest news from the Scheme.

REGISTER YOUR NEW BABY IN TIME!

- Complete the registration form at www.mhcmf.co.za and enclose a certified copy of the birth certificate.
- Forward it to the Scheme within 30 days of the birth of your child. Should the baby's surname differ from yours, please provide the Scheme with an affidavit confirming that the child is your biological child.
- Contributions for the baby will be due from the first day of the month after the month in which the baby was born.
- Babies who are not registered within 30 days of birth will not qualify for benefits and may be underwritten if registered after 90 days.

Note: Should you need to add dependants, please refer to the Scheme's website at www.mhcmf.co.za for the relevant requirements.

UPDATE YOUR MEMBERSHIP DETAILS SHOULD THE FOLLOWING CHANGES OCCUR:

- address, telephone number or other contact details
- banking details
- marital status
- monthly income
- adding or removing dependants
- passing away of the principal member or any registered dependant
- change in employer
- resignation from employer
- leaving the motor industry

CONTRIBUTION STATEMENTS

Each month the Scheme sends a contribution statement to members who pay their contributions directly to the Scheme.

A contribution statement is also sent to all employers each month. The contribution statement sets out the monthly contribution payments and any money that employees of the company may owe to the Scheme. This statement assists your employer to ensure that your contributions are always up to date.

MEMBERSHIP

MANAGING ARREAR CONTRIBUTIONS

You might be behind in your payments to the Scheme if any of the following happens:

- Your employer has not deducted your monthly contribution from your salary. This might happen if you move between dealerships at the same employer and the new human resources consultant does not include you in the payment schedule.
- A backdated salary increase moved you into a higher contribution category.
- You added a dependant and this change was not submitted in time for the next contribution payment.
- Your contract ended with one employer in the motor industry and you started employment with another employer and he or she did not notify the Scheme in time for the next contribution payment.

If you need help with paying your contributions, please contact the Scheme or ask your human resources department to help you with the repayment terms.

Remember: You will retain the same Scheme membership number for life, even if you change employment in the motor industry, unless you are the principal member and pass away and your dependant, such as your spouse or child, becomes the principal member. Notify the Scheme when you change employment in the industry in order for us to keep track of your movements and contribution payments. In this way you will avoid having your benefits suspended when you need medical cover the most.

WAITING PERIOD

CATEGORY	THREE-MONTH GENERAL WAITING PERIOD	12-MONTH CONDITION-SPECIFIC WAITING PERIOD	APPLICATION FOR PMBS
New applicants or persons who have not been members of a medical scheme for more than 90 days before joining	Yes	Yes	Yes
Applicants who were members of a medical scheme for less than two years	No	Yes	No
Change of benefit option	No	No	No
Child dependant born during period of membership	No	No	Not applicable
Involuntary transfers due to change in employment or employer changing to another medical scheme	No	No	Not applicable

The waiting periods are for 3- and 12-months periods, including the PMB category, is very important, as individuals who resign from their medical scheme and who wish to re-join a medical scheme after a few months after developing an illness/condition, will also be subject to the medical Scheme's underwriting. This process is called anti-selection and is legislated to prevent financial exposure and to protect medical schemes.

CHANGING BENEFIT OPTIONS EACH YEAR

You can only change your benefit option once a year. The member guide containing the benefit information and an option selection form will be sent to you in the last quarter of each year, so that you can make an informed decision in time for the following year. If you change your option, benefits on the new option will be available on 1 January of the following year.

You do not need to complete an option selection form if you choose to remain on the same option, but the option selection form is a handy way of making sure that the Scheme has your most recent contact details. Please complete the form if your details have changed.

It is important that you send your request to change your option by the deadline provided, which is in December each year. Option changes will not be approved after the deadline.

EASY STEPS TO SELECT YOUR OPTION FOR 2019

Important: Understand your benefits and choose the right plan that suits your financial and healthcare needs. You are required to notify the Scheme of changes before **31 December 2018.**

HOW DO I CHOOSE A PLAN?	Read and understand the benefits and choose the option that will best suit your financial and healthcare needs or call the contact centre for assistance on 0861 000 300.
HOW DO I INFORM MOTO HEALTH CARE OF MY CHOICE?	Complete an option selection form available from: The call center – 0861 000 300 **OR** Download a form on www.mhcmf.co.za
HOW DO I SUBMIT THE OPTION CHANGE FORM?	Email: membership@mhcmf.co.za Fax: 031 5800 478 Post: PO Box 2338, Durban, 4000
HOW DO I FOLLOW UP?	Find out whether we have received your choice by dialing 0861 000 300.

CLAIMS PROCEDURE

WHO CAN CLAIM?

You and your healthcare providers (general practitioner, specialist, pharmacy or hospital) can submit claims directly to the Scheme.

WHAT INFORMATION MUST BE INCLUDED ON YOUR CLAIMS?

1. Your membership number
2. The Scheme name
3. Your benefit option (for example Optimum, Custom, etc.)
4. Your surname and initials
5. The patient's name and beneficiary code as it appears on your membership card
6. The name and practice number of the service provider
7. The date of service
8. The nature and cost of treatment
9. The pre-authorisation number, if applicable
10. The tariff code
11. The ICD-10 code
12. If you paid for the service, attach proof of payment and highlight it clearly. Proof of payment can be a receipt from the healthcare provider, an electronic fund transfer (EFT) slip or a bank deposit slip.

REASONS WHY CLAIMS ARE REJECTED

- Incorrect member or dependant information
- Dependants are not registered or their details do not appear on the claim
- No pre-authorisation number was obtained for treatment that required pre-authorisation
- Benefits not available
- Claims will not be paid if the benefit category you are claiming from has been depleted

Ensure that all the required information is reflected on the claim (as indicated above)

Where do I send my claim?
Email: claims@mhcmf.co.za
Fax: 031 5800 429
Post: PO Box 2338, Durban, 4000

Claims received after the claiming period has expired

Claims must reach the Scheme within 4 months (i.e. 120 days) of the treatment date. The Scheme will not pay claims that are older than 4 months. You will be responsible for paying the claim if you have submitted it to us after 4 months.

Claims received after you have resigned from the Scheme

When you resign from your employer, your Scheme membership of the Scheme ends and you will not be allowed to access healthcare services. If you or your healthcare providers claim for healthcare services rendered after the date that you resigned from the Scheme, the claim will not be paid.

Scheme exclusions

You must ensure that the procedure, treatment or product you plan to claim for qualify, for benefits before obtaining it, as the Scheme will not pay for any services that are excluded in terms of the Scheme Rules. You will be responsible for paying those costs directly to the healthcare providers. Scheme exclusions are listed on page 46. Alternatively, visit **www.mhcmf.co.za** for a complete list of exclusions.

Please submit your claims directly to claims@mhcmf.co.za.

FIGHT AGAINST FRAUD!

Fraud is a serious issue that affects your medical scheme benefits.

Fraud is an unlawful and intentional misrepresentation that results in actual or potential wrong-doing to the Scheme.

The Scheme's fraud line is managed by an independent team that ensures that members reporting fraud remain anonymous. The location of the secure call centre is not made public to ensure the protection of caller records. All callers remain anonymous, unless they choose to reveal their identities. If you know of any fraud that is taking place or being planned, put an immediate stop to it by calling the anonymous, 24-hour, toll free fraud line on **0800 200 564**.

Examples of fraud:

- A member who is not ill allowing his or her healthcare provider to claim for services in exchange for a sick note.
- A member allowing an individual, who is not a registered beneficiary of the Scheme, to use his or her membership card at a healthcare provider to receive medical services.
- A member claiming for spectacles who receives sunglasses from the healthcare provider.

IF YOU ARE FOUND TO HAVE COMMITTED FRAUD, THE SCHEME MAY:

1. Cancel your membership
2. Insist that you pay back any amounts the Scheme had previously paid relating to the fraudulent matter
3. Open a criminal case against you
4. Report you to your employer

HOW DO I REGISTER FOR CHRONIC MEDICATION?

ESSENTIAL/CUSTOM OPTION

STEP 1

Ask your network doctor to complete the chronic application form

STEP 2

Your network doctor will submit the form, together with a copy of the script, to the chronic department on your behalf

STEP 3

Notification of the outcome will be sent to both you and your doctor

STEP 4

Take your original prescription to the approved network pharmacy to obtain your medication

HOW DO I REGISTER FOR CHRONIC MEDICATION?

HOSPICARE/HOSPICARE NETWORK, CLASSIC, CLASSIC NETWORK, OPTIMUM OPTIONS

STEP 1

Send the prescription inclusive of the diagnosis codes (ICD10 codes) to the chronic department via:

a) Fax 031 5800 625
b) Email chronic@mhcmf.co.za

STEP 2

Your pharmacist/healthcare provider may call the chronic team on 0861 000 300 to register you telephonically for your chronic conditions/medication

STEP 3

Notification of the outcome will be sent to both you and your doctor

STEP 4

HOSPICARE CLASSIC

Take your original prescription to a network pharmacy to obtain your chronic medication

STEP 4

HOSPICARE NETWORK CLASSIC NETWORK

Send your script to Medipost Courier Pharmacy via

a) Fax – Number: 0866522001
b) Email- motohealth@medipost.co.za

STEP 4

OPTIMUM

Collect your medication from the pharmacy

Remember, if you use a network pharmacy, co-payments may be avoided

Remember: Chronic medicines approved from the additional non-PMB chronic condition benefit on the Classic, Classic Network and Optimum options will be paid subject to an annual limit.

DID YOU KNOW?

Did you know that you may ask for a list of medications for your condition which Moto Health Care will fund on your Option? (This list is called a Formulary and will assist your doctor in prescribing a medication which would not cost you money.) Dial **0861 000 300** to find out more.

Members on the Essential and Custom options who require chronic medication, will be assisted by the prescribing network provider.

All registered members will receive a letter reflecting the following information:

- list of medicine authorised or rejected as chronic
- authorisation period
- a care plan outlining the authorised treatment and benefits

To ensure that you continue to obtain your chronic medication, **a new prescription needs to be submitted every 6 months.**

PRE-AUTHORISATION PROCESS

The pre-authorisation process ensures that the treatment or procedure is both necessary and appropriate. Except in emergencies, pre-authorisation must be obtained 48 hours before any hospital admission.

Pre-authorisation is required for the following, among others:

- all admissions to hospital
- outpatient treatment in a hospital, i.e. when you do not stay overnight at the hospital
- admission to a day hospital
- MRI or CT scans or radio-isotope studies
- Access to patient care programmes
- emergency ambulance transportation
- specialised and surgical dentistry in hospital
- visits to a specialist if you are on the Custom and Essential options
- additional consultations on the Classic and Classic Network options once your savings are depleted

Ask your healthcare practitioner for a full description of:

- the reason for admission to hospital or for the scan
- the associated medical diagnosis
- the planned procedure
- all the tariff and ICD-10 codes that the doctor intends to use
- Additional information required
- Your membership number
- Name and date of birth of the patient
- Date of admission
- Name and practice number of the provider
- Name and practice number of the hospital

Remember: In case of an emergency you may obtain authorisation within 48 working hours. Any of your relatives/family/friends may phone to obtain a pre-authorisation number if it is not possible for you to phone.

You may request a quotation for planned procedures prior to the admission by sending the quotation to auths@mhcmf.co.za.

2019
BENEFITS

ESSENTIAL OPTION

MONTHLY CONTRIBUTION			
SALARY BAND	**MEMBER**	**ADULT**	**CHILD**
R0 – R3 000	R345	R207	R139
R3 001 – R6 500	R362	R217	R143
R6 501 – R9 500	R525	R315	R211
R9 501 +	R603	R362	R242

OUT-OF-HOSPITAL BENEFITS

Not sure what we mean? Refer to glossary on page 50.

PRIMARY CARE NETWORK ONLY	
General practitioners (GPs)	Unlimited at the primary care network service provider
Prescribed medicines	
Acute	Unlimited at the primary care network service provider – subject to network formulary
Over the counter (OTC)	Single member = 3 prescriptions Family = 5 prescriptions
Chronic	Five conditions covered (see page 12) Subject to primary care network service provider protocols No benefit if a non-network service provider is used
Optometry Optical benefit available per beneficiary every 24 months	1 optical test per beneficiary per year 1 pair of clear, standard mono- or bifocal lenses in a standard frame **OR** Contact lenses to the value of R480 R185 towards a frame outside the standard range Subject to primary care network service provider protocols No benefit if a non-network provider is used
Basic dentistry	Per beneficiary per annum: • one dental examination • scaling • eight primary extractions • eight fillings • polishing
External prostheses	Per family = R5 720

ESSENTIAL OPTION

Medical and surgical appliances (in- and out-of-hospital)	The following appliances are subject to the annual limit of R2 480 per family
Glucometers	R750 per beneficiary every 2 years
Nebulisers	R750 per family every 3 years
Other Appliances – once every 4 years	Subject to clinical protocols

ADDITIONAL BENEFITS	
Maternity	Antenatal care from the primary care network service provider x2 2D scans per pregnancy. 3D and 4D scans are paid up to the rate of 2D scans
Out-of-area or emergency visits	Per family = three visits to a maximum of R1 000
Preventative care High Risk members as identified by GP Subject to GP referral and case management	Cholesterol Blood glucose Blood pressure Tuberculosis screening Clinical breast examination (ultrasound) Prostate-specific antigen Pneumococcal and influenza vaccines
Patient care programmes (Diabetes, HIV, oncology)	Subject to registration and clinical protocols

ESSENTIAL OPTION

IN-HOSPITAL BENEFITS

Public hospital	Unlimited treatment in accordance with Scheme protocols
Private hospital	Resuscitation and stabilisation only Subject to pre-authorisation within 48 hours of admission and managed care protocols
GPs and specialists	Unlimited treatment in a state facility in accordance with Scheme protocols
To-take-out medicine	Up to 7 days
Internal Prostheses	Per family = R8 590 where approved during hospital admission
Oncology	Where approved during hospital admission Subject to state and managed care protocols
Pathology	Where approved during hospital admission Subject to state and managed care protocols
Radiology	Where approved during hospital admission Subject to state and managed care protocols
Maternity	Treatment in accordance with Scheme and state protocols Antenatal care available from a primary care network provider for the first 20 weeks. Patient will be referred to a State Facility for Specialist care and the confinement.
Ambulance	Emergency road transport only

This option is exempt from PMBs. Terms and conditions apply including specific exclusions.

CUSTOM OPTION

MONTHLY CONTRIBUTION			
SALARY BAND	**MEMBER**	**ADULT**	**CHILD**
R0 – R3 200	R938	R753	R235
R3 201 –R5 800	R985	R787	R246
R5 801 – R8 500	R1 078	R865	R271
R8 501 – R10 500	R1 237	R990	R310
R10 501 +	R1 717	R1 375	R429

OUT-OF-HOSPITAL BENEFITS

Not sure what we mean? Refer to glossary on page 50..

PRIMARY CARE NETWORK ONLY	
General practitioners (GPs)	Unlimited at the primary care network service provider
Specialists	M = R3 570 M+ = R7 150 Subject to network GP referral, pre-authorisation and managed care/Scheme protocols
Medicines Acute Over the counter (OTC) Chronic	 Unlimited at the primary care network service provider – subject to network formulary Single member = 5 prescriptions Family = 7 prescriptions 25 conditions (see page 12) Subject to primary network service provider protocols No benefit if a non-network provider is used
Optometry Optical benefit available per beneficiary every 24 months	1 optical test per beneficiary per year 1 pair of clear, standard mono- or bifocal lenses in a standard frame **OR** Contact lenses to the value of R480 R185 towards a frame outside the standard range
Dentistry Basic - per beneficiary per annum Specialised	 Per beneficiary per annum: • one dental examination • scaling • eight primary extractions • eight fillings • polishing Per adult beneficiary – 1 set of acrylic dentures every 24 months

CUSTOM OPTION

MRI, CT, PET and radio isotope scans	Sub-limit per beneficiary = R2 530, subject to specialist limit
External prosthesis	R9 540 per family per annum. Subject to clinical protocols
Medical and surgical appliances (in and out of hospital)	The following appliances are subject to the annual limit of R6 610 per family
Glucometers **Nebulisers** Other appliances – once every 4 years	R750 per beneficiary every 2 years R750 per family every 3 years Subject to clinical protocols

ADDITIONAL BENEFITS	
Maternity	Antenatal care from the primary care provider 2x 2D Scans per pregnancy. 3D and 4D scans are paid up to the rate of 2D scans
Out-of-area or emergency visits	Per family = 3 visits to a maximum of R1 000
Patient care programmes (Diabetes, HIV, oncology)	Subject to registration and managed care protocols

This option is exempt from PMBs. Terms and conditions apply including specific exclusions.

CUSTOM OPTION

IN-HOSPITAL BENEFITS

Overall Annual Limit (OAL)	Single member = R295 380 Family = R519 100 All services are subject to pre-authorisation and managed care protocols
Public hospital	Unlimited treatment in accordance with Scheme and state protocols
Private hospital **Network hospital: Life Healthcare**	Subject to the overall annual limit and use of the Scheme network hospitals A 30% co-payment will be applied for voluntary use of a non-network provider
GPs and specialists	Unlimited treatment in accordance with Scheme protocols and use of Network Providers Admission to private hospital subject to overall annual limit Claims paid up to the agreed rate with the provider
To-take-out medicine	Up to 7 days
Internal prostheses	Per family per annum = R14 310 where approved during hospital admission
Alternate care instead of hospitalisation	Per family = 30 days to a maximum of R19 920
Mental health (in and out of hospital)	Subject to the overall annual limit and up to a sub-limit of R21 090 Subject to clinical protocols
Alcohol and drug rehabilitation	100% of the negotiated rate, at a South African National Council on Alcoholism and Drug Dependence (SANCA)-approved facility, subject to the mental health sub-limit
Oncology	Per family = R66 240, subject to overall annual limit
Pathology	Per beneficiary = R6 950, subject to overall annual limit
Radiology	Per beneficiary = R6 950, subject to overall annual limit
Medical and surgical appliances (in and out of hospital)	Per family = R6 610, subject to overall annual limit
Maternity	Confinement: Public hospital – Treatment in accordance with Scheme protocols Private hospital – Subject to private overall annual limit and use of the hospital network providers
Ambulance	Emergency road transport only

HOSPICARE OPTION

MONTHLY CONTRIBUTION			
OPTION	**MEMBER**	**ADULT**	**CHILD**
Hospicare Network	R1 711	R1 450	R425
Hospicare	R1 982	R1 675	R493

OUT-OF-HOSPITAL BENEFITS

Not sure what we mean? Refer to glossary on page 50.

	HOSPICARE NETWORK	HOSPICARE
Day-to-day	As part of an approved treatment plan	As part of an approved treatment plan
General practitioners (GPs) and specialists	270 DTPs; PMB treatment only Specialists subject to preferred provider rates	270 DTPs; PMB treatment only Specialists subject to preferred provider rates
Medicines Acute Chronic Network provider Co-payment for non-formulary medicine Co-payment for non-network provider	 270 DTPs; PMB treatment only 26 conditions (see page 12) Medipost Pharmacy 20% 30%	 270 DTPs; PMB treatment only 26 conditions (see page 12) Scheme's pharmacy network 20% 30%
Non-CDL chronic medicine limit	270 DTPs; PMB treatment only	270 DTPs; PMB treatment only
Optometry	270 DTPs; PMB treatment only	270 DTPs; PMB treatment only
Dentistry Basic and specialised	270 DTPs; PMB treatment only	270 DTPs; PMB treatment only
Auxiliary services	270 DTPs; PMB treatment only	270 DTPs; PMB treatment only

HOSPICARE OPTION

ADDITIONAL BENEFITS	HOSPICARE NETWORK	HOSPICARE
Maternity	12 antenatal visits x2 scans per pregnancy 3D and 4D scans are paid up to the rate of 2D scans x2 paediatric visits Pregnancy related vitamins	12 antenatal visits x2 2D scans per pregnancy 3D and 4D scans are paid up to the rate of 2D scans. x2 paediatric visits Pregnancy related vitamins
Medical and surgical appliances	270 DTPs; PMB treatment only	270 DTPs; PMB treatment only
Hearing aids	270 DTPs; PMB treatment only	270 DTPs; PMB treatment only
Mental health	270 DTPs; PMB treatment only	270 DTPs; PMB treatment only
Child immunisations	Up to the age of 6 years, as per Department of Health protocols	Up to the age of 6 years, as per Department of Health protocols
Patient care programmes (Diabetes, HIV, oncology)	Subject to registration and managed care protocols	Subject to registration and managed care protocols

IN-HOSPITAL BENEFITS

	HOSPICARE NETWORK	HOSPICARE
All services are subject to pre-authorisation and managed care protocols	**Network hospital: Life Healthcare PMBs only**	**Any hospital – PMBs only**
Public and private hospital	Unlimited – PMBs only 30% co-payment for use of non-network provider	Unlimited – PMBs only
GPs and specialists	270 DTPs; PMB treatment only	270 DTPs; PMB treatment only
To-take-out medicine	Up to 7 days	Up to 7 days
Organ transplant *	Unlimited – PMBs only	Unlimited – PMBs only
Prostheses	Unlimited – PMBs only	Unlimited – PMBs only
Reconstructive surgery	Unlimited – PMBs only	Unlimited – PMBs only
MRI, CT, PET and radio isotope scans	Unlimited – PMBs only	Unlimited – PMBs only
Alternate care instead of hospitalisation	Unlimited – PMBs only	Unlimited – PMBs only
Mental health	100% of Scheme rate subject to managed care protocols	100% of Scheme rate subject to managed care protocols

HOSPICARE OPTION

Alcohol and drug rehabilitation	100% of negotiated rate, at a South African National Council on Alcoholism and Drug Dependence (SANCA)-approved facility Subject to managed care protocols	100% of negotiated rate, at a South African National Council on Alcoholism and Drug Dependence (SANCA)-approved facility Subject to managed care protocols
Dialysis	Unlimited – PMBs only	Unlimited – PMBs only
Oncology Treatment covered at DSP rates if a network provider is used	Unlimited – PMBs only	Unlimited – PMBs only
Pathology and radiology	Unlimited – PMBs only	Unlimited – PMBs only
ADDITIONAL BENEFITS		
Only the 7 non-PMB procedures listed are covered in hospital at a network provider and is paid at the Scheme rate	Tonsillectomy Adenoidectomy Basic dentistry – up to the age of 8 Grommets Carpal tunnel Varicose veins Bunionectomy	Tonsillectomy Adenoidectomy Basic dentistry – up to the age of 8 Grommets Carpal tunnel Varicose veins Bunionectomy

***Organ transplant benefit includes:**

- Heart, liver and kidney transplants, including harvesting and transportation costs
- Corneal transplant, including harvesting and transportation costs

All requests will be subject to clinical protocols and use of a national donor only.

CLASSIC OPTION

ANNUAL SAVINGS LIMIT (ASL)			
OPTION	**MEMBER**	**ADULT**	**CHILD**
Classic Network	R6 228	R5 304	R1 560
Classic	R7 286	R6 196	R1 820
MONTHLY CONTRIBUTION			
OPTION	**MEMBER**	**ADULT**	**CHILD**
Classic Network	R2 883	R2 452	R723
Classic	R3 373	R2 868	R843

OUT-OF-HOSPITAL BENEFITS

Not sure what we mean? Refer to glossary on page 50.

	CLASSIC NETWORK	CLASSIC
General practitioners (GPs) and specialists	Subject to ASL	Subject to ASL
Medicines Acute Over the counter (OTC) Preventative medicines	Subject to ASL **R190 per event per day** Paid from ASL – refer to page 7	Subject to ASL **R190 per event per day** Paid from ASL – refer to page 7
Optometry Subject to ASL	Per beneficiary: 1 examination, a frame of up to R780 and 2 lenses every 24 months OR contact lenses of up to R1 530 instead of glasses per year	Per beneficiary: 1 examination, a frame of up to R780 and 2 lenses every 24 months OR contact lenses of up to R1 530 instead of glasses per year
Dentistry: Basic and specialised Please note that, while dentures are covered, there is a limit of 1 set of dentures every 4 years per beneficiary. General anaesthetic is available for children under the age of 8 for extensive basic treatment and this is limited to once every 24 months per beneficiary. Cover is available for the removal of impacted wisdom teeth in theatre but must be pre-authorised by emailing a detailed quotation and clear panoramic radiograph.	Subject to ASL	Subject to ASL
Auxiliary services	Subject to ASL	Subject to ASL

CLASSIC OPTION

ADDITIONAL BENEFITS (not paid from ASL)		
Chronic medicines Non-CDL chronic medicine Network provider Co-payment for non-formulary medicine Co-payment for use of non-network provider	26 conditions – unlimited (page 12) – plus 10 conditions, subject to sub-limits: M0 – R4 300 M1 – R8 400 M2 – R10 500 M3 – R11 500 M4 – R13 000 M5+ – R15 000 Medipost Pharmacy 20% 30%	26 conditions – unlimited (page 12) – plus 10 conditions, subject to sub-limits: M0 – R4 300 M1 – R8 400 M2 – R10 500 M3 – R11 500 M4 – R13 000 M5+ – R15 000 Scheme network pharmacy 20% 30%
Maternity Subject to registration onto the patient care programme	12 antenatal visits x2 2D scans per pregnancy. 3D and 4D scans are paid up to the rate of 2D scans 2 paediatric visits Pregnancy vitamins	12 antenatal visits x2 2D scans per pregnancy. 3D and 4D scans are paid up to the rate of 2D scans 2 paediatric visits Pregnancy vitamins
Medical and surgical appliances General appliances per family per annum Sub-limits to Appliance Benefit: Glucometer per beneficiary every 2 years Nebuliser per family every 3 years	 R12 267 R750 R750	 R12 267 R750 R750
External Prosthesis per family per annum	R22 344	R22 344
MRI, CT, PET and radio isotope scans	Per beneficiary = 2 scans paid from risk benefits thereafter ASL Subject to pre-authorisation and managed care protocols	Per beneficiary = 2 scans paid from risk benefits thereafter ASL Subject to pre-authorisation and managed care protocols
Hearing aids	Subject to medical and surgical appliance limit	Subject to medical and surgical appliance limit
Hearing aid maintenance	R1 000 per beneficiary per annum	R1 000 per beneficiary per annum
Mental health	Subject to ASL	Subject to ASL
Health Maximiser™	Refer to page 7	Refer to page 7
Extra consultations and medicine (Only once ASL reaches R300)	Single member = 2 visits Family = 5 visits	Single member = 2 visits Family = 5 visits
Patient care programmes (Diabetes, HIV, oncology)	Subject to registration and managed care protocols	Subject to registration and managed care protocols

CLASSIC OPTION

IN-HOSPITAL BENEFITS

Subject to pre-authorisation and managed care protocols	CLASSIC NETWORK	CLASSIC
In-hospital limits	**Network hospital - Life Healthcare**	**Any hospital**
State and private hospital	Unlimited 30% co-payment for using non-network provider	Unlimited
GPs and specialists	At Scheme rate Specialists subject to preferred provider rates	At Scheme rate Specialists subject to preferred provider rates
To-take-out medicine	Up to 7 days	Up to 7 days
Organ transplants (non-PMB cases)	Per family = R61 520 (limit includes harvesting and transportation costs) National donor only	Per family = R61 520 (limit includes harvesting and transportation costs) National donor only
Internal prosthesis	Per family per annum = R33 516	Per family per annum = R33 516
Refractive eye surgery	Per eye = R5 300; maximum of R10 600 for both eyes once per lifetime	Per eye = R5 300; maximum of R10 600 for both eyes once per lifetime
Reconstructive surgery (as part of PMBs)	Per family = R61 520	Per family = R61 520
MRI, CT, PET and radio isotope scans	Per beneficiary = 2 scans paid from risk thereafter from ASL	Per beneficiary = 2 scans paid from risk thereafter from ASL
Alternate care instead of hospitalisation	Per family = 30 days to a maximum of R33 130	Per family = 30 days to a maximum of R33 130
Mental health (in- and out-of-hospital)	100% of Scheme rate	100% of Scheme rate
Alcohol and drug rehabilitation	100% of negotiated rate, at a South African National Council on Alcoholism and Drug Dependence (SANCA)-approved facility	100% of negotiated rate, at a South African National Council on Alcoholism and Drug Dependence (SANCA)-approved facility
Oncology in and out of hospital **Non-PMB cases** **PMB cases**	Per family = R500 000 20% co-payment after limit has been reached Unlimited	Per family = R500 000 20% co-payment after limit has been reached Unlimited
Pathology and radiology	At Scheme rate	At Scheme rate
Dialysis	At Scheme rate	At Scheme rate
General dentistry	Subject to ASL and dental protocols	Subject to ASL and dental protocols
Ambulance transport	Emergency – road and air	Emergency – road and air

OPTIMUM OPTION

MONTHLY CONTRIBUTION		
MEMBER	**ADULT**	**CHILD**
R6 204	R5 280	R1 551

OUT-OF-HOSPITAL BENEFITS

Not sure what we mean? Refer to glossary on page 50.

ANY PROVIDER	
Day-to-day limit	M0 – R25 220 M1 – R35 130 M2 – R40 660 M3+ – R47 740
General practitioners (GPs) and specialists	Subject to day-to-day limit
Medicines Acute medicine Over the counter (OTC)	 M0 – R10 370 M1 – R12 370 M2 – R14 500 M3 – R15 790 M4+ – R16 850 R190 per event per day
Optometry	Per beneficiary = 1 examination Per beneficiary = a frame of up to R1 230 and 2 lenses every 24 months **OR** Contact lenses of up to R2 280 instead of glasses per year
Dentistry Basic Specialised	 Single member = R2 230 Family = R4 480 Single member = R12 960 Family = R19 330
Auxiliary services Sub-limits	At a preferred provider, subject to auxiliary sub-limit and day-to-day limits Single member = R4 890 Family = R14 610

OPTIMUM OPTION

ADDITIONAL BENEFITS (paid from risk benefits)	
Chronic medicine Non-CDL chronic medicine limit Co-payment for non-formulary medicine	 26 conditions – unlimited (page 12) – plus 28 conditions, subject to sub-limits: M0 – R6 000 M1 – R12 000 M2 – R13 000 M3 – R15 000 M4 – R16 500 M5+ – R17 500 20%
Maternity	12 antenatal visits x2 2D scans per pregnancy. 3D and 4D scans are paid up to the rate of 2D scans x2 paediatric visits Pregnancy related vitamins
Medical and surgical appliances – general Sub-limits to Appliance Benefit Glucometer per beneficiary every 2 years Nebuliser per family every 3 years	 General per family = R9 500 R750 R750
Hearing aids Per beneficiary every 3 years Hearing aid maintenance	 Unilateral = R11085 Bilateral = R22 170 R1 000 per family per annum
External Prosthesis	Per family per annum = R26 332
Health Maximiser™	Treatments (page 7)
Patient care programmes (Diabetes, HIV, oncology)	 Subject to registration and managed care protocols

OPTIMUM OPTION

IN-HOSPITAL BENEFITS

ANY HOSPITAL Subject to pre-authorisation and managed care protocols	
Public and private hospital	**Unlimited**
GPs and specialists	Unlimited Specialist – subject to preferred provider rates
To-take-out medicine	Up to 7 days
Organ transplants (non-PMB cases)	Per family = R61 520; limit includes harvesting and transportation costs National donor only
Internal prosthesis	Per family per annum = R39 498
Refractive eye surgery	Per eye = R5 300; maximum of R10 600 for both eyes once per lifetime
Reconstructive surgery	Per family = R61 520
MRI, CT, PET and radio isotope scans	Per beneficiary per annum = 2 scans from risk thereafter from the annual day-today limit
Alternate care instead of hospitalisation	Per family = 30 days to a maximum of R37 470
Mental health (in- and out-of-hospital)	100% of Scheme rate – Subject to clinical protocols
Alcohol and drug rehabilitation	100% of negotiated rate, a South African National Council on Alcoholism and Drug Dependence (SANCA)-approved facility Subject to clinical protocols
Oncology	Unlimited
Pathology and radiology	Unlimited
Dialysis	Unlimited and subject to use of preferred provider
General dentistry	Subject to day-to-day limit and sublimits
Ambulance transport	Emergency road and air transport

IMPORTANT TO REMEMBER!

How to get the most out of your option

- Have an annual check-up at your general practitioner to make sure that you are healthy and, if there are any concerns, request your doctor to start treatment sooner rather than later.
- Remember to check if your option has network providers – using these providers will reduce or even prevent a co-payment.
- Where possible, use a day clinic for day procedures, e.g. for a tonsillectomy or adenoidectomy.
- Register on the chronic medicine programme as soon as you've been diagnosed with a chronic condition.
- Visit www.mhcmf.co.za for any new or updated information.

Member online access

(Web-based self-help facility)

Using the Scheme's self-help facility at www.mhcmf.co.za allows you to check your personal and medical scheme information. You can update your contact details, language preferences and other information and view your benefit information and claims statements.

Network Providers

The Scheme has negotiated rates with preferred and designated service providers to ensure that these providers do not charge you more than the agreed rate. This will ensure that your benefits last longer and you get value for money.

Depending on the option you selected, the network providers have agreed to charge negotiated rates, which means that you will not incur a co-payment unless you select a non-network provider.

Members on the Optimum, Classic and Hospicare options have the choice to select their own general practitioners and specialists for non-PMB treatment. It is recommended that one of the preferred providers is used, as this will reduce or eliminate out-of-pocket payments.

Members on the Custom, Classic Network and Hospicare Network options must use the Life Healthcare Group of hospitals as the network provider for in-hospital treatment; alternatively a 30% co-payment will apply.

On the Classic Network and Hospicare Network options, members must use the Medipost Pharmacy network for chronic medication to avoid incurring a 30% co-payment.

DON'T FORGET

It is important that you check whether the Scheme will pay for any procedure, treatment or medicine before accepting it. Failure to check upfront whether it is covered may result in you having to pay for certain services out of your own pocket.

Exclusions to some of the prescribed minimum benefits (PMBs) may be applied upon joining the Scheme.

The diagnosis and treatment of PMBs on the Custom and Essential options are paid in accordance with the registered rules of Scheme. These options are exempt from PMB legislation.

Rates charged by healthcare providers

Ask your doctor whether he or she will be willing to negotiate reduced rates in line with your benefit cover. Should you be admitted to hospital, make use of a network specialist; this will give you peace of mind that the specialist will charge Scheme rates.

Visit **www.mhcmf.co.za** for a list of providers in your area or contact the call centre on **0861 000 300**.

OPTION	CHRONIC MEDICATION NETWORK	MEDICATION OUT-OF-NETWORK CO-PAYMENT	OUT-OF-FORMULARY CO-PAYMENT	ACUTE MEDICATION NETWORK	OUT-OF-NETWORK HOSPITALISATION
CUSTOM	Subject to network formulary/pharmacy	N/A	Subject to protocols	Subject to network formulary/pharmacy	30%
HOSPICARE NETWORK	Medipost Pharmacy	30%	20%	N/A	30%
HOSPICARE	Scheme pharmacy network	30%	20%	N/A	N/A
CLASSIC NETWORK	Medipost Pharmacy	30%	20%	Scheme pharmacy network	30%
CLASSIC	Scheme pharmacy network	30%	20%	Scheme pharmacy network	N/A
OPTIMUM	Any	N/A	20%	Any	N/A

Useful tips:

- **Pharmacies, doctors and hospital networks:** Use the stipulated networks to ensure no co-payments will apply
- **Pharmacies (generic versus original, brand-name medicine)**: Where possible, ask your doctor or pharmacist to prescribe and dispense generic medicine instead of original, brand-name medicine.

CO-PAYMENT

A co-payment of R1 200 for in-hospital treatment will apply. The following procedures will always incur a co-payment of R1 200 when performed in hospital (to be paid directly by member to the healthcare provider).

Classic, Classic Network and Optimum options

- Arthroscopy
- Colonoscopy
- Gastroscopy
- Sigmoidoscopy
- Joint replacements

Custom Option

- Functional nasal and sinus surgery
- Nail surgery
- Removal of skin lesions
- Treatment of headaches
- Colonoscopy
- Gastroscopy
- Sigmoidoscopy

SCHEME EXCLUSIONS

All medical schemes have a list of services and products that they will not pay for. The Scheme's exclusions are split into general and dental exclusions to make it easy for you to determine what will not be covered by the Scheme.

General exclusions

- Search and rescue
- Complications or the direct and indirect expenses that arise from receiving treatment that is excluded
- Purchase of patent food, including baby food, patent medicines, preparations of the type generally promoted to the public to increase consumption, cosmetics, proprietary preparations, biological substances, contraceptives and slimming preparations, medicines advertised to the public and domestic, biochemical or herbal remedies, except when prescribed by a homeopath, and anti-smoking treatment and substances
- Experimental, unproven or unregistered treatment or practices
- Expenses arising from, or connected to, misconduct, other operations/procedures of choice, other than circumcisions, and preventive procedures

Note: preventive procedures do not include the following:

- preventive influenza measures prescribed by a medical practitioner
- Hibtiter and Tetratiter vaccinations
- vaccinations, as approved by the Department of Health
- preventive malaria measures prescribed by a medical practitioner

- Treatment or operations for purely cosmetic purposes, obesity, including Pickwickian syndrome, infertility and artificial insemination, as described in the Human Tissue Act, Act 65 of 1983
- Treatment for Alzheimer's disease
- Frail care and sickbay care in retirement villages, old age homes or private residences
- Treatment rendered by naturopaths and any other person not registered with the South African Medical and Dental Council as a medical auxiliary or registered with the South African Nursing Council as a registered nurse
- Medical cover outside the borders of South Africa: the Scheme will cover medical treatment rendered in the Southern African Development Community only; treatment will be paid in accordance with the Scheme's prescribed rate and the Scheme will apply the South African currency exchange rate applicable on the date the treatment was rendered
- Members travelling outside the borders of South Africa to participate in non-professional or professional sports must ensure he or she takes out additional cover, as this will not be covered by the Scheme
- Reports, examinations and tests requested for emigration, immigration, visas, insurance policies, employment, scholastic abilities, readiness for school, admission to school and universities, court medical reports, muscle-function tests for fitness, fitness examinations and tests, adoption of children and retirement because of ill health
- All costs of whatsoever nature incurred for treatment of sickness conditions or injuries sustained by a member or a dependant and for which any other party is liable; the member is, however, entitled to such benefits as would have applied under normal conditions, provided that on receipt of payment in respect of medical expenses, the member will reimburse the Scheme any money paid out in respect of this benefit by the Scheme

- Breathing exercises for chronic airway diseases
- Toiletries, cleansing agents, anabolic steroids and sunblock
- Accounts for appointments not kept by members
- All complementary medicines, including vitamins that can be obtained without a prescription
- Telephonic consultations with medical practitioners
- Aphrodisiacs
- Cochlear implants
- Ante- and post-natal exercises or classes, or mother-craft and breast-feeding instructions, unless it forms part of a birth management programme
- Costs that are higher than the annual maximum benefit due to the member and his or her dependants in a given calendar year
- Contact lens cleaning materials and spectacle/contact lens cases
- Experimental, unproven or unregistered treatment or practices
- Medical treatment in a research environment
- Cost of repairs, maintenance, parts or accessories of external appliances
- Skin lesions, except where cancer is proven by submission of histology results
- No benefit will be paid for sunglasses or lenses for sunglasses
- Sleep clinics and holidays for recuperative purposes
- Operations, medicines, treatment and procedures for gender alteration or realignment for personal reasons and not directly caused by or related to illness, accident or disease
- Furthermore, any medical condition or complication that arises at a later stage, whether directly or indirectly, as a result of the original, excluded treatment, is similarly excluded from benefitsunless complications qualify as a prescribed minimum benefit
- Any condition that arises from the deliberate refusal of medical treatment, except in the case of terminally ill patients
- Reversal of vasectomies/sterilisation
- Pain relief machines
- Hyperbaric oxygen therapy
- Professional speed contests or professional speed trials (professional is defined as the beneficiary's main form of income is derived from taking part in these contests)

Dental exclusions

- The cost of general dentistry performed in hospital
- The cost of gold, metal or other inlays in a denture or crown
- Fee for after-hours visits that the Scheme considers as convenience visits
- Bleaching of vital teeth
- Unregistered items and items listed as 'by agreement' or 'not applicable' in the tariff code listing
- Lingual orthodontic treatment
- Services that deviate from the available guidelines of the Department of Health and that are deemed to be excluded from benefits after evaluation of the available information
- Gum guards for sport purposes
- Laboratory costs that, according to the Scheme's norms and judgement, seem to be above the general cost claimed by other dental service providers and laboratories treating similar conditions
- Services or procedures that are regarded by the Scheme as cosmetic, when alternative functional services exist (in which case the benefit will be excluded entirely or in part and/or paid in accordance with the cost of such functional alternative service)
- The cost of a written report compiled by a dental practitioner or specialist for which prior authorisation was not granted by the Scheme

Dental exclusions

Any treatment listed below:

1. Any specialised treatment listed in the Scheme rules as requiring pre-authorisation where no pre-authorisation was obtained
2. Orthodontic treatment for dependants older than 18 years old
3. Orthodontic procedures, including retainers, are limited to once in a lifetime
4. Electrognathographic recordings and other such electronic analysis
5. Metal base to full dentures, including the laboratory cost
6. Soft base to new dentures
7. Diagnostic dentures
8. Pontiacs on second molars
9. Provisional and emergency crowns and associated laboratory cost
10. Ozone therapy
11. Resin bonding for restorations charged as separate procedure
12. Dental bleaching and porcelain veneers
13. Laboratory-fabricated crowns and root canal treatment on primary teeth
14. Gingivectomies
15. Periodontal flap surgery and tissue grafting
16.
    i. surgical tooth exposure for orthodontic reason
    ii. in-hospital surgical tooth exposure that was not pre-authorised as part of an orthodontic treatment plan
    iii. orthodontic re-treatment or unauthorised initial treatment commencing on an orthodontic treatment plan
    iv. orthognathic (jaw correction) surgery and related hospital costs
    v. sinus lift
    vi. bone augmentation
    vii. bone and other tissue regeneration procedures; cost of bone regeneration material (including laboratory costs)
    viii. multiple hospital admissions for extensive conservative (basic) dentistry in young children (only one admission per child every 24 months)
    ix. laboratory delivery fees
    x. cost of mineral trioxide
    xi. cost of gold, precious metal, semi-precious metal and platinum foil
    xii. in-hospital treatment for procedure not considered as invasive based on fear and anxiety in adults
    xiii. surgery associated with dental implants, grafts, etc.
    xiv. in-hospital dental implants, dentectomies, and apicectomies
    xv. mouth guards and snoring appliances and the associated laboratory cost (including material)
    xvi. oral hygiene instructions; PerioChip

COMPLAINTS AND DISPUTES

According to the Scheme rules, members may lodge a complaint with the Scheme in any of the following ways:

contact: 0861 000 300;
email: complaints@mhcmf.co.za; or
write: to Moto Health Care at PO Box 2338, Durban 4000.

When you lodge a complaint, the Scheme will acknowledge receipt within 2 working days. There are, however, complaints that need clinical input and investigation and these claims would take longer to resolve. In these cases the Scheme will respond within 30 days.

HOW TO FILE A COMPLAINT VIA THE INTERNAL PROCESS

1. Call the Customer Service Centre on **0861 000 300** and speak to a service consultant. The member must always obtain a reference number when making a complaint. This reference number is linked to the case (complaint) in the system.
2. If the complaint is not resolved, the member can send the query to the consultant's team leader and/or a customer relationship manager.
3. If the matter is still not resolved, the member may escalate the query to the Scheme's Fund Manager and finally the Principal Officer. At this level, a request may be referred to the scheme's medical advisory panel for their consideration.
4. If the member is still not satisfied, the member can send a letter of appeal to the Scheme or its Medical Advisory Committee. This can be in the form of either a formal letter or an email – with information on the declined decision and further motivation or new clinical evidence.
5. If the decision made by the Medical Advisory Committee is not acceptable, the member can ask the Scheme's Board of Trustees to review the decision.

EXTERNAL COMPLAINT PROCESS

1. Once the member has exhausted the internal complaint process, the member may declare a dispute. On written request from the member wherein the full particulars of the complaint is detailed, including proof of all prior interaction with the Scheme and its contracted service providers, where applicable, the Principal Officer will call a meeting of the Dispute Committee to decide on the matter.
2. If the member is not satisfied with the ruling of the Dispute Committee, the member may lodge an appeal with the Council for Medical Schemes.

The dispute process

Please make use of all internal procedures available to you to lodge a complaint before appealing an outcome.

The appeals process that must be followed, should you not be satisfied with the outcome of your complaint, is:

1. Request in writing that your complaint be escalated to the Disputes Committee.
2. If you are still not satisfied with the outcome of the Dispute Committee's ruling, you can lodge a complaint with the Registrar for Medical Schemes.

MHC'S PARTNERS

We have contracted a network of service providers who provide various administrative and operational services to ensure that you get access to quality healthcare. They are as follows:

CareCross HEALTH

- Primary care service management
- Designated service provider network management
- Preferred provider network management

DENTAL RISK COMPANY "Dentistry at work"

- Dental provider network management
- Dental risk management
- Dental pre-authorisation

mediscor pbm Pharmaceutical Benefit Management Solutions Together

- Formulary management
- Pharmacy benefit management

europ assistance you live we care

- Ambulance services

MMI HOLDINGS | HEALTH

- Billing
- Case management
- Claims processing
- Contributions and debt management;
- Disease management
- Managed care services
- Medicine management
- Membership correspondence services
- Pre-authorisation

multiply wellness & rewards

- Wellness and rewards programme

PPN Preferred Provider Negotiators

- Optometry provider network management
- Cataract surgery management

WHAT DO WE MEAN?

We have included a glossary to make the terminology in the benefit descriptions easy to understand. Please contact us should you need assistance or require a better understanding of the benefits and what they entail.

Annual savings limit
This is the portion of your monthly contribution that is allocated to a savings account that is held in the principal member's name. The money in this account is used to pay for out-of-hospital medical expenses.

Acute medicine
This is medicine that is prescribed for a short period of time to alleviate the symptoms of an acute illness or condition, such as antibiotics for an infection.

Beneficiary
A beneficiary is a principal member or a person registered as a dependant of a member.

Benefits
Your benefits are the amounts that are payable for medical services provided to you or your dependants in terms of the Scheme Rules.

Benefit limits
Your benefits are the amounts that are payable for medical services provided to you or your dependants in terms of the Scheme Rules.

Brand-name/Patented medication
Pharmaceutical companies incur high costs for research and development before a product is finally manufactured and released on the market. The company is given the patent to be the sole manufacturer of the specific medication brand for a number of years to recover these costs. This medication does not yet have generic equivalents.

Chronic disease list (CDL)
The CDL consists of 26 chronic conditions that are covered by the Scheme in terms of the regulations governing all medical schemes.

Chronic diseases
These are illnesses or conditions requiring medication for prolonged periods of time. The Medical Schemes Act 131 of 1998 provides a list of prescribed minimum benefits that indicates the minimum chronic conditions a medical scheme must cover.

Chronic medication
This refers to medication prescribed by a healthcare provider for a prolonged period of time. It is used for a medical condition that appears on the Scheme's list of approved chronic conditions.

Claim
A claim is a request for payment following medical treatment that has been provided by a healthcare provider, such as a general practitioner, specialist or hospital.

Consultation
This refers to an appointment with a healthcare provider, such as your general practitioner, specialist or physiotherapist for treatment.

Contribution
Your contribution is the fixed monthly amount that you pay to be registered as a member of the Scheme.

Co-payment
A co-payment is a portion of the cost of treatment or medication for which you are responsible, usually to pay for a portion of the cost of care that is not covered by a medical scheme.

Designated service provider (DSP)
This is a healthcare provider or group of providers chosen by the Scheme to provide diagnoses, treatment and care to members in respect of one or more prescribed minimum benefit conditions. This includes doctors, pharmacies and hospitals. When you choose not to use a DSP, you may have to pay a portion of the cost of the consultation or treatment from your own pocket.

Disease Treatment Pair (DTP)
A DTP links a specific diagnosis to a treatment and therefore broadly indicates how each of the approximately 270 PMB conditions should be treated.

Exclusions
Exclusions include medical treatment and care that are not covered by the Scheme.

General practitioners (GPs)
GPs are doctors who provide general or primary healthcare services, but do not offer a specialised service.

Generic medicine
This is medicine that has the same chemical ingredients, strength and form (such as a tablet or syrup) as the original, brand-name product. Generic medicine is as safe and effective as the original, brand-name product but is usually more cost-effective.

General waiting period
This is a period during which a beneficiary is not entitled to claim any benefits. This is normally a 3-month period.

Late-joiner penalty (LJP)
A LJP is imposed on the contributions of persons joining a medical scheme when they are 35 years of age or older and had not been members of a medical scheme before 1 April 2001 or have had a break in membership exceeding three consecutive months since 1 April 2001.

Moto Health Care (MHC) tariff
This is the rate at which healthcare providers will be paid for services rendered to Scheme members.

Medicine formulary
A formulary is a preferred list of prescription medicine that is covered by the Scheme.

Network providers
This is a list of service providers who have been contracted by the Scheme to provide medical care to members at an agreed rate.

Network pharmacy
For acute medicine, use the Scheme's network of pharmacies. To see if your pharmacy belongs to the network, contact the call centre on 0861 000 300 or visit the Scheme's website at www.motohealthcare.org.za.

Network hospitals
The Life Healthcare Group of hospitals is the preferred network of hospitals for the Custom, Classic Network and Hospicare Network options.

Non-Chronic Disease List
These are additional diseases that we cover over and above the 26 chronic conditions.

Overall annual limit
This limit is the overall maximum benefit that members and their registered dependants are entitled to according to the Scheme Rules. This is calculated annually to coincide with the Scheme's financial year.

Prescribed minimum benefits
This is a list of conditions that medical schemes have to cover in full according to the Medical Schemes Act.

Preventative care benefits
This is treatment that is given to prevent or reduce the risk of developing a medical condition.

Pre-authorisation
Pre-authorisation is the process of informing the Scheme of a planned procedure so that cover for the procedure can be assessed. Keep in mind that pre-authorisation is not a guarantee of payment.

Primary care network
This is a group of healthcare professionals that delivers primary care services, for example general practitioners, dentists and optometrists. Members on the Custom and Essential options are required to obtain out-of-hospital benefits from these healthcare providers.

Preferred provider
See network providers.

Principal member
A principal member is the main Member that is registered on the Scheme.

Registered dependant
A registered dependant is a person who is dependent on the principal member and is registered by the Scheme to share in the benefits provided to the principal member.

Scheme rate
This rate is the price agreed upon by the Scheme and healthcare service providers for the payment of services that are provided to members of the Scheme.

Shared limit or sublimit
This is a benefit that applies to 2 or more benefit categories. An example is the general dentistry limit and the day-to-day limit on the Optimum option. If members have used the full day-to-day limit, the general dentistry limit will also be depleted. If members use the general dentistry limit, they may still have day-to-day limits, but these will be reduced by what was spent on the general dentistry limit.

Specialists
Specialists are doctors who have specialised in a particular medical field, such as oncology, paediatrics or gynaecology.

Waiting period
A waiting period is a period during which contributions are payable, but where the member is not entitled to benefits.

There are two kinds of waiting periods:

a) a general waiting period of up to 3months

b) a condition-specific waiting period of up to 12 months where pre-existing health conditions are excluded; all medical costs during this period will be the member's responsibility.

CONTACT DETAILS

Call centre:
0861 000 300

Complaints and queries:
info@mhcmf.co.za

Physical address of the Scheme:
279 Kent Avenue
Randburg
2125

Website Address: www.mhcmf.co.za

Postal address:
PO Box 2338
Durban
4000

REGIONAL WALK-IN CENTRE CONTACT NUMBERS

Employers and members who do not use the services of a broker may contact:

Gauteng
011 381 2000

Centurion
012 673 7591

Free State
051 448 4632

Eastern Cape
041 363 0455

KwaZulu-Natal
0861 000 300

Western Cape
021 468 2900

Operating hours
Our call centre is open from **07:00 to 17:00** on weekdays and from **07:00 to 12:00** on Saturdays.

The regional offices are open between **08:00 and 16:00** from Monday to Friday.

OTHER IMPORTANT CONTACT DETAILS:

Ambulance Emergency number –EuropAssistance
0861 009 353

Authorisation for hospitalisation and MRI and CT scans
Call centre: 0861 000 300 – select option 1 and 2
Email: auths@mhcmf.co.za

Authorisation for chronic medication
Optimum, Classic, Classic Network, Hospicare and Hospicare Network options

Call centre: 0861 000 300
Email: chronic@mchmf.co.za

Custom and Essential option members obtain authorisation via the network GP

Claims submission
Call centre: 0861 000 300
Email: claims@mhcmf.co.za

New membership applications
Fax: 031 580 0478
Email: membership@mhcmf.co.za

Confidential HIV Programme contact information
Call: 0860 109 793
Fax: 012 675 3848
Email: ha@mhcmf.co.za

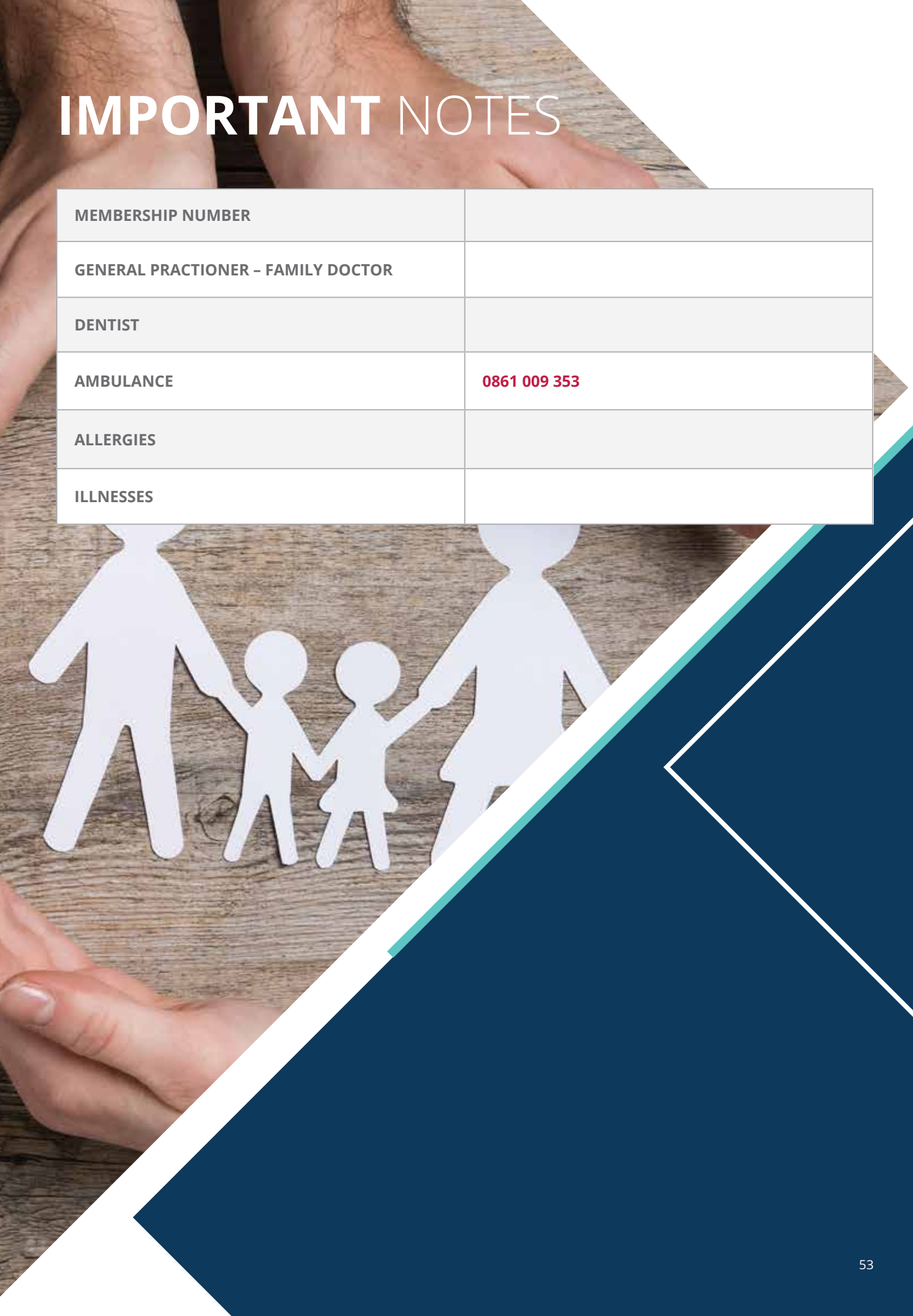
Oncology Treatment Programme
Email: oncology@mhcmf.co.za

Multiply Rewards and Wellness Programme
Call centre: 0861 886 600

HealthSaver
Call centre: 0861 000 300

Report any fraudulent activity
Fraud Call Centre: 0800 200 564

IMPORTANT NOTES



MEMBERSHIP NUMBER	
GENERAL PRACTIONER – FAMILY DOCTOR	
DENTIST	
AMBULANCE	0861 009 353
ALLERGIES	
ILLNESSES	

www.mhcmf.co.za