ENGEN | Medical Benefit Fund

Administered by Discovery Health

Want full cover when you have to see a GP or a specialist?

From 1 January 2019 your benefits for GPs and Specialists have changed and you must use the services of one of the Fund's network GPs or specialists, who are also the designated service providers (DSPs) for all Prescribed Minimum Benefits, to receive full cover

From 1 January 2019, the Fund is introducing network service providers for **all** GP and specialist visits, including those for Prescribed Minimum Benefits (PMB).

When you visit one of the Fund's network service providers, and you have benefits for the treatment they give you, we will pay the provider the full cost of the visit.

This benefits you as the doctor charges the Fund Rate, you do not have to pay in anything yourself (have a co-payment), and you do not have to send us the claim.

If you visit a healthcare provider who is not one of the Fund's network GPs or specialists, we only pay claims up to the Fund Rate. We pay the claim up to the Fund Rate, and you have to pay the difference, between our rate and the healthcare provider's fee, to the provider.

Our GP and specialist networks are comprehensive, transparent, fair and promote competition by allowing any willing provider to participate, or to opt out at any time.

Are there any network GPs or specialists near you?

You should be able to find a network provider near you as 90% of all Engen Medical Benefit Fund members live within 15 km from a network GP; and 77% of all visits to the five most-visited kinds of specialists are from members who live no more than 15 km away from the specialist. A large number of the members visiting non-network specialists are also within 15 km of a network specialist where they could enjoy full cover.

What if there isn't a network provider near you?

That should not be the case. You should be able visit a network GP or specialist for all your planned treatment and care. You will be able find a network provider near you by looking on the MaPS tool at www.engenmed.co.za , by using the Discovery mobile app, or by calling 0800 001 615 for more information.

What if the treatment was for a Prescribed Minimum Benefit (PMB) and your doctor was not on the network?

The Fund's network of GPs and Specialists are also the designated service providers for all Prescribed Minimum Benefit treatment and care.

If it is planned care for a Prescribed Minimum Benefits procedure, you will have full cover if you visit one of the designated service providers on the Fund's network. If your treating GP or specialist is not on the network, we will pay the claim up to the Fund Rate only, and you will have to pay the shortfall to the provider.

If the claim does not clearly show that you received Prescribed Minimum Benefit emergency care (as defined in the Medical Schemes Act), or that there isn't a designated service provider within at least 15 km from your home or workplace, we will also pay the claim as if you visited a non-designated service provider. That means we will pay up to the Fund Rate only.

If it was a medical emergency (as defined in the Medical Schemes Act), or you did not have reasonable access to a designated service provider on the Fund's network, you will have to ask us to reassess the claim. If the healthcare provider did not submit the emergency care claim with the correct codes, you will have to ask the

provider to submit a claim with the correct (emergency) codes, so we can pay it correctly. Providers usually submit these claims correctly first time.

Remember
You must get authorisation if you need to be hospitalised and also for some services you receive while you are not admitted to hospital. When you call for authorisation, you can ask about the nearest network provider for your procedure.

This is how the benefits work

When you visit a GP or specialist **who is** one of the Fund's network providers

This scenario applies to planned PMB and non-PMB treatment and care

Doctor (GP or specialist) charges	Treating doctor charges member R500 for consultation
Rate payable by the Fund	Agreed network rate: R500 for each consultation
Fund pays	Fund pays R500 directly to the doctor

If all the treatment is allowed as part of the Fund's benefits, and you consulted a network provider, you do not have to pay anything.

When you visit a GP **who is not** one of the Fund's network providers

This scenario applies to planned PMB and non-PMB treatment and care

Doctor (GP or specialist) charges	Treating doctor charges member R500 for consultation
Rate payable by the Fund	Fund Rate: R342 for each consultation
Fund pays	Fund pays R342 directly to the doctor

You have to pay the difference between what the doctor charges and the Fund Rate, and any costs for treatment that the Fund does not offer benefits for, directly to the doctor.

You can avoid or minimise these costs if you use a network provider for your planned PMB and day-to-day treatment and care.

What if you don't have a choice?

- You may not have reasonable access to one of the Fund's network providers for the specific procedure. This is in all instances, for PMB and non-PMB care, where the only provider you can get the specific healthcare service from, is more than 15 km from your home or your workplace
- You need emergency medical treatment in a life-threatening situation, or need immediate treatment to prevent organ damage or losing a body part.

In both of these instances, the Fund pays for the treatment in full. You do not have to pay anything yourself.

What must you do to let the Fund know you could only visit a non-network provider?

If was a medical emergency, we will pay the claim in full.

It may not be clear from the claim that you could only receive treatment and care from a non-network provider, and we will only pay up to the Fund Rate. If we are not correct, you will have to ask us to reconsider the claim based on additional information you send us.