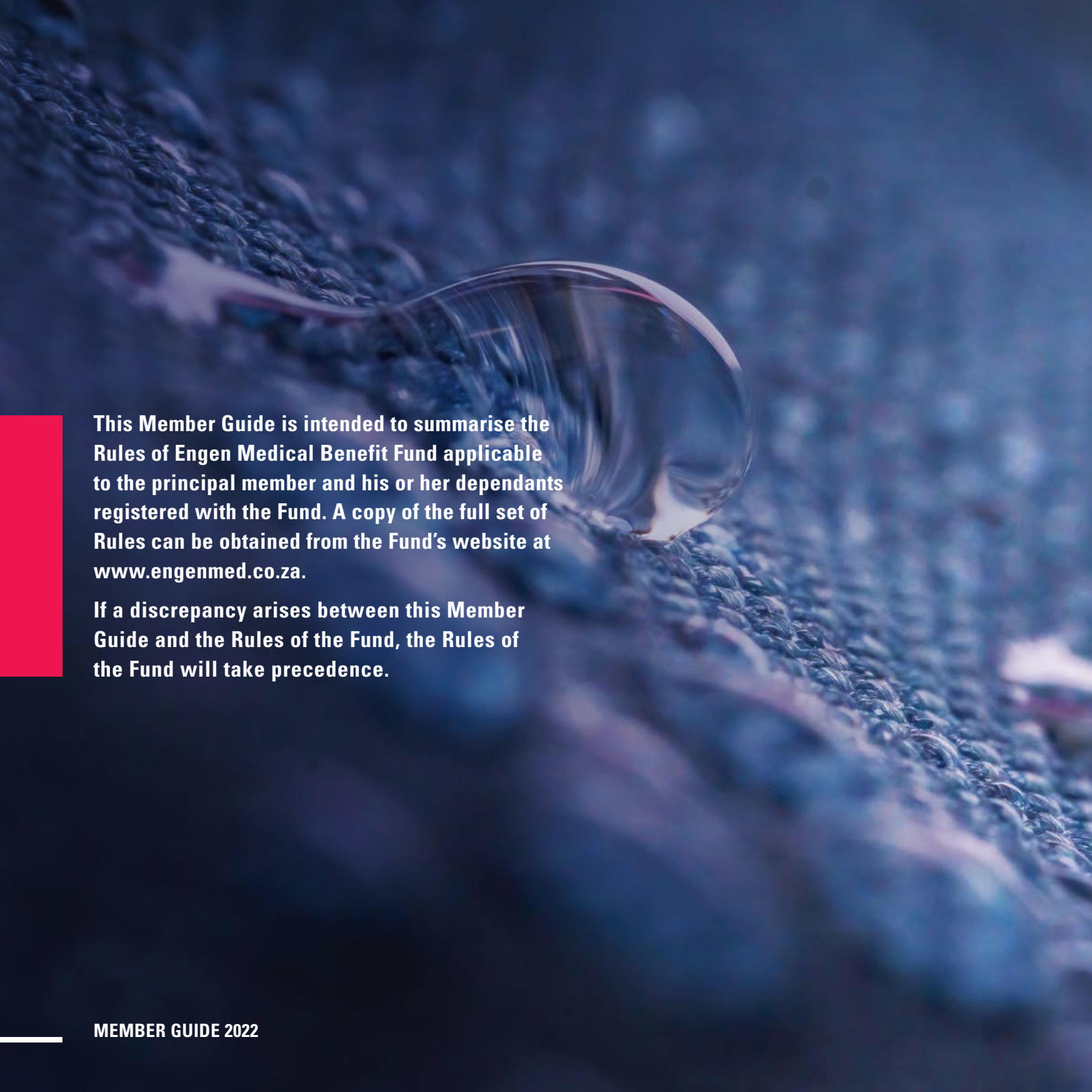
Medical Benefit Fund | ENGEN

Member GUIDE

2022

Administered by Discovery Health



This Member Guide is intended to summarise the Rules of Engen Medical Benefit Fund applicable to the principal member and his or her dependants registered with the Fund. A copy of the full set of Rules can be obtained from the Fund's website at www.engenmed.co.za.

If a discrepancy arises between this Member Guide and the Rules of the Fund, the Rules of the Fund will take precedence.

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INTRODUCTION

Please take time to read this Member Guide and the summary of your benefits so that you know your membership rules and the benefits available to you. Should you have any enquiries regarding your membership and/or benefits, please contact the Client Service Department on 0800 001 615.

OVERVIEW

Engen Medical Benefit Fund was established in 1997 to provide funding for healthcare to Engen employees and their families.

The Engen Medical Benefit Fund is managed by a Board of 10 Trustees. Five of the Trustees are nominated by the Employer and the other five are elected by the members of the Fund.

The Board of Trustees is responsible to ensure compliance with all relevant legislation, setting of the Rules that govern the Fund, determining the benefits available to members and the contributions charged, whilst ensuring the financial stability of the Fund and equitable access to benefits for all members.

GOLDEN RULES

- Get to know the Rules of the Fund. You may find a copy of the Rules at www.engenmed.co.za
- Understand your rights and responsibilities as a member.
- Obtain pre-authorisation where necessary.
- Remember authorisation does not guarantee claims will be paid in full.
- Always make use of the Designated Service Providers (DSP) or the Networks available to you.
- If possible, negotiate rates with service providers to make sure you do not have to pay out of pocket.
- Make use of the wellness benefits offered by the Fund.
- If you have any chronic conditions, enquire about the Fund's specific baskets of care and Disease Management Programmes.
- Check your claims notification or member statement and review the claim details and available benefit limits. You can also review claims information and benefits on the Fund's website www.engenmed. co.za.

MEMBERSHIP

WHO IS ELIGIBLE FOR MEMBERSHIP OF ENGEN MEDICAL BENEFIT FUND?

- The Engen Medical Benefit Fund is a closed medical scheme and membership is restricted to permanent employees, pensioners and disability claimants of Engen Limited.
- At the time of their application, or at any time thereafter, employees who join the Fund may apply to have children and/or adults added to their membership as dependants. Dependants have to qualify for Fund membership.

WHO IS NOT ELIGIBLE FOR MEMBERSHIP OF ENGEN MEDICAL BENEFIT FUND?

- Members of the Fund who resign from the employment of Engen Limited, together with their dependants, lose their membership to the Fund.
- Employees who were not members of the Fund before retirement, or the termination of their services on account of ill-health or other disability, are not eligible to become members of the Fund.
- The dependants of a deceased member who initially retain membership after the death of the main member, but who later resign from the Fund for any reason whatsoever, are not allowed to re-join as members once they have resigned.
- Those dependants of deceased members, or members who are retirees or who suffer from ill-health and disability, lose their membership to the Fund if the Fund terminates their membership as a result of non-payment of contributions.

RETENTION OF MEMBERSHIP IN THE EVENT OF RETIREMENT, ILL-HEALTH OR DEATH

- Members may retain their membership of the Fund when they retire or when their employment is terminated by Engen Limited on account of ill-health or other disability.
- Registered dependants may continue membership in the unfortunate event of the death of the main member as long as they continue to pay all contributions that become due.

How to apply for membership >

Obtain

An application form can be obtained from:

1. Your HR Department; or
2. The Fund's website www.engenmed.co.za
3. You may also apply by using the online application process. Your payroll person will guide you.

Complete

Complete your application in hard copy or online and attach the required supporting documentation.

Submit

Submit the completed application and supporting documentation to your HR Department.

If you are applying online and you have attached all the necessary documents, you don't have to submit a hard copy of the application form. You'll just click 'submit' and we'll process the application.

INCOMPLETE AND OUTSTANDING SUPPORTING DOCUMENTATION

Please note that incomplete applications and/or those submitted without the supporting documentation, as requested when you apply, will not be processed. If you are applying online, you will not be able to continue to submit your application until all the requirements are met. That means you must be ready with electronic copies of all IDs and all other relevant documents which you may need to attach to that online application, before you start the process.

WHEN YOU COMPLETE A HARD COPY APPLICATION FORM

Application forms must be stamped and submitted via your Human Resources (HR) Department. No direct submissions to the Fund can be accepted.

WHEN YOU COMPLETE YOUR APPLICATION FOR MEMBERSHIP ONLINE

Where applicable, please have electronic copies of the following documents ready to insert where the application tool asks you for it:

- Copy of ID(s)
- Copy of Birth Certificate(s)
- Copy of marriage certificate/affidavit
- Proof of student registration
- Proof of disability.

UNDERWRITING

No underwriting and waiting periods apply to employees and their dependants who join the Fund within the first thirty (30) days of employment or after having served the previous scheme's notice period.

All new applicants, who are joining after the date of employment or not immediately after having served the previous scheme's 30 day notice period, are required to complete the medical questionnaire. Applicants must disclose to the Fund information regarding any medical condition for which medical advice, diagnosis, care or treatment was recommended or received over the twelve (12) months prior to their date of application. This requirement applies to the applicant and his/her dependants and includes, but is not limited to, medical conditions and/or diseases that:

- A member or dependant suffers from as at the date of application;
- A member or dependant was diagnosed with sometime over the past 12 months before the application date, including conditions that were diagnosed but managed with lifestyle changes, e.g.high cholesterol;
- A member or dependant was treated for over the previous 12 months before the application date including treatment received and treatment that was recommended, but not necessarily taken;
- A member or dependant obtained medical advice about, not from a doctor but from another healthcare professional such as a pharmacist;
- The member or dependant had any symptoms for which no illness was specifically diagnosed by a doctor, or for which no specific treatment was provided.

If underwriting would have applied at joining, the Fund could retrospectively impose underwriting if the member does not disclose any and all relevant medical information when applying for membership.

WAITING PERIODS

Where an employee joins the Fund after commencing employment or after having served a previous medical scheme's 30 day notice period, the Fund may impose the following waiting periods as provided for in terms of the Medical Schemes Act (No. 131 of 1998):

Category	Three (3) month general waiting period	12 month condition- specific waiting period	Access to Prescribed Minimum Benefits (PMBs) during Waiting Period
New applicants, or persons who have not been a member of a medical scheme for the preceding 90 days.	Yes	Yes	No
Applicants who were members of another medical scheme for less than 2 years.	No	Yes	Yes
Applicants who were members of another medical scheme for more than 2 years and who did not join within 30 days of employment or date of leaving their previous medical scheme.	Yes	No	Yes
Child-dependants born during a period of membership and registered within 30 days of birth/ adoption.	No	No	Yes
Addition of a spouse/life-partner within 30 days of marriage/proof of common household.	No	No	Yes

MEMBERSHIP CARDS

The Fund provides members with a Welcome Pack, which includes a membership card for the main member and all of the adult dependants on his/her membership.

Membership cards may only be used by the registered member and registered dependants. It is fraudulent to permit someone else to use your Fund card and benefits.

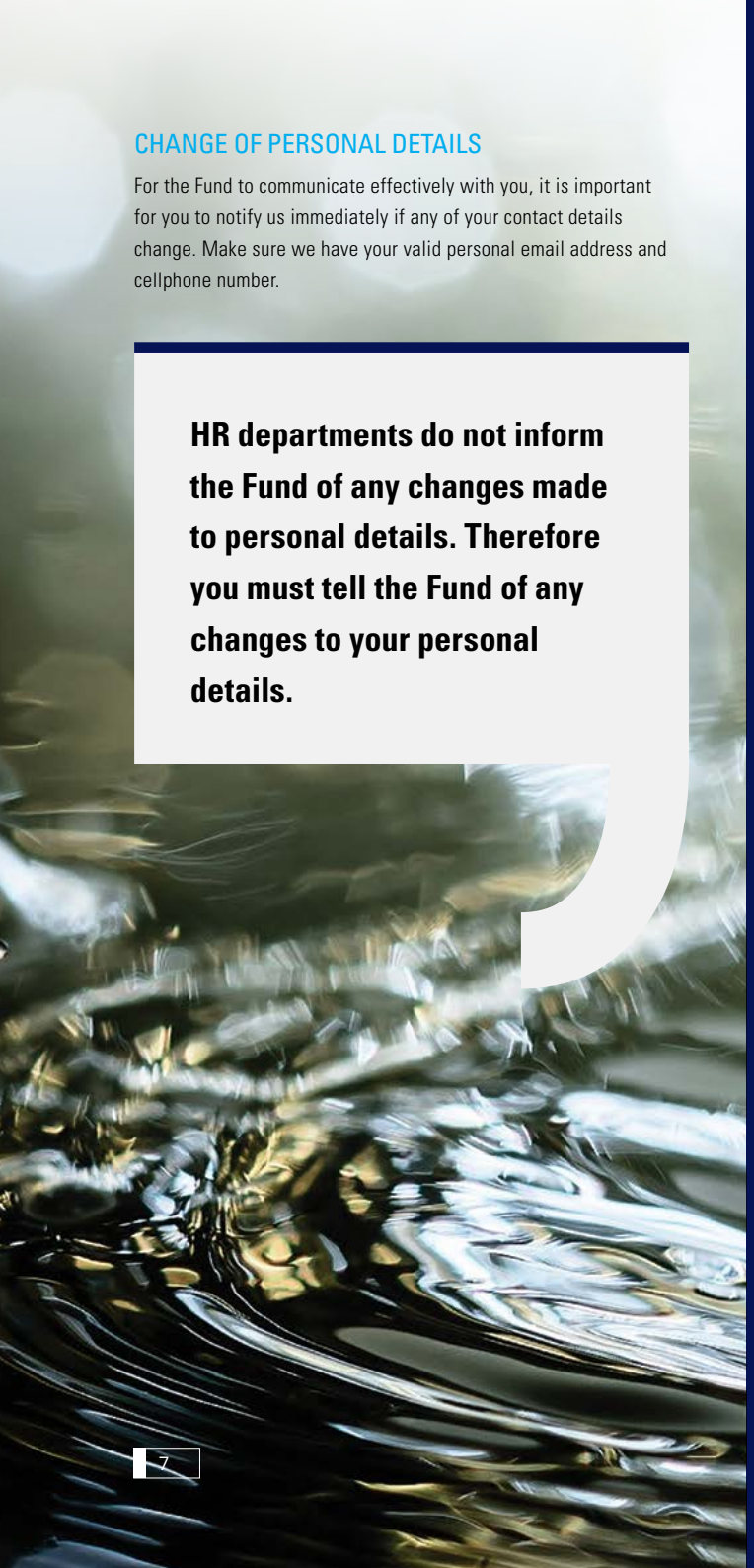
Welcome Packs and membership card(s) are sent to you directly, via the post.

If you have not received your Welcome Pack and membership card within 21-days of submitting your application, please call the Fund's Client Service Department on 0800 001 615 to enquire about the status of your application.

CHANGE OF PERSONAL DETAILS

For the Fund to communicate effectively with you, it is important for you to notify us immediately if any of your contact details change. Make sure we have your valid personal email address and cellphone number.

HR departments do not inform the Fund of any changes made to personal details. Therefore you must tell the Fund of any changes to your personal details.



Update your information – it's as easy as 1… 2… 3…

Step 1

To update your personal information, log on to the Fund's website www.engenmed.co.za and go to the 'YOUR DETAILS' section.

You can also obtain the **Change of personal details** application form from the Fund's website under the tab 'Find a document', or phone our Client Service Department at 0800 001 615 for assistance.

Step 2

Complete the form, ensure it is signed and that a copy of your Identity Document (ID) is attached.

Step 3

Your completed form may be returned to the Fund in one of the following ways:

- Email: membership@engenmed.co.za
- Fax: 011 539 2766
- Registered post:
  Engen Medical Benefit Fund Membership Department
  PO Box 652509
  Benmore 2010

The Fund will not be liable if a member's rights are prejudiced or forfeited as a result of neglect to comply with these requirements.

MONTHLY CONTRIBUTIONS

Membership contributions are deducted by the employer from the employee's monthly salary. This is paid to the Fund every month in arrears on behalf of the member.

The employer subsidy is determined by Engen Limited.

Late contribution payments can result in suspended benefits, or cancellation of membership.

The Fund calculates your contribution using the Contribution Table (applicable to the particular year) based on:

- The income (rate-of-pay/ROP) of the principal member.
- The number of adult dependants defined as spouses, life-partners and any immediate family for whom the principal member is liable, including children from the age of 21 years. Additional adult dependants must be financially dependent on the member and evidence to this effect is required for acceptance on to the Fund; Spouses, life-partners and any immediate family for whom the principal member is financially responsible may apply to register as a dependant, including children who are older than 21 years.
- The number of child dependants: all child dependants younger than 21 years are considered to be child dependants. Children from the age of 21 years, registered as bona fide students at an educational institution up to the age 25 years, subject to providing proof of current registration at a tertiary institution to the Fund annually, are also considered to be child dependants of the main member.

LATE JOINER PENALTIES

If a special dependant (for instance the member's mother or father) who is older than 35, joins the membership, late joiner contribution penalties may be imposed as per the Medical Schemes Act and the membership rules noted in this guide.

TERMINATION OF MEMBERSHIP

You may terminate the membership of any of your dependants by notifying your Human Resources (HR) Department, giving 1 calendar month's written notice to the Fund.

Principal members may only terminate membership when they resign from employment with Engen Limited, or when they provide proof of alternative medical scheme cover (as a dependant on their spouse's medical scheme). A calendar month's notice is required using the necessary Fund documentation.

DO YOU QUALIFY FOR A SUBSIDY FROM THE EMPLOYER?

If you were employed by Engen Petroleum Limited before 1 October 2000, and you were already a registered member of the Fund on 1 January 2019, you qualify to receive a 50% medical aid subsidy from the Employer on retirement.

The subsidy is applicable to the main member, spouse and any children who were registered on the FUND at retirement. Adult dependants, or a spouse who married the retired employee after the date of retirement, are not eligible for this subsidy.

ANNUAL PROOF OF ELIGIBILITY OF CHILD DEPENDANTS

Does your child still qualify to pay for cover as a Child dependant?

The Fund considers your biological or adopted children, step- or foster children as your Child dependants for the sake of contributions, if they are younger than 21 years. However, under certain conditions, the Fund may allow your child, who is between the ages of 21 and 25 years, to continue to pay contributions at Child rates.

We check that your child is still eligible to be registered on your membership

We follow two processes to check whether your child, who is 21 years or older, is still eligible to membership of the Fund and we also check whether we should be charging contributions at Child or at Adult rates.

1. If your child's 21st birthday is approaching, or if they are between the age of 21 and 25, the Fund will follow an eligibility check process to find out whether you should still be paying the lower contributions at Child rates for your child, or whether your child should be moved to adult status and contributions be charged at Adult rates. Three months before the applicable birthdays, the Fund will send information to you and ask you to provide information so we can determine your child's membership status.
2. If you have told us before that your child was a student and/or not earning more than the applicable tax threshold that applied in that year, we will ask you to confirm that their situation has not changed. We will normally request you to submit that confirmation by the end of March in the applicable year.

It is very important that you must respond within the indicated timelines – if you don't, we will assume the child is no longer eligible to pay contributions at child rates, and we will charge contributions at adult rates from the 1st of the month after the child's birthday month.

You must inform us immediately when your child is earning more than the applicable tax threshold, and is older than 21 years. They are then no longer eligible to be registered on the Fund, and we will withdraw their membership.

Is your child, who is older than 21, still eligible to be registered as your dependant on your Fund membership?

A dependant aged 21 or older is not considered to be a Child dependant but can remain on your membership as a child dependant under the following circumstances:

When does your child qualify to remain on the Fund and pay contributions at Child rates.	What proof is required
When your child is 21 to 25 years old, a student at a tertiary institution, fully dependent on you as the main member, and not earning a regular income that is more than the tax threshold that applies in the specific year	To determine your child is still dependent on you for care and support, we require copies of the child's bank statements for the most recent three months, and a copy of the registration certificate from a registered tertiary education institution

Note: If you do not provide the proof we require by the time we requested, we will start charging Adult contribution rates from the month after the qualifying birthday. You will then notice an increase in the Medical Savings Account balance available to you and the family.

If, after we have changed the contribution status of the child, you provide proof of studies that require us to again charge contributions based on Child rates, and if you have already spent the increased Medical Savings Account allocation, you will owe the Fund the amount by which you will have overspent and will have to pay that back to the Fund.

When does your child qualify to remain on the Fund and pay contributions at Adult rates.	What proof is required
When your child is older than 21 years and fully dependent on you as the main member for care and financial support, and not earning more than the tax threshold that applies in the specific year	We require your child's bank statements for the latest 3 months before the eligibility check; or ■ Your child's salary slips for the latest 3 months before the eligibility check, and ■ an affidavit from you, the main member, confirming that your child is still dependent on you for care and financial support. If the dependent is unemployed and does not own a bank account, you must include a statement about this in the affidavit.

When will we withdraw your child's membership from the Fund?

- When you do not provide proof by the due date that your child, who is 21 to 25 years old, is dependent for care and support;
- When the information you provide indicates that your child earns more than the applicable tax threshold for that year;
- When your dependant is older than 21 years and earns more than the applicable tax threshold rate for that year or when you do not respond to our request for information that will allow us to review the child's dependency status.

We withdraw dependants' memberships from the 1st of the month following the month of the applicable qualifying birthday.

Once we have withdrawn any dependant's membership, we will not be able to reinstate their memberships. You should react quickly and provide us with the supporting documents proving your dependant's eligibility to avoid finding yourself in this situation.

What about permanently disabled children?

If your child is permanently (physically or mentally) disabled and dependent on you for care and support, and the Fund has received the necessary proof of such disablement, your child will remain registered on the Fund and pay contributions at child rates irrespective of the age of that child.

STRUCTURE OF BENEFITS

The benefit structure of the Engen Medical Benefit Fund includes a 10% Medical Savings Account (MSA) component for primary care (day-to-day) expenses. Once the MSA has been exhausted, the Primary Care Benefits are paid by the Fund from the insured portion of the benefits, subject to the applicable limits indicated in the Benefit Schedule.

EXPENSES PAYABLE FROM THE FUND'S INSURED OR RISK PORTION

The Fund will cover expenses such as those noted below from the insured or risk portion of benefits. Note that payment may be subject to:

- Pre-authorisation
- Prescribed Minimum Benefits
- Managed Care Protocols and Clinical Guidelines generally accepted in the industry as best practice principles
- Co-payments
- Sub-limits

The following are covered from the insured or risk portion of your benefits:

- Hospitalisation (including ward fees, theatre fees, ward medicine and treatment, surgery and anaesthesia etc.), subject to the use of the Fund's DSPs and authorisation. Post operative rehabilitation benefits provided for a period of 6 weeks, subject to approval.
- A 7 day supply of medication on discharge from hospital (To-take-out/'TTO')
- General Practitioners, specialists and technician consultations and treatment while in hospital
- Physiotherapy and occupational therapy while in hospital
- Organ transplants including donor costs, surgery and immuno-suppressant drugs
- Chemotherapy, radiation and dialysis treatment
- Injuries sustained in motor vehicle accidents, subject to an undertaking in favour of the Fund
- Routine diagnostic endoscopic procedures (performed in a doctor's rooms) or endoscopic procedures as part of an authorised hospitalisation
- Outpatient or emergency department visits with a final diagnosis of a PMB, or Priority Emergency, or leading to an immediate admission
- Surgical procedures performed in doctors' rooms *In lieu of hospitalisation* (full cover for Designated Service Provider (DSP) specialists or GPs)
- Pathology
- Prescribed Minimum Benefits in- and out-of-hospital (full cover when the services of DSP providers are used)
- In-hospital dentistry – theatre and Anaesthetist accounts for children under the age of 8 years
- Specialised radiology such as CT, PET and MRI scans and radio-isotope studies, subject to authorisation and applicable limits
- Basic radiology
- Benefits for confinements (including home delivery), a defined set of pre- and post-natal maternity benefits, and specific benefits for children under the age of 2 years
- PMB Chronic Disease List chronic medication, subject to registration on the Chronic Illness Benefit
- Prostheses (some limits may apply)
- Hearing aids (including repairs), subject to sub-limits. Benefits for a second hearing aid subject to clinical criteria and authorisation
- Appliances i.e. nebulisers, glucometers and blood pressure monitors, subject to applicable limit
- Ambulance and emergency services through ER24
- Home-nursing, step-down facilities and hospice services as an alternative to hospitalisation, subject to approval and applicable limit
- HIV management
- Infertility interventions and investigations in line with PMBs
- Conservative and specialised dentistry including orthodontics, subject to applicable limits
- Maxillo-facial and oral surgery
- Screening and preventative care benefits (as stipulated).

EXPENSES PAYABLE FROM YOUR MEDICAL SAVINGS ACCOUNT (MSA) AND PRIMARY CARE BENEFITS

In any financial year, Primary Care (day-to-day) Benefits are first covered from your MSA until your funds are used up. Once the MSA limit has been reached in that year, the following services are paid for from the Insured Risk Benefits, subject to the limits indicated in the Benefit Schedule:

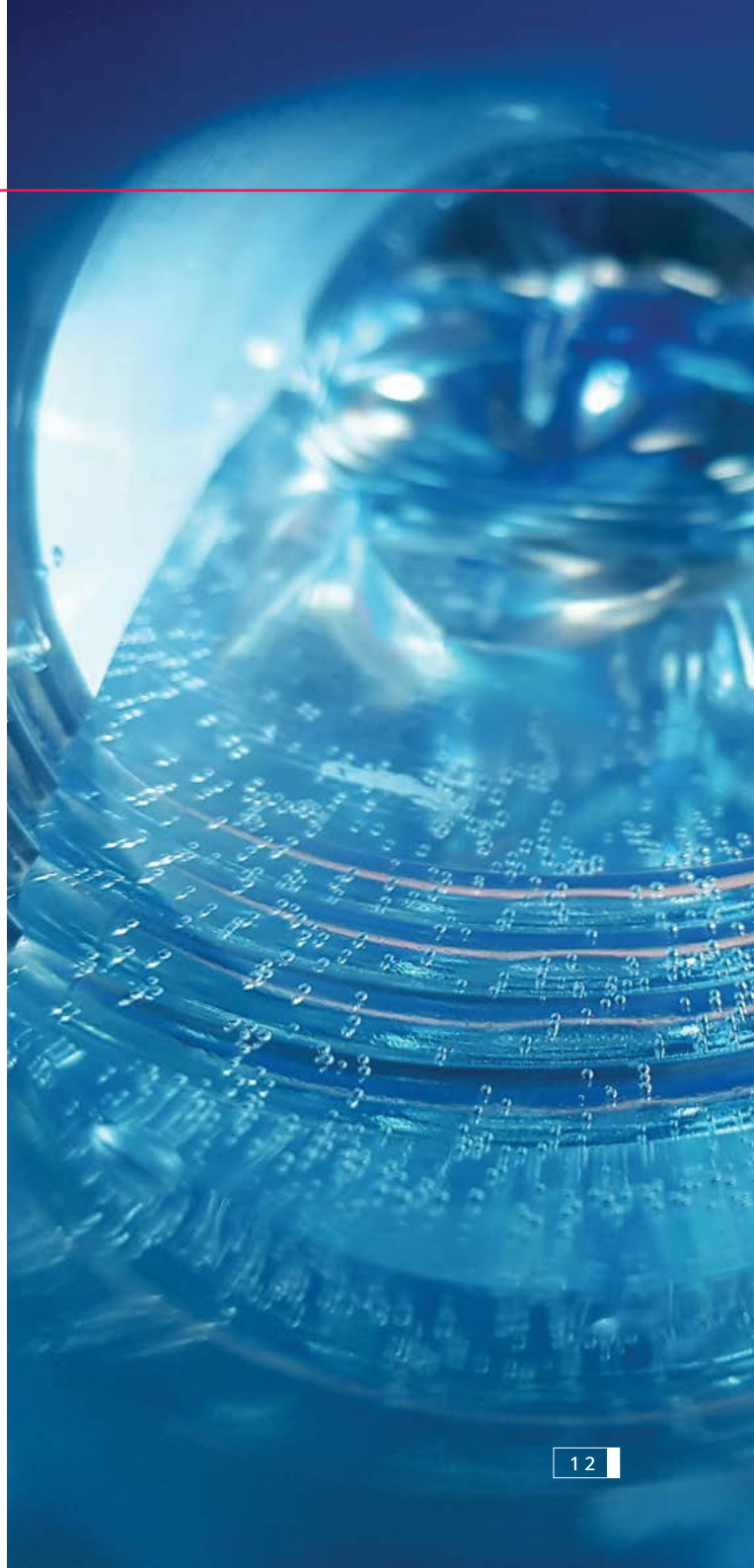
- General Practitioner, medical specialist and registered private nurse practitioner consultations and non-surgical procedures out-of-hospital
- Auxilliary services:
  - Acupuncture
  - Chiropractic treatment
  - Dietetics
  - Non-surgical prostheses (for instance crutches)
  - Audiology and speech therapy
  - Occupational therapy
  - Private nursing and registered private nurse practitioners
  - Podiatry/chiropody
- Eye tests
- Prescribed acute medication
- Homeopathy and Naturopathy consultations and medication
- Physiotherapy and bio-kinetics out-of-hospital
- Psychology and social services

The following services will simultaneously fund from MSA and your Insured Risk Benefits:

- Basic Dentistry
- Spectacles and/or contact lenses

The following services will fund from MSA only:

- Self-medication or medication obtained over-the counter



Designated Service Providers (DSP)

The Fund has Designated Service Provider's (DSPs) in place for Prescribed Minimum Benefits (PMBs) and specific other treatment and care. You should make sure that you use these appointed DSPs to minimise any co-payments for services obtained in- or out-of-hospital.

Visit the Fund's website at **www.engenmed.co.za** and log on to the MaPS tool to find a DSP provider near you.

Fund appointed DSPs for Prescribed Minimum Benefits (PMBs)

- For Ambulance services: ER24.
- Hospitals in the KeyCare Hospital Network
- The Premier A or Premier B Specialist Network and any specialists in the KeyCare Network
- The Discovery Health GP Network and any KeyCare Network GP
- Your chosen Discovery Health Premier Plus GP for HIV, Diabetes, Mental Health and Cardio Care.

Note: Exceptions are only allowed in an emergency as defined in the Medical Schemes Act, No. 131 of 1998.

These are specific providers of healthcare services, for example hospitals, GPs and specialists, who have agreed to provide services according to certain agreed rules. The Fund pays these providers directly.

When you use the service of a DSP, your treatment or care is in line with clinical guidelines and you have authorised the services, all claims including Prescribed Minimum Benefits, are paid in full. This means you will not have to make any out-of-pocket payments.

When you need to go to hospital for a planned PMB procedure or treatment, and want the Fund to pay all costs related to the care in full, your admitting doctor must be a DSP GP or Specialist and you must go to a hospital in the KeyCare Hospital Network.

If you do not use the services of the DSP

For PMB claims to be funded in full, you must use a DSP for certain services, as indicated in this booklet and your Benefit Schedule. If these providers are not used, the Fund may pay claims up to the agreed rate only, or apply co-payments.

You will not have to make any co-payments if you have involuntarily obtained a PMB service (had no other choice) from a provider other than a DSP, and it is an emergency, for example hospital admissions where the service was not available from the DSP or would not have been provided without unreasonable delay as there was no DSP within a reasonable distance from your place of business or residence.

The Fund's DSPs for the diagnosis, treatment and ongoing care costs (which may include medicine) for Prescribed Minimum Benefit (PMB) conditions are:

- Certain DSP Premier Rate Specialists and General Practitioners (GPs), who have agreed to deliver services in accordance with their Direct Payment Arrangement (DPA) with the Fund
- Contracted KeyCare hospitals for all in-hospital treatment and care
- Your chosen Discovery Health Premier Plus GP for HIV, Diabetes, Mental Health and Cardio care
- SANCA, RAMOT or Nishtara Lodge for all PMB benefits related to drug and alcohol detoxification and rehabilitation.
- Other service providers, as selected by the Fund from time to time.

It is likely that the Fund will contract with and appoint more DSPs, in its ongoing efforts to control and reduce costs for members.

Pre-authorisation is required to access the following benefits

- Hospital admissions/home nursing/step down/sub-acute/ rehabilitation and hospice, and all services in lieu of hospitalisation
- Some radiology scans: IVP tomography, contrast studies, bone densitometry, MRI, PET and CT scans
- All internal appliances and prostheses
- All chronic medication
- Certain Outpatient procedures.

SOME BENEFITS HAVE LIMITS

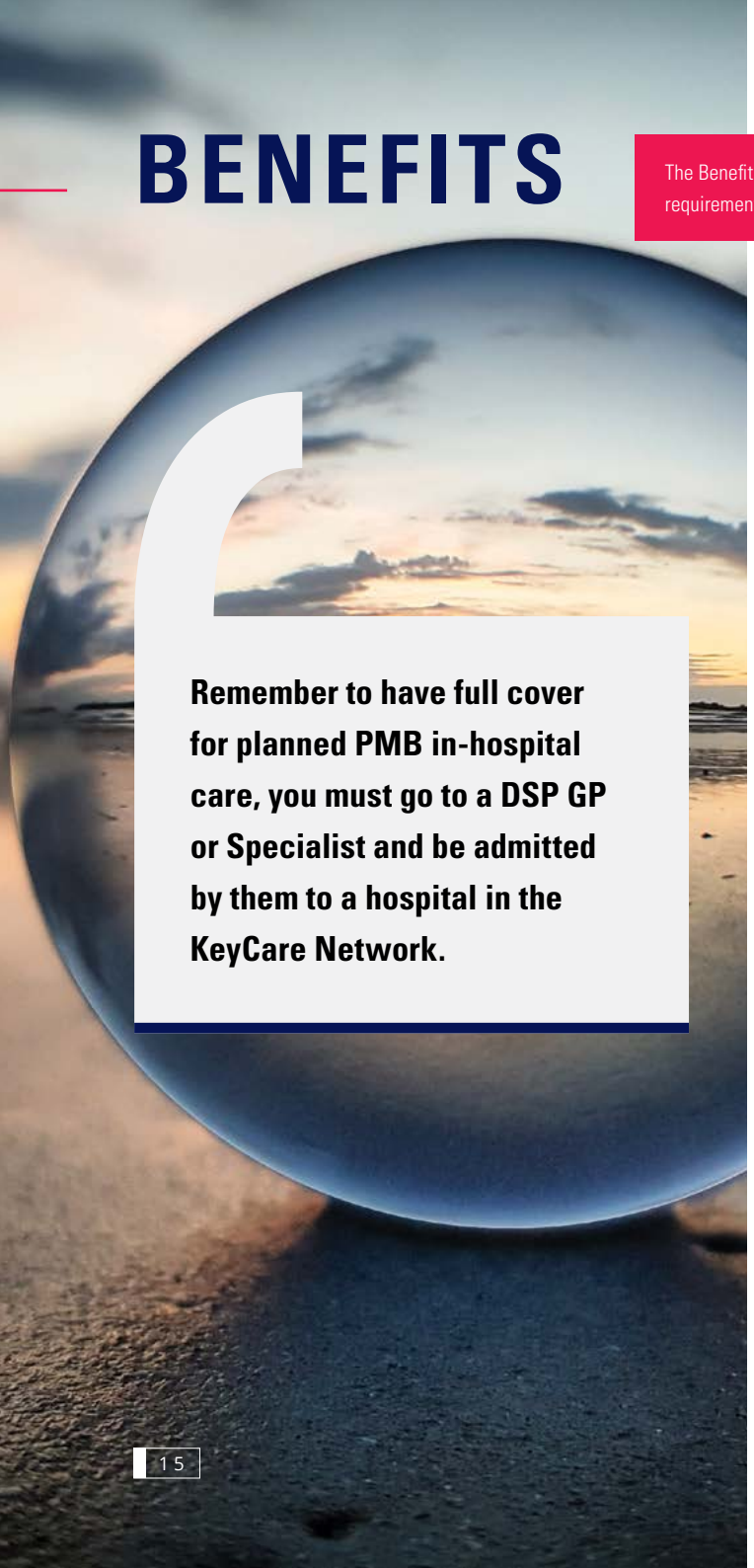
Please refer to the Benefit Schedule in this booklet for the specific limits that apply to some of the benefits.

Expecting a baby? You must register:

When your pregnancy is confirmed, you must register by pre-authorising the confinement. Once you have registered, your maternity benefits will be paid for from the Young Families Benefit.

BENEFITS

The Benefit Schedule shows the expenses that are covered by the Fund and limits, co-payments, authorisation requirements and Network arrangements that may apply.



Remember to have full cover for planned PMB in-hospital care, you must go to a DSP GP or Specialist and be admitted by them to a hospital in the KeyCare Network.

HOSPITAL ADMISSION AND TREATMENT WHILST IN HOSPITAL

The details of the authorisation, including information about possible exclusions, will be emailed to you (if we have your email address and you are requesting the authorisation), your treating healthcare professional and the hospital.

Make sure to clarify any uncertainty you may have with your treating practitioner or the Fund prior to your admission, as some procedures, items and medication may not be covered, or you may have to pay some of the costs. Should the treating practitioner disregard the terms and conditions of the authorisation, you will remain responsible for the costs incurred.

- Where possible, make use of a hospital in the KeyCare Network, specialists and other medical service providers on the Fund's Network lists to optimise benefits and minimise co-payments for treatment while in hospital. Please visit the Fund's website at www.engenmed.co.za to find the nearest Network GP or Specialist to you.
- Funding of accommodation in a private ward is subject to a motivation from the attending practitioner and authorisation.
- A co-payment applies in the case of elective investigative endoscopies, if these procedures are performed in hospital (Colonoscopy, Sigmoidoscopy, Proctoscopy, Gastroscopy, Cystoscopy, Arthroscopy, Laparoscopy and Hysteroscopy).

AUTHORISATION – IS A CLINICAL CONFIRMATION, NOT A GUARANTEE OF PAYMENT

Pre-authorisation is provided based on a clinical decision and enables the Fund to ensure the treatment provided to you is clinically appropriate and cost-effective. It should be noted that pre-authorisation is not a guarantee of payment.

Failing to obtain an authorisation may, in terms of the Rules of the Fund, lead to claims not being paid, or substantial co-payments, even if the medical condition is a PMB.

Specialised dentistry

- Specialised dentistry is limited, based on the size of your family. If the treatment is performed in theatre with pre-authorisation, the complete treatment event, including all related accounts (e.g. dentist, surgeon), are paid from this limit with the exception of theatre and anaesthetist accounts, which will be paid from the unlimited hospital benefit.
- When a maxillo-facial surgeon performs a standard dental procedure in theatre, the event is still payable from your annual specialised dentistry limit for the family. Only when a maxillo-facial surgeon performs surgery pertaining to the jaw and face that is specialised and pre-authorised, will services be paid from the unlimited insured risk portion of the Fund's benefits.

The payment of unauthorised services

If you fail to obtain authorisation as required in terms of the Rules, the Fund may:

- Pay for the service from your available MSA for a non-PMB diagnosis, or reject the account if you do not have medical savings available; or
- Apply a penalty equal to the difference between 100% of the Fund rate and the cost charged by the service provider for a PMB diagnosis.

Cover for chronic conditions

- The Fund covers approved chronic medicine for the 26 Prescribed Minimum Benefit (PMB) Chronic Disease List (CDL) conditions.
- We will pay your approved PMB chronic medicine in full up to the Fund Medicine rate if it is on the Fund's medicine list (formulary).
- If your approved chronic medicine is not on the medicine list, we will pay your chronic medicine up to the Maximum Medical Aid Price (MMAP).
- Out-of-pocket expenses can be avoided by using alternative products that are less expensive. Discuss your options with your treating provider or pharmacist.
- The Fund also provides chronic illness benefits for non-PMB conditions. You must use the medicine on a continuous basis, for more than 3 consecutive months. This benefit is limited, as indicated in the Benefit Schedule.
- You must apply for cover by completing a Chronic Illness Benefit application form, with the help of your doctor, and submitting it for review. For a condition to be covered from the Chronic Illness Benefit, there are certain benefit entry criteria that need to be met.
- If your Chronic Disease List (CDL) condition is approved from the Chronic Illness Benefit, the Chronic Illness Benefit will cover certain procedures, tests and consultations for the diagnosis and ongoing management of the condition, in line with Prescribed Minimum Benefits.
- If you suffer from a related condition, you must make use of the services of a Premier Plus GP, who can register you on one of the following Care programmes:

Diabetes Care Programme

The Diabetes Care Programme is designed to offer our diabetic members the optimal care from the best service providers in a coordinated network, to ensure the best outcomes and quality of life for our members. To access the programme, you need to be registered on the Chronic Illness Benefit with either type 1 or type 2 Diabetes. A GP in the Premier Plus GP network can enroll you onto the programme.

The Diabetes Care Programme is based on clinical and lifestyle guidelines.

The programme gives you and your Premier Plus GP access to various tools to monitor and manage your condition and to ensure you have access to high-quality coordinated care. You and your GP can track your progress on a personalised dashboard displaying your unique Diabetes Management Score. This will help you to identify the steps you should take to manage your condition and remain healthy over time.

In addition to the standard treatment basket of procedures and consultations available to members registered on the Chronic Illness Benefit with Diabetes, members who join the Diabetes Care Programme will have access to an additional dietician and one biokineticist consultation per year.

Cardio Care Programme:

The Cardio Care Programme is designed to offer our members approved for certain heart-related conditions the optimal care from the best service providers in a coordinated network, to ensure the best outcomes and quality of life for our members.

To access the programme, you need to be 18 years or older and registered on the Chronic Illness Benefit with hypertension, hyperlipidaemia and/or ischaemic heart disease.

A GP in the Premier Plus GP network can enroll you onto the programme.

The Cardio Care Programme is based on clinical and lifestyle guidelines. The programme gives you and your Premier Plus GP access to various tools to monitor and manage your condition and to ensure you have access to high-quality coordinated care. You and your GP can track your progress on a personalised dashboard displaying your unique Cardio Care Management Score. This will help you to identify the steps you should take to manage your condition and remain healthy over time.

Mental Health Care Programme:

The Mental Health Care Programme is designed to offer our members diagnosed with acute or episodic Major depression the optimal care from the best service providers in a coordinated network, to ensure the best outcomes and quality of life.

A GP in the Premier Plus GP network or a psychologist in the Mental Health Care Programme Network can do the assessment to confirm the diagnosis and enroll you onto the programme.

The programme, will give your healthcare provider access to tools to monitor and manage your condition, ensuring you have access to high-quality coordinated care.

By joining the Mental Health Care Programme, you will have access to up to 3 consultations with your enrolling GP;

Referral to a psychiatrist for a psychotherapy consultation; and

Additional psychotherapy consultations.

In addition to the above benefits, if enrolled by a Premier Plus GP, you also have access to antidepressant medicine.

Log on to the Fund website at www.engenmed.co.za to find the nearest Premier Plus GP to you.

The Fund covers the following Prescribed Minimum Benefits Chronic Disease List conditions:
Addison's disease
Asthma
Bipolar mood disorder
Bronchiectasis
Cardiac failure
Cardiomyopathy
Chronic renal failure
COPD and emphysema
Coronary artery disease
Chron's disease
Diabetes insipidus
Diabetes mellitus type 1
Diabetes mellitus type 2
Dysrhythmia (arrhythmia)
Epilepsy
Glaucoma
Haemophilia
Hyperlipidaemia
Hypertension
Hypothyroidism
Multiple sclerosis
Parkinson's disease
Rheumatoid arthritis
Schizophrenia
Systemic lupus erythematosis
Ulcerative colitis

How to avoid out-of-pocket expenses

- **Confirm** that we have your latest email and cellphone details as authorisation confirmation will be sent to you on the contact details that we have on system in the event of a hospital admission.

- **Read the authorisation letter/SMS** and make sure you understand the terms and conditions i.e., Fund exclusions and limits associated with the procedure. If you have any questions, or are not sure about anything, please speak to your treating healthcare professional and/ or one of our Case Managers before you are admitted to hospital.

- **You may go** to any hospital as long as your procedure is authorised. To have your Prescribed Minimum Benefit treatment in hospital covered in full, your DSP GP or Specialist must send you to a hospital in the KeyCare Hospital Network. Hospitals in the KeyCare Network are the Fund's Designated Service Providers for Prescribed Minimum Benefits.

- As far as possible you should make use of a the services of a **Network Provider** (a contracted doctor/specialist) as the Fund has negotiated fees with them and they are not allowed to charge more than has been agreed with them by the Fund. If they do charge more than the agreed upon rate, please notify us without delay so that we can assist you in resolving the matter. If you do not use the services of these Network providers, and your doctor or specialist charges more than the Fund rate, you will have to pay the difference. The Fund's Network GPs and Specialists are also its Designated Service Providers for all Prescribed Minimum Benefit-related care.

- Very few anaesthetists charge at the Fund rate. It is therefore a good idea to ask your doctor/surgeon which anaesthetist he/she makes use of and negotiate fees with them **upfront**. To avoid paying any out of pocket costs for these providers when your treatment or procedure is a planned PMB, you must be admitted to a KeyCare Network Hospital by a DSP GP or Specialist.

Preventative healthcare

Preventative care is an important part of maintaining good health and we encourage our members to make use of this special benefit. We pay screening and preventative care benefits from the Fund's risk pool of benefits. Refer to the Benefit Schedule for more detail.

COVER FOR THE FOLLOWING:

Immunisations and vaccinations

- Flu vaccination – 1 per beneficiary per year
- Pneumaccoccal immunisation – subject to entry criteria.

Baby and child immunisations

- Standard immunisations for children up to the age of 12 years in accordance with the Department of Health protocols
- MMR vaccine for measles, mumps, and rubella (also called German measles).

Health risk assessments covered from your Insured Risk Benefits

- Screening benefits (for adults)
- Blood glucose test
- Total serum cholesterol test
- Blood pressure test
- Faecal occult blood test
- Human papilloma virus (HPV) screening.

Children's screening benefits

- Basic hearing and dental screenings
- BMI, health behaviour and milestone tracking for children 2 to 18 years old
- Head circumference for children 2 to 5 years

Other screening benefits covered from your Insured Risk Benefits

- Prostate Antigen Specific (PSA) tests
- Colorectal cancer screenings
- Pap Smears
- Mammography.

The Fund assists you when you want to stop smoking

A smoking cessation benefit, paid from the Medical Savings Account is available. The benefit is limited, as indicated in the benefit schedule.

The amount that was initially paid from your MSA will be reimbursed if, after the treatment, the nicotine test result is negative.

BENEFIT FOR OUT-OF-HOSPITAL MANAGEMENT AND APPROPRIATE SUPPORTIVE TREATMENT OF GLOBAL WORLD HEALTH ORGANISATION (WHO) RECOGNISED DISEASE OUTBREAKS

COVID-19

For the duration of the COVID-19 pandemic, the Fund pays for in- and out-of-hospital treatment and care when you have contracted the Virus.

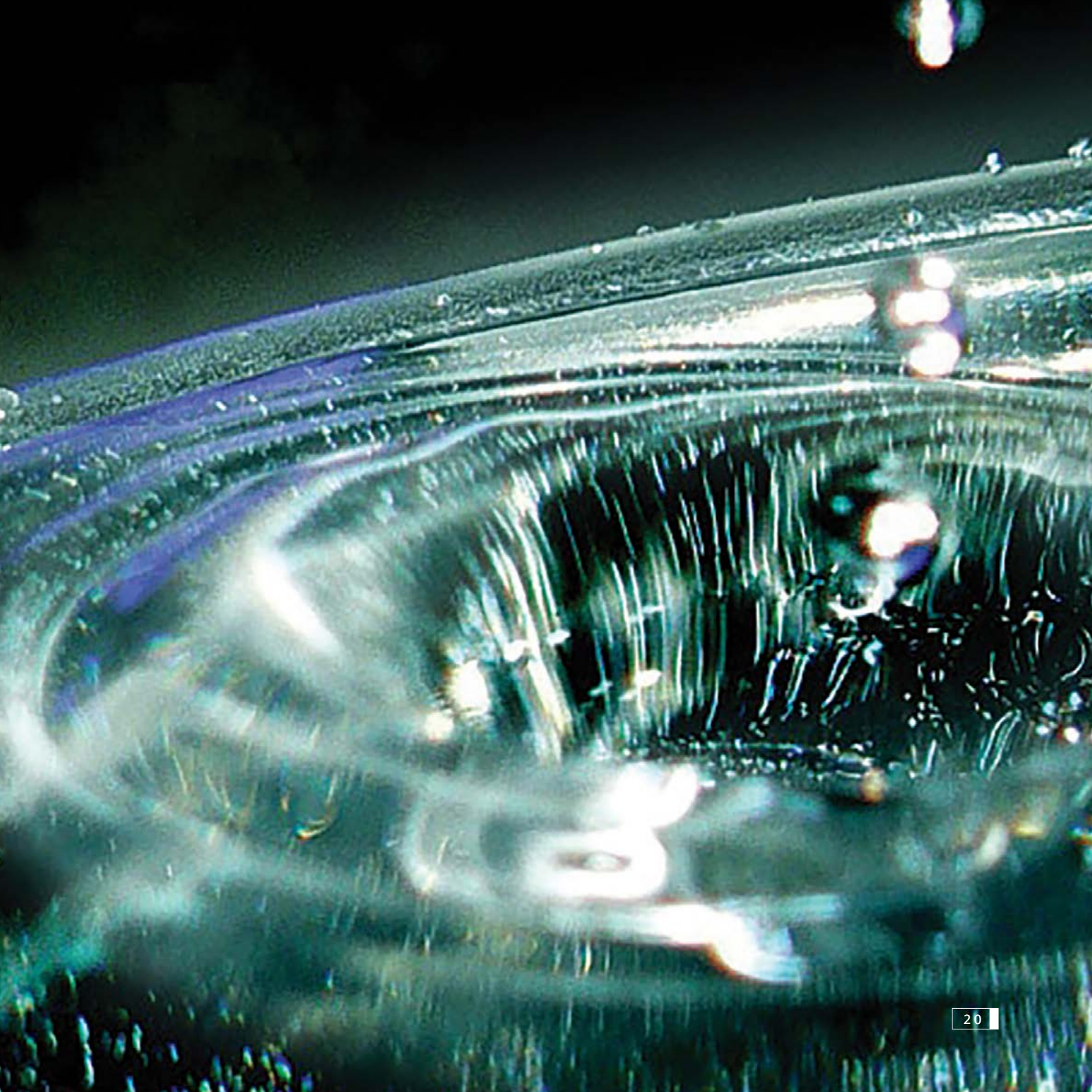
Some of the benefits are related to Prescribed Minimum Benefits and the Fund will pay for those in full, provided you use the services of the Designated Service Providers, as may be necessary. These benefits are also subject to clinical guidelines and protocols.

The Fund provides some benefits over and above those required as Prescribed Minimum Benefits.

You have benefits for the following out of hospital services for COVID-19:

- Screening consultations with a nurse or GP. These are unlimited benefits.
- Access to a defined basket of pathology services, which include:
  - Up to 2 PCR COVID-19 tests per person per year, subject to PMB;

  Please note: all testing is subject to referral.
- Access to a defined basket of X-rays and scans
- Consultations with a nurse or GP
- Supportive treatment
- Vaccines, including the administration costs
- Treatment and care for persons suffering from long COVID-19, where the symptoms persist for more than 21 days after the initial infection.



BENEFIT SCHEDULE

In-hospital cover

A list of the network and/or designated service providers (DSPs) is available at www.engenmed.co.za or by calling the Client Service Department on 0800 001 615

Service	Benefit	Limits (Subject to managed care rules and protocols)	Authorisation Requirements	Designated Service Provider (DSP/ Network Provider)
Admission to hospital – Failure to pre-authorise any planned hospital admission will result in a R1 000 co-payment				
Hospital stay in a general, labour or high care ward or intensive care unit, theatre, including costs of dressing materials consumed and equipment used while in hospital	100% of Fund rate, subject to PMB	Unlimited cover	Yes, at least 48 hours prior to admission or within 24 hours of an emergency admission	KeyCare Network Hospital Network for all PMB
Psychiatric hospitalisation	100% of Fund rate, subject to PMB	21 days per beneficiary per year or 15 outpatient psychotherapy sessions, subject to Prescribed Minimum Benefits		KeyCare Network Hospital Network for all PMB
Day clinic or day theatre admission	100% Fund rate	Unlimited cover		KeyCare Network Hospital for all PMB
Treatment whilst in hospital				
Consultations, surgical procedures, physiotherapy, ward and theatre medication and blood transfusions	100% of the DSP or Fund rate	Unlimited cover	Forms part of the related hospitalisation	Subject to Specialist/GP DSP/ Network for all PMB
Anaesthetics administered in theatre	100% of Fund rate	Unlimited cover		
Pathology	100% of Fund rate	Unlimited cover		
Endoscopic investigations	100% of Fund rate	Unlimited cover	Yes, at least 48 hours prior to procedure. A co-payment of R1 330 applies for each elective scope (non-PMB treatment)	
To Take Out (TTO) drugs	100% of Fund rate	7 day supply No levy applicable	Forms part of the related hospitalisation	–
Organ transplants (organ and patient preparation, harvesting and transportation and immunosuppressant medication)	100% of Fund rate	R474 000 per family per year, subject to Prescribed Minimum Benefits	Yes, at least 48 hours prior to admission or within 24 hours of an emergency admission	–
Spinal Care Programme In and out of hospital management of spinal care and surgery for defined clinically appropriate procedures, which include Lumbar Fusion, Cervical Fusion, Laminectomy, Laminotomy	100% of the Fund Rate at Network Hospital. Non-Network Hospital account paid up to 80% of the Fund Rate only.	Unlimited. Subject to authorisation, treatment guidelines and clinical criteria and a basket of care. In hospital procedures limited to one procedure per year Out-of-hospital conservative treatment subject to basket of care.	Yes, at least 48 hours prior to procedure for in-hospital and out-of-hospital conservative treatment.	Hospital in the Spinal Hospital Network
Spinal prostheses or devices	Paid in full, up to 100% of the Fund Rate if obtained from DSP.	If obtained from non-DSP provider, limited to R26 250 for one level; R52 500 for two or more levels.		DSP suppliers of the devices
Renal dialysis, including procedure, treatment and associated medication and drugs	100% of Fund rate	Unlimited cover	Yes	–

Service	Benefit	Limits (Subject to managed care rules and protocols)	Authorisation Requirements	Designated Service Provider (DSP/ Network Provider)
Drug and alcohol rehabilitation	100% of Fund rate, limited to PMB	Limited to 3 days in-hospital treatment for drug and alcohol detoxification. Limited to 21 days in-hospital treatment for drug and alcohol rehabilitation per beneficiary per year. The number of admissions for detoxification per year is unlimited if it is followed directly by rehabilitation. Once the rehabilitation limit is reached, subsequent detoxification will not be covered.	Yes, at least 48 hours prior to admission or first out-of-hospital consultation	SANCA, RAMOT or Nishtara Lodge
Internal prostheses	100% of Fund rate Multiple external and internal prostheses are subject to a joint overall limit of R95 000 per beneficiary per year and to the sub-limits as indicated	The following limits apply per prostheses type per procedure per year: Hip or Knee replacement devices Unlimited if supplied by a Network provider. Limited to R30 900 per prosthesis per admission if obtained from a non-network provider	Yes. as part of the related hospitalisation	–
		Shoulder replacement devices Unlimited if prosthesis is supplied by the Fund's network provider. Limited to R42 950 per prosthesis per admission if the prosthesis is not supplied by the Fund's network provider **Artificial Limbs** Below the knee R25 300 Above the knee R42 500 **Artificial eyes** R25 300 **Finger joint prostheses** R6 300 **Pacemakers** Unlimited if pacemaker is supplied by the Fund's Network provider. If not supplied by the Fund's Network supplier, paid up the Fund rate for the device **Internal cardiac defibrillator** Unlimited from a Network provider. If not supplied by the Network provider, paid up to the Fund rate for the device **Cardiac valves** (each) R40 300 **Aortic aneurism repair grafts** R168 300 **Cardiac stents** (maximum of 3 stents per beneficiary per year) Unlimited if stent is supplied by the Fund's network provider. Limited if device is not supplied by a network provider: Drug-eluting stent: R14 520 Bare metal stent: R10 330		

Service	Benefit	Limits (Subject to managed care rules and protocols)	Authorisation Requirements	Designated Service Provider (DSP/ Network Provider)
Dentistry: maxillo-facial surgery	100% of Fund rate	Unlimited	Yes, at least 48 hours prior to admission or within 24 hours of an emergency admission	–
Admission to hospital				
Voluntary admission: Hospital stay and all related services including consultations, surgical procedures, treatment, medication, physiotherapy, anaesthetics, etc.	100% of Fund rate	Unlimited cover	Yes, at least 48 hours prior to admission or within 24 hours of an emergency admission	KeyCare Hospital Network for all planned PMB
#Emergency/involuntary non-DSP admission: qualifies for the same benefits as for a DSP hospital admission	100% of Fund rate, subject to PMB	Unlimited cover	Yes, at least 48 hours prior to admission or within 24 hours of an emergency admission	KeyCare Hospital Network/hospitals with whom the Fund contracted at agreed rates
#emergency as defined in The Medical Schemes Act, No. 131 of 1998				
Motor vehicle accidents and third party claims				
Payment is subject to an undertaking and completion of an accident injury form and report by the member	100% of Fund rate	Unlimited cover	Yes, at least 48 hours prior to admission or within 24 hours of an emergency admission	KeyCare Hospital Network/hospitals with whom the Fund contracted at agreed rates
Post-operative therapy and rehabilitation				
Post-operative therapy and rehabilitation	100% of Fund rate	Post–operative physiotherapy, occupational and speech therapy, limited to a six-week period for the same condition for which the patient was hospitalised	Yes, before treatment commences	–
	100% of cost	Surgical appliances		
Out-of-hospital cover				
Chronic medication				
PMB CDL Chronic medication benefit is applicable to members and/or dependants registered on the Chronic Illness Benefit	100% of Fund rate	Unlimited cover (subject to MMAP, chronic medicine list and PMBs)	Yes, once diagnosed	Any pharmacy or dispensing doctor
Bluetooth-enabled glucose monitoring device	100% of the Fund rate	Limited to one device per person	Registration for Diabetes on the Chronic medication benefit	At Network pharmacy
Non-PMB Chronic medication	100% of the Fund Medicine Rate (MMAP)	Includes cover for approved medication and injections where ongoing treatment is required in excess of three months. Limited to R14 700 for a single member and R28 700 per family per year	Yes, once diagnosed	Any pharmacy or dispensing doctor
Specialised medication benefit	100% of Fund rate. In certain instances a co-payment may apply	Limited to R167 500 per family per year	Benefits for a defined list of specialised medication, authorised based on clinical motivation by the treating healthcare professional	Co-payments applied by the pharmacy must be paid by the member, directly to the pharmacy
Outpatient procedures and emergency visits				
Outpatient or casualty procedure that results from a procedure previously requiring hospital admission (within 48 hours post-event)	100% of Fund rate	Unlimited cover	Yes, at least 48 hours prior to procedure or within 24 hours of an emergency admission	At DSP

Service	Benefit	Limits (Subject to managed care rules and protocols)	Authorisation Requirements	Designated Service Provider (DSP/ Network Provider)
Outpatient or casualty consultations, procedures, medication and treatment defined as an #emergency	100% of Fund rate	Unlimited cover	None	At DSP
Specialist and GP consultations and treatment out-of-hospital – includes cover for face-to-face, tele- and virtual consultations (as may be appropriate)				
Consultations, material and visits (including outpatient visits)	100% of DSP or Fund rate from MSA, once MSA is depleted, up to the Primary Care (day-to-day limit)	M R3 000 M + 1 R4 900 M + 2 R5 800 M + 3 R6 300 M + 4 R7 300	Paid in full at DSP for PMB or non-PMB services. If services of non-DSP providers are used, paid up to 100% of the Fund rate only	DSP: Discovery GP Network Premier A or Premier B Specialist Networks
Specialist and GP consultations and treatment out-of-hospital (continued)				
Procedures performed in doctors' rooms (Specialists and GPs)	100% of Fund rate	Unlimited		–
Diabetes or Cardio Care Programmes	100% of the Fund Rate	Non PMB, GP-related services in a defined basket of care	Subject to referral by the Network GP and registration on the Chronic Illness Benefit for the related conditions	Premier Plus GPs in the Discovery GP Network
Mental Health Care Programme	100% of the Fund Rate	Non PMB, GP-related services in a defined basket of care	Subject to referral by the Network GP	Premier Plus GPs in the Discovery GP Network
Oncology				
Any oncology treatment including chemotherapy, medicines and materials used, radiation in- and out-of-hospital and PET scans	100% of Fund rate	A threshold of R220 000 applies per beneficiary per year, subject to Prescribed Minimum Benefit. Once the threshold is reached, non-PMB claims are paid at 80% of the Fund rate	Yes, registration on oncology programme required and submission of a treatment plan	Use of DSP
Stoma and oxygen products	100% of Fund rate	Subject to joint limit of R28 200 per family per year for Stoma therapy and Oxygen devices		Use of DSP
Advanced Illness Member Support Programme provides comprehensive out-of-hospital palliative care for members with end-of-life stage cancer and other diseases	100% of the Fund Rate, unless PMB	Unlimited	Yes, subject to the Fund initiating registration on the Programme Subject to clinical criteria. Psychosocial support, medical care from dedicated teams and Hospice, supportive treatment such as oxygen, pain control and home-based nursing.	Applicable DSP and/ or Networks for the specific services rendered
Radiology and pathology				
Radiology and Pathology: including all radiology and pathology, X-rays Includes endoscopic investigations performed in doctors' rooms	100% of Fund rate	Unlimited cover	Yes, forms part of a related hospitalisation Endoscopic investigations preformed in doctor's rooms do not require authorisation	Use of DSP: Ampath, Lancet and Pathcare
Specialised radiology				
MRI and CT scans	100% of Fund rate	Limited to 2 scans per beneficiary per year in- and out-of-hospital, subject to Prescribed Minimum Benefits	Yes, at least 48 hours prior to procedure.	–

Service	Benefit	Limits (Subject to managed care rules and protocols)	Authorisation Requirements	Designated Service Provider (DSP/ Network Provider)
Clinical and medical technologists				
Clinical and medical technologists: includes services rendered, materials and apparatus supplied	100% of Fund rate	Unlimited cover	No pre-authorisation required	–
Maternity benefit				
Hospital and confinements, water births and pre- and post-natal care by a midwife. Includes cover for face-to-face, tele- and virtual consultations, as may be appropriate	100% of the Fund Rate	Unlimited cover	Yes, registration on the Maternity Programme	
The following benefits apply specifically in relation to pre- and post-natal care and children under the age of 2 years. The benefits will not be paid for from the Primary Care Benefits				
Midwife, GP or gynaecologist ante-natal consultations during pregnancy	100% of the Fund Rate	Limited to 12 visits per pregnancy per year	Yes, registration on the Maternity Programme	DSP GP or Specialists
Midwife, GP or gynaecologist consultation after the delivery	100% of the Fund Rate	Limited to 1 visit per pregnancy	Yes, registration on the Maternity Programme	DSP GP or Specialists
Consultations with a counsellor or psychologist for post-natal mental healthcare services	100% of the Fund Rate	Limited to 2 sessions per pregnancy	Yes, registration on the Maternity Programme	
Lactation consultation with a registered nurse or lactation specialist	100% of the Fund Rate	Limited to 1 consultation per pregnancy	Yes, registration on the Maternity Programme	
GP, paediatrician or ENT visits for registered children under the age of 2 years	100% of the Fund Rate	2 visits per child 2 years or younger	Yes, registration on the Maternity Programme	DSP GP or Specialists
Ante-natal ultrasound examinations	100% of the Fund Rate	Limited to 2 examinations per pregnancy. All ultrasound scans, including 3D and 4D scans, paid at the rate for 2D scans only	Yes, registration on the Maternity Programme	
Ante-natal classes (in- and out of hospital) or pre-and-post natal consultations with a registered nurse *Includes exercise classes and/or visits*	100% of the Fund Rate	Limited to 5 classes per confinement	Yes, registration on the Maternity Programme	
Nutrition assessment with a dietician after the delivery	100% of the Fund rate	Limited to 1 assessment per confinement	Yes, registration on the Maternity Programme	
Pathology	100% of the Fund Rate	Restricted to benefits for a defined basket of pregnancy-related blood tests only	Yes, registration on the Maternity Programme	Fund Network provider
Genetic or chromosome screenings	100% of the Fund Rate	One of the listed tests, per pregnancy ■ Nuchal Translucency Test, or ■ Non-invasive Prenatal Test (NIPT), or ■ T21 Chromosome Test	Yes, registration on the Maternity Programme	
Pregnancy-related External Medical Items (for registered essential devices such as breast pumps or nebulisers)	75% of the Fund Rate	Limited to R5 350 per pregnancy Note: the 25% shortfall amount will not be funded from MSA	Yes, registration on the Maternity Programme	
Chronic appliances				
Oxygen therapy, including oxygen products, cylinders, ventilation expenses, and stoma products	100% of Fund rate	Subject to joint limit of R28 200 per family per year	Yes, subject to management and prior approval by the Fund	Subject to DSP

Service	Benefit	Limits (Subject to managed care rules and protocols)	Authorisation Requirements	Designated Service Provider (DSP/ Network Provider)
Medical and surgical appliances – excludes benefits for internal medical appliances and prostheses listed above, but includes conditions not covered under the post-operative/rehabilitation benefit				
Medical and surgical appliances, including Wheelchairs and Hearing Aids. (Includes the net cost after discount for the supply and fitment of hearing aids and hearing aid repairs)	100% of Fund rate	Limited to R28 200 per family per year	No pre-authorisation required	–
Second hearing aid (issued in the same year for the same family member)		Limited to R13 800 per family per year	Subject to clinical criteria, motivation and authorisation	
Dentistry				
Basic Dentistry	100% of Fund rate from MSA. Once MSA is depleted, up to the Primary Care (day-to-day) limit	M R4 200 M + 1 R5 300 M + 2 R6 500 M + 3 R8 000 M + 4+ R9 300	None	
Specialised dentistry. Includes: inlays, crowns, bridges, study models, metal-base dentures and the repair thereof, oral medicine, periodontics, orthodontics, prosthodontics and osseo-integrated implantology	100% Fund rate from Insured Benefits	M R9 400 M + 1 R13 000 M + 2 R16 300 M + 3 R19 100 M + 4+ R20 900	None (unless in-hospital treatment is required) Benefit confirmation is required for orthodontic work	In-hospital dentistry and maxillo-facial surgery: refer to in-hospital cover above
In-hospital dentistry and maxillo-facial surgery: refer to in-hospital cover above				
Blood transfusions				
Blood transfusions	100% of Fund rate, subject to Prescribed Minimum Benefits	Unlimited cover	No authorisation required	–
Ambulance services				
Air and road emergency services for emergency medical transport or inter-hospital transfers	100% of Fund rate at DSP	Unlimited if ER24 is used	Yes, subject to authorisation Any unauthorised use of ambulance services will be limited to the Fund rate, negotiated with the DSP and be subject to Prescribed Minimum Benefits	Through DSP ER24
Step-down, recuperation and rehabilitation facilities				
Step down, sub-acute (physical) rehabilitation facilities In lieu of hospitalisation. Subject to Managed Care Rules and Protocols	100% of Fund rate	Unlimited	Yes, subject to authorisation. Services must follow pre-authorised hospitalisation	Subject to DSP/facilities with whom the Fund has negotiated agreed rates

Service	Benefit	Limits (Subject to managed care rules and protocols)	Authorisation Requirements	Designated Service Provider (DSP/ Network Provider)
Home-based acute care Includes devices for home-monitoring (based on clinical need) for qualifying members ■ in lieu of hospitalisation, or ■ after early discharge, or ■ as a continuation of care after discharge from hospital, or ■ home-based readmission prevention	100% of the Fund Rate	Unlimited	Subject to clinical criteria and pre-authorisation Subject to the Fund's basket of care	Applicable DSP and/or Networks for the specific services rendered
Private nursing and registered private nurse practitioners, including frail/hospice care				
Private nursing and registered private nurse practitioners, including frail/hospice care	100% of Fund rate from MSA. Once MSA is depleted, 80% of Fund rate from Primary Care (day-to-day benefits)	R28 700 per family per year	Yes, subject to authorisation. Services must follow pre-authorised hospitalisation	–
HIV management				
HIV treatment	100% of Fund rate	Unlimited cover, subject to formularies	Yes	PMB DSP Hospitals/ DSP HIV Premier Plus GPs
Screening and Preventative Care Benefits OMB DSP Hospitals/DSP Premier GPs				
Pharmacy screening benefits				
Pharmacy Screening Benefit for adults	100% of the Fund Rate	1 or all of these tests (if conducted at the same time) per beneficiary per year ■ Blood glucose test ■ Blood pressure test ■ Total serum cholesterol test ■ BMI		At an accredited provider in the Fund's Network, and participating pharmacies
Pharmacy screening benefit for children	100% of the Fund Rate	1 or all of these tests (if conducted at the same time) per beneficiary per year ■ Basic hearing and dental screenings ■ Body mass index for children between the ages of 2 up until their 18th birthday (including counselling) ■ Head circumference for children between 2 and 5 years old ■ Blood pressure for children between the ages of 3 up until their 18th birthday Health behaviour and milestone tracking for children between the ages of 2 up until their 18th birthday		At an accredited provider in the Fund's Network, and participating pharmacies
Other screening benefits				
Pap smear (benefit for LBC/PAP smear)	100% of the Fund Rate	One screening test every 3 years (Count started in 2020) One screening test every year for HIV positive beneficiaries or beneficiaries with an abnormal Pap smear result Subject to clinical entry criteria and authorisation		

Service	Benefit	Limits (Subject to managed care rules and protocols)	Authorisation Requirements	Designated Service Provider (DSP/ Network Provider)
Mammogram	100% of the Fund Rate	One Mammogram (inclusive of an ultrasound) paid every 2 years. (Count started in 2020) One Mammogram or MRI breast screening paid every year and a once off BRCA testing for at risk beneficiaries. Subject to clinical entry criteria and authorisation		
Faecal Occult Blood Test (or faecal immunochemical test)	100% of the Fund Rate	1 of the listed tests paid every 2 years for all beneficiaries between the ages of 45 and 75. (Count started in 2020) 1 Colonoscopy per year for at risk members, or those with a positive test result. Subject to clinical entry criteria		
Trauma recovery benefit				
Cover for specific trauma-related incidents. The benefit is paid up to the end of the year following the one in which the traumatic event occurred. Benefits are paid according to the general Rules in terms of Designated Service Providers and clinical entry criteria	100% of the Fund Rate	Allied and therapeutic healthcare services M R20 950 M + 1 R28 450 M + 2 R34 700 M + 3 R40 250	Subject to clinical criteria and authorisation	
		External medical and surgical items R28 200 (per family)	Wheelchairs, hearing aids, crutches and other external medical items paid up to the annual limit for medical and surgical items. Second hearing aid limited to R13 800 per beneficiary per year, subject to authorisation	
		Prescribed medicine M R5 800 M + 1 R8 600 M + 2 R9 900 M + 3 R11 400 M + 4+ R12 700	Joint limits for all Prescribed Medicine, whether trauma-related or not	
		Prosthetic limbs R88 250 (per beneficiary) (with no further access to the external medical items limit)	Applies where the loss of limb was due to a trauma. These costs do not add up to any other prostheses limits.	

Service	Benefit	Limits (Subject to managed care rules and protocols)	Authorisation Requirements	Designated Service Provider (DSP/ Network Provider)
World Health Organization (WHO) Global Outbreak Benefit	For out-of-hospital management and supportive treatment of global WHO recognised disease outbreaks. Subject to Prescribed Minimum Benefits, the use of the services of the Fund's DSP/Preferred providers as applicable, protocols and the condition and treatment meeting the Fund's entry criteria and guidelines.			
COVID-19				
Consultations: Screening and/or other consultations with a nurse or GP Consultations for members identified to be at-risk due to co-morbidities	100% of the agreed rate at DSP for PMB or 100% of Fund Rate for non-DSP or non-PMB	Unlimited	Subject to the use of the services of a DSP GP Limited to 1 Virtual consultation with a nurse or GP at a DSP Pharmacy	DSP GPs/Preferred Provider Nurses/DSP Pharmacies
Pathology		Limited to 2 PCR tests per person per year, subject to PMB and 2 pre-admission PCR tests per asymptomatic person per year	Limited to a defined basket of pathology, subject to referral by healthcare practitioner	DSP GP/Specialists
X-rays or scans		Unlimited	Limited to a defined basket of X-rays and scans	
Home monitoring of at-risk COVID-19 positive patients		Unlimited	1 Pulse Oximeter person and up to 3 consultations with a wellness consultant	Preferred Providers
Vaccines Including administration costs		Unlimited	Clinical guidelines apply	
Out-of-hospital treatment and care of long COVID-19 Available to patients for whom the symptoms of the infection persist after 21 days of the initial infection		Unlimited	Yes, subject to authorisation and a basket of care	DSP GPs/Preferred Provider Nurses

Primary Care (day-to-day benefits), subject to payment from the Medical Savings Account

Primary Care (day-to-day) benefits are first paid from the MSA. Once the MSA is exhausted for the year, benefits are paid as described below.
The MSA, available upfront for the year, is equal to 10% of the total annual contribution for the member/member family

Consultations and non-surgical procedures						
General Practitioner, medical specialists, homeopaths, naturopaths and registered private nurse practitioners, including services and fees charged on an outpatient basis Cover for face-to-face, tele- and virtual consultations	100% of the agreed or Fund rate for GPs and Specialists. Other providers paid at 100% of the Fund rate	M M + 1 M + 2 M + 3 M + 4+	R3 000 R4 900 R5 800 R6 300 R7 300	Registered private nurse practitioner's consultations and services include the cost of vaccinations and injection material, e.g. the administering of mumps, measles and rubella (MMR) vaccinations PMB-related conditions, including the 270 DTPs, in-hospital and ante-natal consultations are not included under this benefit	Subject to DSP: Discovery GP Network and Premier A or Premier B Specialist Network
Acute, homeopathic and naturopathic medicine						
Acute, homeopathic and naturopathic medicine	100% MMAP from MSA, then from Primary Care (day-to-day) limit	M M + 1 M + 2 M + 3 M + 4+	R5 800 R8 600 R9 900 R11 400 R12 700	Includes medicine, material for injections and vaccinations and medicine dispensed to outpatients	–	

Service	Benefit	Limits (Subject to managed care rules and protocols)	Authorisation Requirements	Designated Service Provider (DSP/ Network Provider)
Self-medication Over-the-counter (OTC) medication	100% of cost	R310 per prescription per beneficiary per day and available funds from the MSA	Only medicine that a pharmacist is entitled to prescribe and dispense	–
Optical				
Eye tests and tonometry tests	100% of Fund Rate from MSA. Simultaneously accrues to the optical limit	1 eye test and 1 tonometry test per beneficiary per year	Tests must be performed by a registered optometrist	–
Spectacles, lenses, frames and contact lenses Includes cover for hardening, tinting, reflective lens coating and refractive eye surgery	100% of The Fund rate, from MSA. Simultaneously accrues to the optical limit	Single member R5 200 Family R10 500 The above includes a frame sub-limit of R1 700 per beneficiary per year every two years from date of last service	Sunglasses, spectacle cases, solutions or kits for contact lenses are excluded	–
Paramedical and associated healthcare services – includes cover for face-to-face, tele- and virtual consultations (where appropriate)				
Acupuncture	80% of Fund rate	Limited to R1 900 per family per year		–
Chiropractic treatment		Limited to R3 500 per family per year Any one consultation limited to the rate at which the Fund will reimburse a GP consultation	Includes the cost of treatment and X-rays	–
Dietetics		Limited to R1 200 per family per year		–
Non-surgical prostheses (for which a benefit is not provided elsewhere in this Schedule)	80% of cost	Limited to R3 400 per family per year	For example crutches and other smaller devices	–
Audiology and speech therapy	80% of Fund rate	Limited to R3 400 per family per year		–
Occupational therapy		Limited to R3 400 per family per year		–
Physiotherapy, biokinetics		Limited to R3 400 per family per year		
Private nursing and registered private nurse practitioners, including frail/hospice care		Limited to R28 700 per family per year	Subject to case management and prior approval Includes private nursing/frail care/ hospice treatment prescribed by a medical practitioner, excludes general care	–
Podiatry/Chiropody		Limited to R2 300 per family per year	Must be prescribed by a medical practitioner	
Clinical Psychology: consultations, therapy, treatment	PMB: 100% of Fund rate Non-PMB: 80% of lesser of the claimed amount or the Fund rate	Limited to R9 400 per family per year, subject to Prescribed Minimum Benefits		–
Preventative care				
Smoking cessation	100% of Fund rate	Limited to R760 per beneficiary per month from the MSA	Claims paid from MSA will be reimbursed, subject to a negative nicotine test result	–
Human Papiloma Virus (HPV) Screening	100% of Fund rate	Limited to R590 per beneficiary per year from the MSA	Used as a screening test for female members who receive abnormal results after a cervical cystology screening test (abnormal PAP test)	
Implanon contraceptive device	100% of Fund rate	Limited to MSA		

SPECIAL FEATURES

SUBSTANCE ABUSE FOCUS

You have access to South African National Council on Alcoholism and Drug Dependence (SANCA) approved facilities as in-patients for drug and alcohol rehabilitation. Please contact the Client Service Department for confidential support and a referral to an appropriate treatment facility, should you be in need of assistance. Daily limits and annual limits apply, and pre-authorisation is compulsory.

ONCOLOGY PROGRAMME

Members registered on the Oncology Programme have access to chemotherapy, medicines and materials, radiation in- and out-of-hospital and PET scans. All Oncology treatment allocates to a threshold, whereafter non-PMB treatment pays at 80% of the Fund Rate only.

If the treatment is PMB-related, the Fund will continue to pay for any authorised treatment that may still be necessary. You must make use of the Fund's DSPs, where applicable.

HIV/AIDS MANAGEMENT PROGRAMME

It has been demonstrated that by proactively managing HIV or AIDS, those who have been diagnosed as HIV positive, can live a healthy and fulfilling life. When you register for our HIV Programme you are covered for the care that you need. You can be assured of confidentiality at all times. Call us on 0800 001 615 or email hiv@engenmed.co.za to register.

EMERGENCY MEDICAL EVACUATIONS – ER24

If you ever find yourself in a situation where you require emergency transport for medical reasons, you are in the very best hands. The ambulance benefits, which are covered under insured benefits, include medically appropriate emergency transport response services provided by ER24. This benefit is available by contacting 084 124.

SELF SERVICE FACILITIES

The Fund's website has been specifically developed for the benefit of members, and by registering on the site, you are able to review your monthly statements, claims and personal information on-line.

To register, simply visit www.engenmed.co.za and register by entering your membership number and identification or passport number.

Trauma Recovery Benefit

The Trauma Recovery Benefit helps to preserve the funds in your Medical Savings Account and Primary Care benefit after certain traumatic events, by providing access to additional cover for specific day-to-day treatment. The benefit pays certain day-to-day medical care costs related to the traumatic event in the year it happened, and in the year after it happened, without using the funds in your Medical Savings Account or the Primary Care Benefit.

The benefit is subject to specific clinical criteria related to certain traumatic events or conditions, and registration. Your access to the benefit is activated after admission into hospital for one of the specific traumas, once the event has been appropriately reviewed and the benefits have been approved. Specific, limited day-to-day benefits will be provided for the following trauma-related events or conditions:

- Crime-related injuries, Conditions related to near drowning, Poisoning or Severe anaphylactic (allergic) reactions requiring more than five days stay in an ICU
- Paraplegia (paralysis of the lower half of the body affecting both legs, for example due to a blunt force injury of the spinal cord); or
- Quadriplegia (paralysis of both arms and legs, for example due to a blunt force injury to the spinal cord
- Severe burns
- External or internal head injuries
- Loss of a limb or limbs

ADMINISTRATIVE REQUIREMENTS

CLAIMS ADMINISTRATION

To qualify for benefits, a claim must be submitted to the Fund by not later than the last day of the fourth month, following the month in which the service was rendered. If you believe a claim has been rejected in error, you have 60 days to report the error and resubmit the claim failing which the claim will be classified as stale

As the member of the Fund you are responsible for monitoring and reviewing your claims notifications/ statements and for acting promptly where a claim is not reflecting, or has not been paid. This will ensure that such claims do not become stale. Claims submitted after they have become stale, will not be paid by the Fund (in line with Regulation 6 of the Medical Schemes Act No.131 of 1998).

If you pay cash for any services received, remember to submit the claim with the receipt as proof of payment, using the appropriate 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).

As a member you are responsible for ensuring the Fund is informed of any changes to your banking details.

Please note: changing your banking details with your Human Resources (HR) Department does not update your banking details with the Fund. You can safely update your bank account details online on the Fund's website or complete the appropriate form and submit it to the Fund, so we can make the changes.

Payment of claims is always subject to Fund Rules, rates and limits, and Managed Care Protocols and Guidelines may apply.

Remember to obtain pre-authorisation at least 48 hours prior to a planned event or within 24 hours following an emergency

Membership statements

Claims notifications will be sent to you electronically where we have your email details. Member statements will also be available on the Fund's website **www.engenmed.co.za**. Please note that statements will only be prepared when you claim from the Fund.

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) will be allocated to the MSA and R900 towards the Fund's risk pool.
- If you have a positive balance in the MSA at month-end, we will add interest on that amount.
- If you resign from the Fund, any MSA balance will be kept for a 4 month period to settle any claims that were incurred before your resignation. Any remaining, positive MSA balance will be paid out to you in the 5th month after your resignation, or be transferred to your new medical scheme (if you will have a MSA benefit at the new scheme).
- On termination of membership, the Fund may use any positive balance in the MSA to offset any debt you owe to the Fund, which may include outstanding contributions.
- The Fund advances 12 months of MSA to you effective 1 January of each year. Overdrawn MSA (i.e. if you have used an amount from your advanced MSA that exceeds the amount you have contributed at the time of your resignation) will have to be repaid when you resign from 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 MSA available at the end of the financial year (31 December) the positive balance will be carried over to the next year.
- In the unfortunate event of your death, the MSA balance due to you will be transferred to your dependants should they decide to continue membership of the Fund or, in the absence of such dependants, paid into your estate.

WHAT THE FUND DOES NOT COVER

There are certain medical expenses the Fund does not cover. We call these exclusions.

Exclusions are placed on benefits to protect all members of the Fund from unnecessary events and treatments that may be abused or cause the general cost of the Fund's contributions to become unaffordable.

THE FUND WILL NOT COVER THE DIRECT OR INDIRECT CONSEQUENCES OF THE FOLLOWING, EXCEPT AS REGULATED IN THE PRESCRIBED MINIMUM BENEFITS:

- Cosmetic procedures, for example, otoplasty for jug ears; removal of portwine stains; blepheroplasty (eyelid surgery); removal of keloid scars; hair removal; nasal reconstruction (including septoplasties, osteotomies and nasal tip surgery); and healthcare services related to gender reassignment
- Treatment for obesity
- Treatment for infertility, subject to Prescribed Minimum Benefits
- Frail care (care not related to a medical condition)
- Experimental, unproven or unregistered treatment or practices
- CT angiogram of the coronary vessels and CT colonoscopy
- The purchase of the following, unless prescribed:
  - Applicators, toiletries and beauty preparations;
  - Bandages, cotton wool and other consumable items such as dental floss, toothbrushes or toothpaste eye solutions or kits for contact lenses;
  - Patented foods, including baby foods;
  - Tonics, slimming preparations and drugs;
  - Household and biochemical remedies;
  - Anabolic steroids;
  - Multivitamins and;
  - Sunscreen agents.

Unless otherwise decided by the Fund, benefits in respect of these items, on prescription, are limited to one month's supply for every prescription or repeat thereof.

- Costs of search and rescue
- Any costs that another party is legally responsible for
- Facility fees at casualty facilities (these are administration fees that are charged directly by the hospital or other casualty facility), unless stated differently for specific benefits
- Costs related to participation in reckless activities where, based on an objective test for reasonable behavior, the Beneficiary is deemed to be risking injury recklessly, such activities as solo-mountaineering, speed contests and extreme endurance marathons
- Willfully, self-inflicted injuries, except PMB, subject to clinical review
- Bleaching of vital teeth, metal inlays in dentures and front teeth
- Examination for insurance, school camps, visa, employment or executive purposes
- Accommodation in old age homes, spas or resorts
- Healthcare appointments not kept
- Travelling costs, except emergency medical transportation as authorised
- Sunglasses or spectacle cases
- Accommodation and/or treatment in headache or stress relief clinics.

IMPORTANT TERMINOLOGY

CO-PAYMENT

A co-payment is a fee that you are required to pay directly to the service provider if there is a difference between the cover provided by the Fund and the cost charged by the service provider. Co-payments will also apply if you do not make use of appointed DSPs.

DESIGNATED SERVICE PROVIDERS (DSP)

Designated Service Providers are healthcare professionals with whom the Fund has made special arrangements to provide members with effective and cost-efficient services in relation to Prescribed Minimum Benefits (PMB), and in some instances, non-PMB care.

These healthcare professionals will not request upfront payment from you as their claims are paid in full.

Where the use of DSP is indicated, you must make use of their services. If you choose not to use the DSP services, claims from non-DSP providers will be paid up to the Fund rate only, and co-payments will apply.

The following are DSPs:

- the Discovery GP Network;
- the Premier A and B Specialist Networks;
- Hospitals in the KeyCare Network;
- ER24 for emergency medical transportation.

Your chosen Discovery Health Premier GP for HIV, Diabetes, Mental Health and Cardio Care, and nurses contracted to the Scheme to deliver home-based care in lieu of hospitalisation.

You can find information about a DSP near you on www.engenmed.co.za

EMERGENCY MEDICAL CONDITION

An emergency medical condition is any sudden and unexpected onset of a health condition that requires immediate medical or surgical treatment, where failure to provide such 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.

MMAP (MAXIMUM MEDICAL AID PRICE)

MMAP (Maximum Medical Aid Price) is a reference price model which serves as a guide to determine the maximum medical scheme price that schemes will reimburse for a pharmaceutical product that is interchangeable with other more cost-effective alternatives.

Co-payments that may result from MMAP pricing can be avoided by using alternative products that are less expensive, such as generic medicine. The Fund Medicine rate is based on MMAP. The use of the most appropriate alternative should always be discussed with your treating practitioner or pharmacist.

FUND RATE

The Fund rate is the rate at which the Fund will pay for medical services as approved by the Board of Trustees. This rate is based on the Discovery Health rate.

PRIORITY EMERGENCIES

There are instances where treatment at a DSP out-patient or emergency department is classified as an emergency although it may not be a PMB. The Fund will pay for such emergencies from the insured (risk) benefit and not from your MSA.

PREFERRED PROVIDERS

Preferred Providers are healthcare professionals with whom the Fund has made special arrangements to provide members with effective and cost-efficient services.

These healthcare professionals will not request upfront payment from you. The Fund does not restrict you to utilise the services of these Preferred Providers.

Rather we recommend their use, where they are available, to optimise benefits and minimise co-payments. If you make use of the services of non-preferred providers, claims will be paid up to the Fund rate only, and you will have to pay for any shortfalls.

PRESCRIBED MINIMUM BENEFITS (PMBs)

Prescribed Minimum Benefits are defined in the regulations of the Medical Schemes Act, No. 131 of 1998, as being the minimum level of benefits that are available to all medical scheme members and their dependants. The diagnosis, medical management and treatment for these benefits are not limited and are paid according to specific codes, treatment plans and conditions. You must use the services of the Fund's appointed Designated Service Providers for PMBs. A total of 270 diagnoses and 26 chronic conditions are listed as PMBs.

COMBATING FRAUD

Healthcare provider claims are normally paid in good faith. Claiming patterns and behaviours are only properly reviewed and validated after payment has been made. Discovery Health has a large database, which allows for the detection of unusual conduct or discrepancies. If an irregularity warrants an investigation by the Forensic Department, the relevant provider, or member, is always given the opportunity to respond.

If, however, it becomes clear from the investigation that someone has committed fraud, the perpetrator may face criminal or civil charges. If a healthcare professional is involved, fraudulent activity may result in the provider losing a career in healthcare by having their required professional registration cancelled. The Fund may also no longer pay the provider directly, or not at all. Members who are guilty of committing fraud, could lose their healthcare cover altogether and employees could face disciplinary action and be fired.

HOW YOU CAN HELP COMBAT FRAUD

If you have even the slightest suspicion that someone is committing fraud, report all information you have to the Discovery fraud hotline, using any of the following contact details:

- Toll-free phone: 0800 004 500
- SMS: 43477
- Toll-free fax: 0800 007 788
- Email: discovery@tip-offs.com
- Post: Freepost DN298, Umhlanga Rocks. 4320
- Or send an email directly to the fraud department: discovery@tip-offs.com

You may remain anonymous and we will handle all calls and contact in strict confidentiality. We will list any person found guilty of committing fraud on a register and take steps to recover any money members, or the Fund, may have lost in the process.

Ex-Gratia Policy

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

The Board of Trustees may, in its absolute discretion, increase the amount payable in terms of the Rules of the Fund , or grant additional benefits, as an Ex-Gratia award. The Board has appointed and mandated the Ex-Gratia Committee to review the applications and motivations received, and to act on behalf of the Board of Trustees in making funding decisions for each case. Ex-Gratia requests are considered on an individual basis and any decision made, will in no way set a precedent or determine future policy. Decisions taken by this Committee are final and are not subject to appeal or dispute and do not set a precedent.

COMPLAINTS AND APPEALS PROCESS

If you are not satisfied with the manner in which your claims were processed or wish to lodge a complaint, the process you need to follow is:

1. Contact the Fund's Client Service Department during office hours and try to resolve your query.
2. If the result is not considered to be satisfactory by you, you may ask that it be escalated to more senior resources in the Administrator's Service Team, such as a Team Leader or Manager.
3. If you are not satisfied, you may in writing request the Principal Officer of the Fund to attend to the matter. You can send the query to the normal email or postal addresses of the Fund, but address it to the Principal Officer.
4. Should you not accept the outcome of the escalation process to the Principal Officer, you may lodge a complaint in writing, for the attention of the Fund's Disputes Committee, c/o The Principal Officer, (the details are available on the website). The Disputes Committee will meet to decide on your complaint or dispute, and determine the procedure to be followed. You have the right to be heard at these proceedings, either in person or through a representative.
5. If you are still dissatisfied after the decision made by the Disputes Committee, you may take your appeal further by approaching the Council for Medical Schemes for resolution.

Council for Medical Schemes
Block A Eco Glades 2 Office Park
420 Witch-Hazel Street
Ecopark Centurion 0157
Telephone: 012 431 0500
Fax: 012 431 7544
Customer care call number: 0861 123 267
Email address: complaints@medicalschemes.co.za

PROTECTING YOUR PERSONAL INFORMATION

Personal information about you, your spouse and your dependants includes information about their health, financial status, gender, age, contact numbers and addresses.

When you become a member of the Fund, you trust us with personal information about yourself and your dependants. We are committed to protecting your right to privacy. We collect, use, share and otherwise process your personal information in line with the Protection of Personal Information Act ("POPIA") for the following purposes:

- for the administration of your benefits;
- for the provision of managed care services to you;
- for the provision of relevant information to a contracted third party who requires this information to provide a healthcare service to you;
- to analyse risks, trends and profiles;
- to share your personal information with external health care providers for the purposes of evaluating certain clinical information, when you require medical treatment.

Examples of this include:

- Getting your personal information from other relevant sources, including healthcare providers, contracted service providers and further processing of such information to assess and value a claim for medical expenses. We may at any time verify with the relevant sources that your personal information is true, correct and complete;
- Getting information from, and sharing information with your employer, that is relevant to your application for membership, with due regard for considerations of confidentiality in respect of your state of health;
- Communicating with you about any benefit or contribution changes.

If a third party, even your own wife or husband, asks the Fund or Administrator for any of your personal information, we will share it with them only if:

- you have already given your consent for the disclosure of this information to that third party; or
- we have a legal or contractual duty to give the information to that third party, or
- we need to share it with them for risk analytical or fraud detection, prevention or recovery purposes.

You must give consent for someone else to act on your behalf

If you want a third party to act on your behalf, for instance when you are in hospital, you must complete a 'Permission to make information available to a third party' form (available on the Fund's website or from the call centre). It is advisable that you consider your position on granting such access, and complete a consent form before you are no longer able to manage your own affairs. If you don't, the Fund will not be able to disclose your personal information to a person making enquiries on your behalf, even if that person is your spouse.

You have the right to know what personal information the Fund and Administrator holds about you. If you wish to receive this information please complete an 'Access Request Form', attached to the PAIA manual on the Fund's website, and specify the information you would like to receive. We will take all reasonable steps to confirm your identity before providing details of your personal information. We are entitled to charge a fee for this service and will let you know what it is at the time of your request.

If you believe we failed to adequately protect your information, we encourage you to first follow our internal complaints process to resolve the complaint. We explain the complaints and disputes process on the website (www.engenmed.co.za). If you are not satisfied after this process, you have the right to lodge a complaint with the Information Regulator.

CONTRIBUTIONS

– effective 1 January to 31 December 2022

The Scheme will only collect contributions for a maximum of four children, without limiting the number of child dependants that may be registered on the Fund. Penalties may be applied to a late joiner, in line with the Regulations to the Medical Schemes Act (Act 197 of 1998).

Total contributions, including contributions in respect of the individual medical savings account

Income Category	Total Contributions		
	Principal Member	Adult Dependant	Child Dependant
R0 – R6 150	R2 282	R2 011	R688
R6 151 – R17 800	R3 532	R2 792	R980
R17 801+	R4 324	R3 574	R1 188

CONTACT DETAILS

CLIENT SERVICE DEPARTMENT

For all your general enquiries (claims, membership, information, etc.)

Phone: 0800 001 615

Fax: 011 539 2766

service@engenmed.co.za

AMBULANCE AND MEDICAL EMERGENCY SERVICES

Phone: 084 124

MEMBER CLAIMS SUBMISSION

Postal address:

Claims Department PO Box 652509
Benmore 2010

claims@engenmed.co.za

Fax: 0860 329 252

MATERNITY REGISTRATION

0800 001 615

APPLIANCE AND PROSTHESES AUTHORISATIONS

0800 001 615

ONCOLOGY REGISTRATIONS AND AUTHORISATION

oncology@engenmed.co.za

WEBSITE QUERIES

webinfo@engenmed.co.za

CHRONIC MEDICATION AND RENAL DIALYSIS REGISTRATIONS AND QUERIES

chronicqueries@engenmed.co.za

CIB_APP_FORMS@engenmed.co.za

HIV REGISTRATION AND AUTHORISATION

hiv@engenmed.co.za

HOSPITAL AUTHORISATION

0800 001 615

ESCALATED COMPLAINTS

service@engenmed.co.za

REPORTING FRAUD

Report irregular or fraudulent claims.

Email: forensics@discovery.co.za

To stay anonymous, call our Fraud Hotline on 0800 004 500
or email: discovery@tip-offs.com

When sending through a report, please include your membership number and the details of the claim you are querying. If you have any general inquiries on your claims or policy, kindly email service@engenmed.co.za.

Engen Medical Benefit Fund, registration number 1572, is regulated by the Council for Medical Schemes and administered by Discovery Health (Pty) Ltd, registration number 1997/013480/07, an authorised financial services provider.

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