Medical Benefit Fund | ENGEN

Administered by Discovery Health

1ST EDITION NEWSLETTER 2022

HOW LONG CAN MY CHILD DEPENDANT STAY ON THE SCHEME?

HOW LONG CAN YOUR CHILD DEPENDANT STAY ON YOUR MEMBERSHIP?

The Fund grants membership to any of your child dependents who are younger than 21 years without asking you whether they are still dependent on you for care or support. They may be when they are not earning enough to be self-sustaining or when they are students at registered tertiary institutions.

When your child is about to have their 21st birthday, or at every following birthday up to their 25th birthdays, you will be asked to prove their dependency. If your submission meets the requirements, we will let you know and the Fund will continue to charge their contributions based on 'Child' rates, up until their 25th birthday.

This depends on the Fund Rules.

SEND US PROOF OF THEIR DEPENDENCY

Your child, who is 21 years or older, may stay on as a child dependant up to their 25th birthday if

- they are registered as a student at a registered tertiary institution; or
- they are financially dependent on you for ongoing care and support.

You must send us the following information so we can confirm the ongoing membership and the contributions payable:

- Proof that your child dependant is a registered student: Send the official registration certificate to the Fund. If the child dependant turns, or is older than 21 years, on or after the end of March 2022, the Fund must receive the proof of the student registration at least 30 days before that dependant's 21st birthday. You must supply annual proof of studies, up to the child's 25th birthday.

  Proof of studies for children whose 21st to 25th birthdays are in the first three months of a year, must be provided by 31 March.

- Proof of income for dependants who are 21 to 25 years old: If your student child is working, i.e., not studying full time, or not a student but still financially dependent on you, we require proof of their dependency. Please send copies of their bank statements or salary slips for the three months immediately before their 21st, and up to their 25th birthdays. Also, send us an affidavit where you confirm that they are financially dependent on you for family care and support. If your child earns below the threshold of R7,605 per month in 2022, they can remain on the Fund, and pay adult contribution rates. Note: the threshold is adjusted annually.

Please send the documents to confirmation@engenmed.co.za.

If you have any questions, please contact our Call Centre on 0800 001 615.

WHAT ARE THE RULES WHEN YOUR CHILD IS OLDER THAN 21 YEARS AND FINANCIALLY DEPENDENT ON YOU?

The Fund Rules determine these dependants must pay contributions at 'Adult' rates.

The contributions are higher for adult dependants. So, if your child no longer qualifies to pay contributions based on child rates, your monthly contributions will increase from the first of the month following your child's qualifying birthday. This will apply to all dependants who are 21 years or older, who are financially dependent on the principal member, and to all child dependants who are still studying after their 25th birthdays, providing they do not earn more than R7,605 per month in 2022.

If your child earns more than R7,605 per month they will no longer be eligible to stay on as members of the Fund.

What if you don't provide proof of dependency for your child who is 21 years or older?

If you do not respond and provide proof that your child is a student or financially dependant on you in the time allowed, the child will no longer be eligible, and we will end their membership of the Fund.

IMPORTANT TO NOTE

After we have made changes to the contributions payable for your child dependant, or when we have withdrawn the membership, no backdated changes will be allowed during the year. Please be sure to comply with the Fund's request and submit proof of dependency when requested.

HOW CHANGES TO YOUR FAMILY COMPOSITION IMPACT YOUR MEDICAL SAVINGS ACCOUNT

We calculate and allocate your Medical Savings Account balance based on the number of dependants registered on your membership on 1 January of that year. This gives you an annual upfront medical savings that is used to pay all claims received from 1 January for that year.

Remember:

No debt will be created, and you will not have to repay any Medical Savings Account debt to the Fund if you respond on time to the requests to prove your dependants' eligibility.

When we request it, please send the documents to confirmation@engenmed.co.za

When there are changes to the composition of your membership during the year, we need to adjust the Medical Savings allocation. This may result in debt owed by you to the Fund.

We can best illustrate how this happens by giving you some examples:

Example 1

On 1 January Mr Jacobs, his wife, and three children are registered on the Fund. The Fund allocates 12 months' worth of medical savings to the membership for Mr and Mrs Jacobs at adult rates, and for the three children at child rates.

During the year, one of the dependants turns 21. We don't receive proof of dependency as requested and then calculate the contribution and allocate the Medical Savings Account (MSA) based on adult rates for that child for the rest of the year.

Mr Jacobs submits proof that his child is a student and the Fund approves a backdated change to allow the rate at which contributions are charged for the child to be changed back to 'Child' rates.

Debt will be created when: Mr Jacobs has used the available money in the Medical Savings Account, that was allocated based on expected contributions at adult rates. He will then need to pay the difference between the available Medical Savings Account balance based on the Child rates and the actual amount spent back to the Fund.

Example 2

On 1 January, Mr Skosana, his wife, and three children are registered on the Fund. One of the children, Zinzi, is 22 years old.

The Fund allocates 12 months' worth of medical savings for Mr and Mrs Skosana and Zinzi at adult rates, and for the other two children at child rates. In May of the year, Mr Skosana provides proof that Zinzi is **registered as a student**. He also provides the proof of student registration.

The Fund recalculates the available Medical Savings Account (MSA) for the year for the Skosana family. Based on Zinzi's amended status, the total available MSA for the year is less than the amount that was initially allocated.

This created debt: When Mr Skosana submitted proof that Zinzi is a student, the family had already spent a large portion of the allocated MSA for the year. The amount spent was more than the lower annual MSA after the change was made and Zinzi's contributions were based on child rates. The change in May – to charge contributions for Zinzi based on child rates instead of adult rates that were charged from 1 January – now means that the Skosana family has overspent on their MSA and an amount is owing to the Fund.

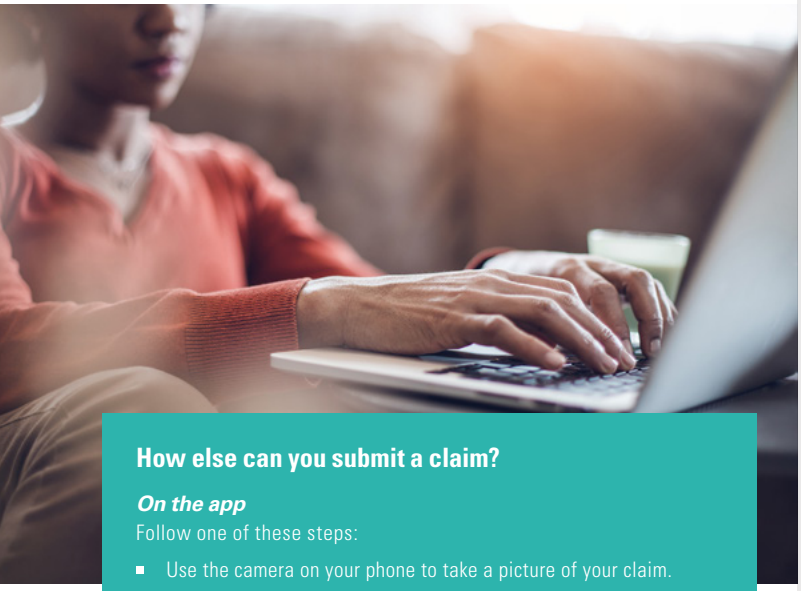
If you find yourself in the same position as one of the members in our examples, you will have to pay the overspent amount back to the Fund.

DISCONTINUATION OF CLAIMS BOXES

DISCOVERY CLAIMS BOXES WILL BE REMOVED

Discovery has decided to remove all claims boxes across the country. This is because members seldom use the boxes.

To prove that point: only 10 Engen Medical Benefit Fund member used this service in the past 12 months.



How else can you submit a claim?

On the app

Follow one of these steps:

- Use the camera on your phone to take a picture of your claim. Submit picture on the app.
- Use your phone to scan the code on your claim provided by your healthcare professional.

By email

Scan and email your claim to claims@engenmed.co.za.

By post

Send your claims to Engen Medical Benefit Fund Claims:
PO Box 652509, Benmore, 2010

WHAT TO REMEMBER

Ensure your claim has the following details:

- Full name of main member
- Membership number
- Name of patient (main member or registered dependant)
- Name of provider and practice number
- Treatment date
- Details of the service (tariff code, procedure code, and explanation)
- The diagnosis code (ICD-10 code)
- Proof of payment if you have settled your account

If your healthcare provider has already submitted the claim, you do not have to send us another copy.

Healthcare professionals, hospitals and pharmacies in our networks usually send us your claims directly. If you use a network provider, you do not have to send us a claim.

You only need to submit a claim if you have paid the healthcare professional and you need to claim the money back from us.

You must submit your claim within four months from the date of service After this, the claim expires, and we will not pay you back for the claim.

CARRY-OVER SAVINGS FROM MSA

MEDICAL SAVINGS ACCOUNT (MSA)

You contribute 10% of your total monthly contribution into a Medical Savings Account (MSA). For example, if your total Fund contribution is R1,000, an amount of R100 (10% of R1,000) goes to your MSA and R900 goes to the pool of money from which the Fund pays risk claims.

If you have a positive MSA balance, we add monthly interest on that amount.

If you resign from the Fund, the Fund will keep the money in your MSA for four months to pay any outstanding healthcare claims that were incurred before your resignation. We will pay any positive MSA balance to you in the 5th month after your resignation, or the balance will be transferred to your new medical scheme (if you have an MSA benefit at the new scheme).

When your membership ends, the Fund may use the money that is left in your MSA to pay off any debt you owe to the Fund. This may include outstanding contributions.

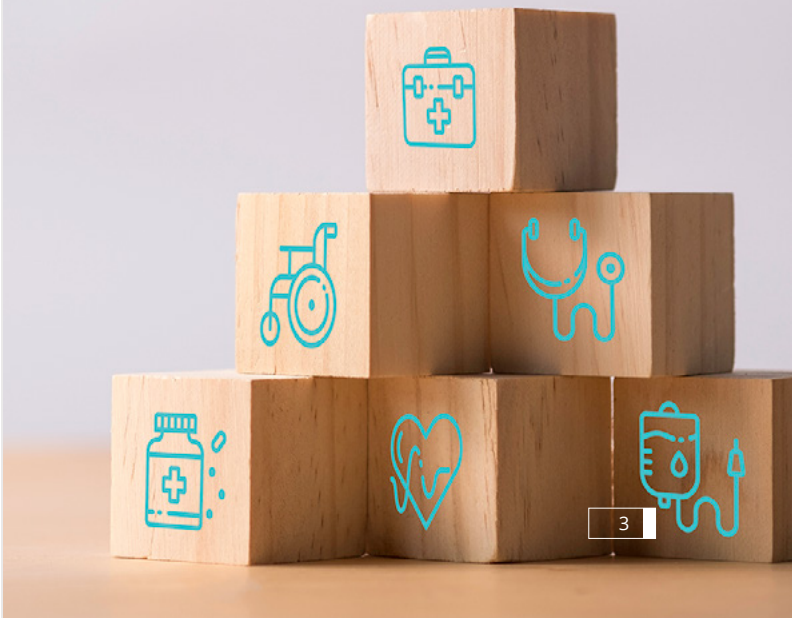
On 1 January of each year, the Fund makes an upfront amount, equal to 12 months' worth of your MSA contributions available to you to use in advance. If you resign from Fund during the year, and you have used more from your advanced MSA than you have contributed, you will have to repay the difference that you have overspent to the Fund.

Payments from the MSA will be made at 100% of the Fund rate, subject to funds being available at the date on which a claim is processed.

If you have money available in your MSA at the end of the financial year (31 December), that money will be carried over to the next year.

If you die, your MSA balance will be transferred to your dependants if they decide to continue membership of the Fund. If you don't have dependants, the money will be paid to your Estate.

If you pay cash for any healthcare services, remember to submit the claim with the receipt as proof of payment. Use the correct contact details of the Fund, as provided in this Member Guide, or as communicated by the Fund from time to time. You will be reimbursed at the relevant Fund rate (refer to the Benefit Schedule for details) and you may request the Fund to pay differences between claimed amounts and benefit amounts from your Accumulated Medical Savings Account (AMSA)



COVID-19 – HOW TO ACCESS THE BASKET OF CARE

WHAT YOU NEED TO KNOW ABOUT BENEFITS FOR COVID-RELATED ILLNESS

The Fund provides excellent benefits to cover costs related to the COVID-19 pandemic. We provide benefits for in- and out-of-hospital healthcare services related to the virus.

This WHO Benefit ensures you have access to screening consultations, testing, and management and appropriate supportive treatment as long as they meet the Fund's Benefit entry criteria.

KNOW YOUR RISKS

Find out what your risk status is by completing the COVID-19 risk assessment. The questions in the assessment will help you find out if you have symptoms that are linked to COVID-19 or if you may have been exposed to COVID-19 and need a consultation with a doctor. Once you have successfully completed the risk assessment, you get access to additional funding for screening consultations and tests.

WHAT YOU ARE COVERED FOR

The WHO Benefit offers cover for out-of-hospital healthcare services related to COVID-19. This means that you have cover for COVID-19 diagnosis and treatment when you are not admitted to hospital. This is in addition to any hospital benefits if you are admitted to hospital for COVID-19 treatment.

The basket of care includes:

- Screening consultations with a nurse or network GP (either virtual consultations, telephone or face-to-face), after you have completed a risk assessment
- Two COVID-19 PCR screening tests, if referred by your doctor, or referred by a network GP when you may be at risk of having contracted COVID-19
- Two pre-admission COVID-19 tests required by hospitals before admitting you for treatment not related to COVID-19
- A defined basket of care for COVID-19-positive members, which includes pathology, X-rays and scans, chest physiotherapy and psychotherapy benefits
- Cover for a list of supportive medicines
- Consultations with a nurse or Network GP (virtual consultations, telephone consultations or face-to-face consultations)
- Benefits for the home monitoring of COVID-19-positive members, which includes a pulse oximeter and up to three consultations for each person every year
- COVID-19 vaccinations and booster shots
- Benefits for out-of-hospital treatment and care of long COVID-19 in cases where the symptoms carry on after 21 days of the initial infection

Your cover depends on the following

- You must use the Fund's designated service providers (DSPs), where applicable.
- You must meet certain clinical entry criteria.

Any recommended treatment and healthcare services that are not included in the basket of care are paid from your available day-to-day benefits, or in accordance with Prescribed Minimum Benefits, where applicable.

Approved in-hospital treatment related to COVID-19 is covered from the Hospital Benefit in accordance with Prescribed Minimum Benefits (PMBs), where applicable.

COVID-19 VACCINE

The COVID-19 vaccine is aimed at preventing COVID-19-related disease and deaths, and to prevent transmission between individuals. If you have not yet been vaccinated or need your booster shot, it is a good idea to take action now, and get vaccinated.

Even if you get the virus, the vaccine is designed to help prevent you from getting seriously ill. The vaccine contains weakened or inactive parts of the virus, which teach the body's immune system to recognise the virus as a threat when it attacks, and to promptly fight the virus.

It typically takes a few weeks after vaccination for the body to build protection (immunity) against the COVID-19 virus. That means it is possible that a person could still get COVID-19 just after vaccination. This is because the vaccine has not had enough time to provide protection. Sometimes after vaccination, the process of building immunity can cause symptoms, such as fever. These symptoms are normal and are a sign that the body is building immunity.

Vaccines are critical in the battle against COVID-19, but as we learn how they work best, it is still important to continue to protect yourself by washing your hands regularly, wearing a mask and practising safe social distancing.

The cost of COVID-19 vaccines, which includes the cost of administering the vaccine, is covered as Prescribed Minimum Benefits (PMBs).

You must register on the National Department of Health's Electronic Vaccine Data System (EVDS) to be vaccinated.

GET THE FACTS AND FOLLOW PREVENTIVE STEPS

COVID-19 and the flu season overlap in South Africa, so it is crucial to have the seasonal flu vaccination as protection against influenza. Please visit the COVID-19 information hub to understand the facts around COVID-19 and the preventive measures that help protect your health.

You can get vaccinated at any facility that provides the service.

TRAVELLING? WHAT TO DO IF YOU NEED MORE THAN A MONTH'S WORTH OF MEDICINE

It's possible to travel again; it just takes some planning. If you have a chronic condition or have a repeat prescription, making sure you have enough of your medicine is an important part of the process.

Depending on where you're going, and how much medicine you need, you can use your benefits for the medicine, as long as you let us know ahead of time.

You can request authorisation via email or by calling us.

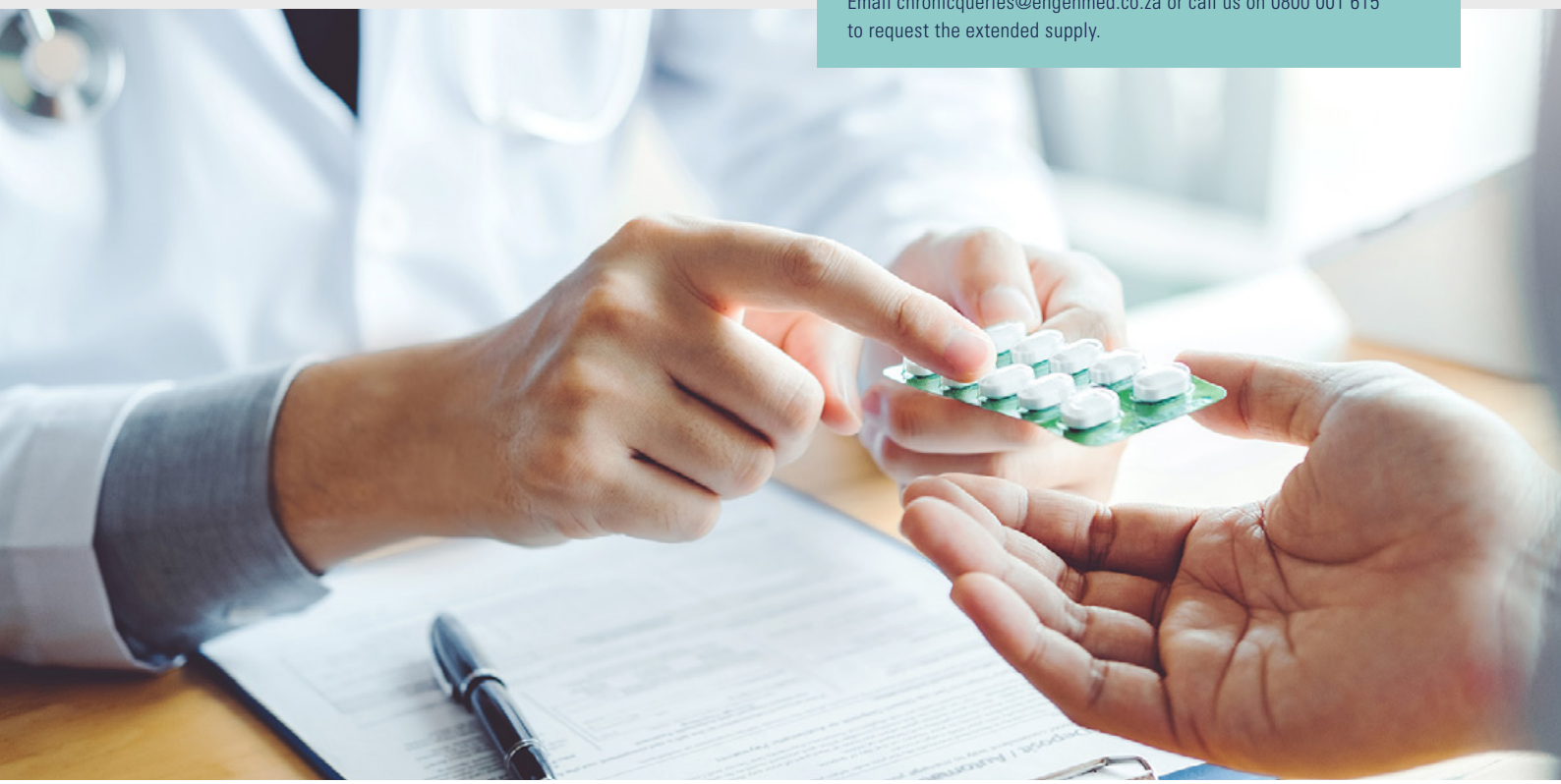
YOUR COVER FOR AN EXTENDED SUPPLY OF MEDICINE

You've always been able to apply for cover for an extended supply of medicine if you're planning to visit other countries. Now, you can apply even if you're staying inside South Africa's borders, and it's now easier to apply.

How much medicine you can get ahead of time depends on where you're going	
One extra month's supply of your medicine	■ Going far from your usual network pharmacy in South Africa ■ Going overseas
Up to four extra months' supply of your medicine	■ Going overseas ■ Travelling in South Africa far from a network pharmacy
Five or six extra months' supply of your medicine	■ Going overseas ■ Travelling in South Africa far from a network pharmacy You must have proof of where you're going and how long you will be there

If you need to get a supply for a longer period, contact us and let us know. The Fund will decide whether or not to cover a supply of more than six months' medicine case by case.

Email chronicqueries@engenmed.co.za or call us on 0800 001 615 to request the extended supply.



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