Medical Benefit Fund | ENGEN

Administered by Discovery Health

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COVER FOR MEDICINE

WHAT IS COVERED?

As an Engen Medical Benefit Fund member, your cover for medicine includes cover for Over the Counter (OTC), acute (day-to-day prescribed) and chronic medicine.

COVER FOR SELF-MEDICATION: OVER THE COUNTER (OTC) MEDICINE

Limited to R310 per script per beneficiary per day and to medicine which a pharmacist is entitled to prescribe, paid from your Medical Savings Account.

COVER FOR ACUTE OR DAY-TO-DAY PRESCRIBED MEDICINE

Acute medicine is medicine that is prescribed for a short term for a condition or illness that is not long lasting. You have cover for prescribed acute medicine from your available day-to-day benefits.

Acute, homeopathic or naturopathic medicine includes medicine, material for injections and vaccinations prescribed by a person legally entitled to prescribe.

COVER FOR CHRONIC MEDICINE

You have access to a list of medical conditions and treatments under Prescribed Minimum Benefits (PMBs). The PMBs cover the 26 chronic conditions on the Chronic Disease List. To access PMB cover, you need to meet certain terms and conditions.

Please find more information on the Chronic Illness Benefit medicine list here

DIABETES CARE PROGRAMME

THE DIABETES CARE PROGRAMME GIVES YOU EXTRA HELP FOR DIABETES

We understand that living with diabetes comes with many challenges and requires daily efforts to manage. The Fund's Diabetes Cardiometabolic Care (DCC) Programme brings together a team of health professionals that will help guide you to get high-quality coordinated healthcare and improved outcomes.

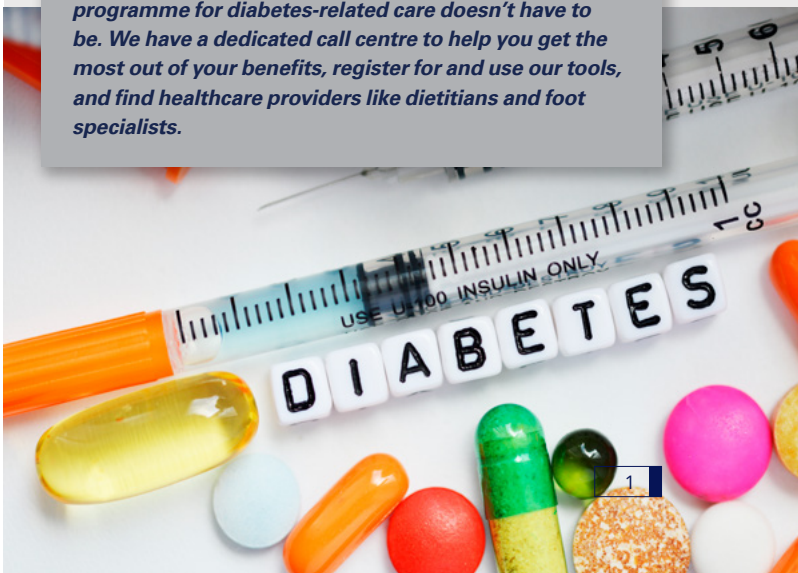
WHAT IS THE DIABETES CARE PROGRAMME?

The Diabetes Care Programme, and your Premier Plus doctor, will help you to actively manage your diabetes. The programme gives you and your Premier Plus doctor access to various tools to monitor and manage your condition and to ensure you get high quality, coordinated healthcare, and the best outcomes.

You and your doctor can track your progress on a personalised dashboard, displaying your unique Diabetes Management Score. This will help to identify the steps you should take to manage your condition, and stay healthy over time. The programme also unlocks cover for valuable healthcare services from healthcare providers like dietitians and biokineticists.

Studies have shown that patients have the best health outcomes when one doctor leads their care, and coordinates with other healthcare providers like dietitians and foot specialists. By getting care from a team who all work together and follow the same plan, you don't get different advice from different doctors that leave you wondering which advice to follow, or how well you're managing your condition.

Managing diabetes is complicated. Using our care programme for diabetes-related care doesn't have to be. We have a dedicated call centre to help you get the most out of your benefits, register for and use our tools, and find healthcare providers like dietitians and foot specialists.



HOW CAN YOUR CARE NAVIGATOR HELP YOU?

Our dedicated Care Navigator call centre is here to help you:

- Understand your cover for diabetes and diabetes-related care
- Register to use our digital tools and maximise your rewards
- Choose and engage with allied healthcare providers (such as dietitians and podiatrists)
- Understand and make the best use of your available benefits.

If you are registered on the Chronic Illness Benefit for diabetes, you can join the Diabetes Cardiometabolic Care Programme offered by the Fund.

How do I contact a care navigator?

- Email: Members_DCI@discovery.co.za
- Call: 0860 44 44 39

Please save these contact details if you are already registered for the Diabetes Cardiometabolic Care Programme. Our Care Navigator team can answer any questions you have about your cover for diabetes.

YOU ALWAYS HAVE COVER FOR PRESCRIBED MINIMUM BENEFITS (PMBs)

WHAT IS A PRESCRIBED MINIMUM BENEFIT (PMB)?

PMBs are guided by a list of medical conditions as defined in the Medical Schemes Act. According to this, all medical schemes have to cover diagnosis, treatment and care costs related to:

- An emergency medical condition
- A defined set of 271 diagnoses
- 26 chronic conditions (Chronic Disease List conditions).

WHAT MUST HAPPEN FOR YOU TO ACCESS PMB BENEFITS?

There are certain requirements to meet before you can benefit from PMBs. These are:

1. **Your condition must qualify for cover and be on the list of defined PMB conditions**
   You should send the Fund the results of your medical tests that confirm the diagnosis of your condition. This will allow us to identify that your condition qualifies for the treatment. Your doctor must provide the correct information, confirming the diagnosis. You must also register on the Fund's disease management programmes to qualify for PMB cover. For more information on where to send completed application forms see the Guide to PMBs.
2. **Your treatment must match those in the defined benefits on the PMB list**
   There are standard treatments, procedures, investigations and consultations for each PMB condition on the list, outlined by the Medical Schemes Act. These defined benefits are supported by thoroughly researched and evidence based treatment guidelines.
3. **You must use the Fund's Designated Service Providers (DSPs) for full cover**
   If you do not use a DSP, we will pay up to 80% of the Fund Rate and you will be responsible for the difference between what we pay, and the actual cost of your treatment. This does not apply in emergencies though. In an emergency, you can go directly to hospital and notify the Fund of your admission as soon as possible. In the case of an emergency, you are covered in full for the first 24hrs or until you are stable enough to be transferred to a DSP. Remember, benefits not included in the PMBs are paid for from your available plan benefits, where appropriate and according to the rules of your health plan.

Find healthcare providers in our networks on our website

YOU AND YOUR DEPENDANTS MUST REGISTER TO GET COVER FOR PMBs

How do I register a Prescribed Minimum Benefit condition?

There are different types of PMB cover. These include cover for: in-hospital admissions, conditions under the Chronic Disease List, out-of-hospital management of PMB conditions, and treatment of PMB conditions, such as HIV or oncology.

To apply for out-of-hospital PMBs, or cover for a Chronic Disease List (CDL) condition, you must complete a Prescribed Minimum Benefit or a Chronic Illness Benefit application form.

- Up to date forms are always available on our website here under Application forms.
- For more information on the PMB Chronic Disease List conditions, HIV or Oncology and how to register, visit our website here and search under Benefit guides.
- To confirm your in-hospital cover for PMB conditions, you can call us on 0800 001 615 and request an authorisation. We will then tell you about your cover.

WHY IT'S IMPORTANT TO REGISTER YOUR PMB

We pay for specific healthcare services related to each of your approved conditions. These services include approved treatment, medicine, consultations, blood tests and other defined tests. These are paid for from your Prescribed Minimum Benefits and will not affect your day-to-day benefits.

We will pay for treatment or medicines that fall outside the defined benefits and that are not approved, but this is paid from your available day-to-day benefits.

MENTAL HEALTH

PANDEMIC GETTING YOU DOWN? YOUR SUPPORT FOR MENTAL HEALTH

The pandemic has affected everyone's mental health. Even if you've remained physically healthy, the stress of lockdown alert levels, changing regulations and worrying about health and finances affect your mental health.

According to the World Health Organization, during the COVID-19 pandemic it has become 25% more common for people worldwide to have anxiety, or depression. There's nothing to be ashamed of if you're one of these people.

Just like anyone can get COVID-19 (a physical disease), anyone can have a mental illness like depression or anxiety. And you have cover for treatment for mental and physical health.

MENTAL HEALTH IS AS REAL AS PHYSICAL HEALTH

The brain is an organ just like your lungs or heart. This means illness can also be in the brain. Only a trained professional like a doctor can diagnose mental illness. This is because different conditions have different signs and symptoms. Only a doctor can decide if you, or a loved one, is just stressed or has clinical depression.

Take emotional pain as seriously as physical pain and see a doctor if you need to. You can also help by encouraging loved ones to visit a GP or psychologist, if you suspect that something's wrong.

ANY ILLNESS NEEDS MEDICAL TREATMENT

You need a doctor to diagnose physical and mental health conditions so you know what treatment you need. Just like you need antibiotics to recover if a doctor diagnoses you with bronchitis, you also need treatment for mental illness.

YOUR COVER FOR EPISODES OF DEPRESSION

You have cover for episodes of depression. **To get access to the benefits offered in the Mental Health Care Programme, you must visit a Premier Plus GP or a psychologist who is part of our Mental Health Care Programme**.

They will talk to you about your symptoms. If they diagnose you with depression, they will register you on the Mental Health Care Programme and the Fund will pay for the following treatment without using the available money in your Medical Savings Account:

- Up to three visits to the Premier Plus GP or psychologist who registered you
- If the GP or psychologist thinks it's necessary, we pay for you to visit a network psychiatrist
- Sessions of talk therapy (psychotherapy)
- If a GP registered you, we also pay for medicine to treat depression

How to find a Premier Plus GP

Log in to www.engenmed.co.za, click on **DOCTOR VISITS** and then search for a network provider under **GP and specialist designated service provider (DSP) network search facilities**. Otherwise, call us on 0800 00 16 15.

YOUR COVER FOR BIPOLAR MOOD DISORDER AND SCHIZOPHRENIA

Visiting a GP and getting diagnosed is the first step towards better mental health. If they refer you and a psychiatrist diagnoses you with a lasting mental illness like bipolar mood disorder or schizophrenia, ask them to register you on the Chronic Illness Benefit. Once you're registered, the Chronic Illness Benefit covers the medicine you need to take to manage your condition, and treatment in your psychiatrist's office.

Sources

World Health Organization. COVID-19 pandemic triggers 25% increase in prevalence of anxiety and depression worldwide, 2 March 2022.

SCREENING AND PREVENTION

WHY SHOULD I BOTHER GOING FOR SCREENING TESTS?

Screening tests check your body's health when you don't have any symptoms of a disease. Having a screening test done is the same as checking a car's oil, water and tyre pressure just to make sure you don't run into problems later. The sooner you find possible health problems, the easier they are to manage; you can even avoid serious disease.

It might feel like a waste of time if your screening tests come back normal, but it's still worth it. One of the best ways for you to make sure you live a long, healthy life is to find out that you are healthy, or to find the problem early, and have time to manage it well before it becomes a problem.

WHICH SCREENING TESTS DO WE PAY FOR?

The Fund pays for the following screening tests at a network pharmacy without using the money in your Medical Savings Account:

- **Adults (18 years or older)**
  You can get your blood pressure, blood sugar, cholesterol and body mass index (BMI) checked at the same time once a year. This can tell you if you're at risk for conditions such as heart disease, stroke or diabetes.
- **Children**
  Age 2 to 17: You can have your child's body mass index (BMI) calculated and have basic hearing and dental screenings done.
  Age 2 to 17: The Fund pays for milestone tracking for these beneficiaries.

The Fund also covers the following screening tests:

- Depending on your risk of breast cancer:
  - Standard risk: mammogram (once every two years)
  - High risk: mammogram or MRI breast screening (every year) and a once-off BRCA testing.
- Depending on your health:
  - Standard risk: Pap smear (once every three years)
  - If you have HIV, or a previous Pap smear result was abnormal: Pap smear (once every year)
  - HPV Screening for female members who receive abnormal test results after a PAP smear is paid from the Medical Savings Account.
- A prostate-specific antigen (PSA) test (once every year)
- A faecal occult blood test (once every two years if you are 45 to 75 years old).

WHAT IF THE TESTS FIND SOMETHING?

We have benefits and care programmes to help you if you are diagnosed with heart disease, diabetes, HIV or AIDS, or cancer. Our programmes give you additional benefits to cover the treatment you need for your condition without using up the money in your Medical Savings Account. The programmes also help support you and your treating doctor.

How to join our care programmes:

- For diabetes, call 0800 00 16 15 to join the Diabetes Management Programme.
- For heart disease, call 0800 00 16 15 to join the Cardiovascular Management Programme
- For HIV or AIDS, email hiv@engenmed.co.za to join the HIV Management Programme
- For cancer, email oncology@engenmed.co.za to join the Oncology Management Programme

How to find a network doctor close to you
Log in to www.engenmed.co.za, click on **DOCTOR VISITS** and then search for a network provider under **GP and specialist designated service provider (DSP) network search facilities**. Otherwise, call us on 0800 00 16 15.

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