MBMED

2026
MEMBER GUIDE

Your health. Your benefits. Your best life.

1 GET IN TOUCH

GENERAL QUERIES ABOUT BENEFITS, CLAIMS & MEMBERSHIP

@ mbmed@medscheme.co.za

086 000 2109, Monday to Friday, 8:30 to 16:00

CLAIMS SUBMISSIONS

@ claims@medscheme.co.za

MEDICAL EMERGENCIES AND AMBULANCE SERVICES

NETCARE 911 – 082 911

HOSPITAL AND SPECIALISED RADIOLOGY AUTHORISATIONS

@ mbmed.authorisations@medscheme.co.za

0860 000 2109

MEMBER PORTAL: mbmedmembers.medscheme.co.za

EMAIL ADDRESSES TO RESOLVE YOUR QUERIES EVEN FASTER

To speed up member query turnaround times and avoid unnecessary delays, please use the email addresses below for your specific query or issue.


General enquiries, including specialist referral management and preferred general practitioners mbmed@medscheme.co.za


Dental and orthodontic quotes mbmeddental@medscheme.co.za


Hospital authorisations mbmed.authorisations@medscheme.co.za


Chronic medicine management mbmedcmm@medscheme.co.za


Queries for out-of-hospital (ambulatory*) Prescribed Minimum Benefits mbmedapmb@medscheme.co.za


Oncology management cancerinfo@medscheme.co.za


Aid for AIDS afa@afadm.co.za


Claims submissions claims@medscheme.co.za

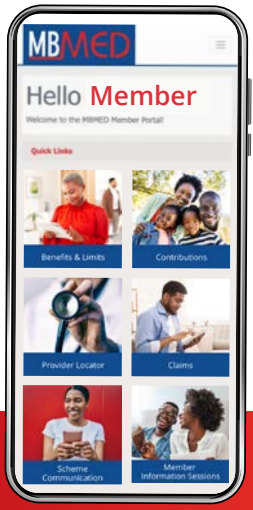

Ex gratia requests corpexgratia@medscheme.co.za


Membership mbmedmembership@medscheme.co.za

* Medical care (ambulatory care) that is provided on an outpatient basis, without the need for an overnight hospital stay

NOTE: This Member Guide is for information purposes only and does not supersede the Rules of the Scheme. In the event of any discrepancy the Rules will prevail. A copy of the Rules can be obtained from Medscheme, the Administrator for MBMed at mbmed@medscheme.co.za.

HOW TO REGISTER ON THE MEMBER PORTAL



By registering on the secure Member Portal, you can check up on claims and various benefits online, instead of having to contact the Scheme.

To register as a user on the MBMed Member Portal, simply follow the steps below:

1. Visit the MBMed website on mbmedmembers.medscheme.co.za.
2. Click on '***Register Main Member***'.
3. On the next screen, enter your membership number and click on the '***I agree to the MBMED terms & conditions***' check box. Click '***NEXT***'.
4. You will receive an OTP (One Time Pin) via SMS to your cellphone. Enter the OTP and click on '***Confirm OTP***'.
5. Complete the registration form and click on '***FINISH***'.
6. When you have registered, the sign in page will appear. Please use your registered email address and password to access the portal.

IMPORTANT: *Your email address and contact details must be correct and correspond with our records. When choosing and typing in a username and password, remember that the password is case-sensitive.*

What you will find on the Member Portal

- View your benefits and available benefit limits
- All personal and general communication
- AGM documents, Rules and forms
- Member Guide
- Medicine Price List (MPL)
- HealthCloud
- Provider locator for PGPs and specialists
- Claims history
- Submit claims
- Apply for chronic and hospital authorisations
- View your authorisation status
- Member Information Session slide packs

2 2026 MEMBER CONTRIBUTIONS

This table shows the **total** (member + employer) contribution and does not reflect the subsidy (if any) paid by Mercedes-Benz South Africa Ltd (MBSA) on your behalf. Please contact the MBSA Human Resources Division for details of the Company Medical Scheme Subsidy Policy.

	Income Band	Principal Member	Adult Dependant	Child Dependant
1	R0 - R29 819	R3 239	R2 666	R738
2	R29 820 - R33 469	R3 747	R3 084	R854
3	R33 470 - R44 909	R4 586	R3 818	R1 094
4	R44 910 – R46 599	R4 613	R3 839	R1 151
5	R46 600 - R58 869	R4 923	R4 151	R1 236
6	R58 870 – R73 419	R5 291	R4 571	R1 317
7	R73 420 +	R5 693	R4 988	R1 476

2026 Member Contributions are subject to confirmation by the Council for Medical Schemes.

HOW TO STRETCH YOUR BENEFITS

- Use the Scheme's pharmacy network to avoid unnecessary co-payments.
- Consider paying in cash and then claiming back to get discounts (unless you are registered on the Chronic Medicine Management programme).
- Get a quote from the doctor before undergoing any planned, elective procedure and check with the Contact Centre how much will be paid. Negotiate with your doctor to charge (at least closer to) the amount covered by the Scheme.
- Please remember that a specialist might charge higher rates. You should therefore confirm the rate and Scheme benefit that is available for payment before admission.
- Ask for generic medicine whenever possible.
- Think twice about undergoing elective surgery procedures.
- If your doctor recommends a particular line of treatment and you feel uncertain about whether it is necessary, ask for a second opinion.
- If an operation is scheduled for the afternoon or evening, arrange for hospital admission after 12pm.
- Maintain a healthy lifestyle, as prevention is always the better option.
- Make healthier choices to avoid or better manage chronic conditions.
- Use your annual health check and screening tests to identify potential chronic diseases early, e.g. hypertension, diabetes, obesity.

COMBATTING FRAUD, WASTE, ABUSE AND ERROR (FWAE)

Unnecessary and fraudulent expenses drain resources from medical aid schemes. Every rand lost through FWAE is money taken from the shared pool of member contributions. That means higher premiums and fewer benefits for you.

How you can help

- Check your claims for accuracy
- Keep your membership card and details safe
- Never share your membership number
- Don't accept cash for claims you didn't receive
- Report suspicious behaviour via the official whistleblower channels

Be alert. Be accountable. Be the reason we stay protected.

HOW TO SUBMIT A CONFIDENTIAL REPORT ON FWAE

Call the live answering service on **0800 112 811**

Report and make a submission online at **www.whistleblowing.co.za**

Email your report to **information@whistleblowing.co.za**

Send your report to Whistle Blowers via **WhatsApp** on **031 308 4664**

Download the secure **Whistle Blowers app** from Google Play or the Apple App Store. The app guides you through the reporting process.

Send your report via **SMS to 33490** from anywhere in South Africa at a cost of R1.50.

Fax your report to Whistle Blowers toll-free on **0800 212 689**

Send your report to Whistle Blowers via Freepost KZN665, Musgrave, South Africa, 4062

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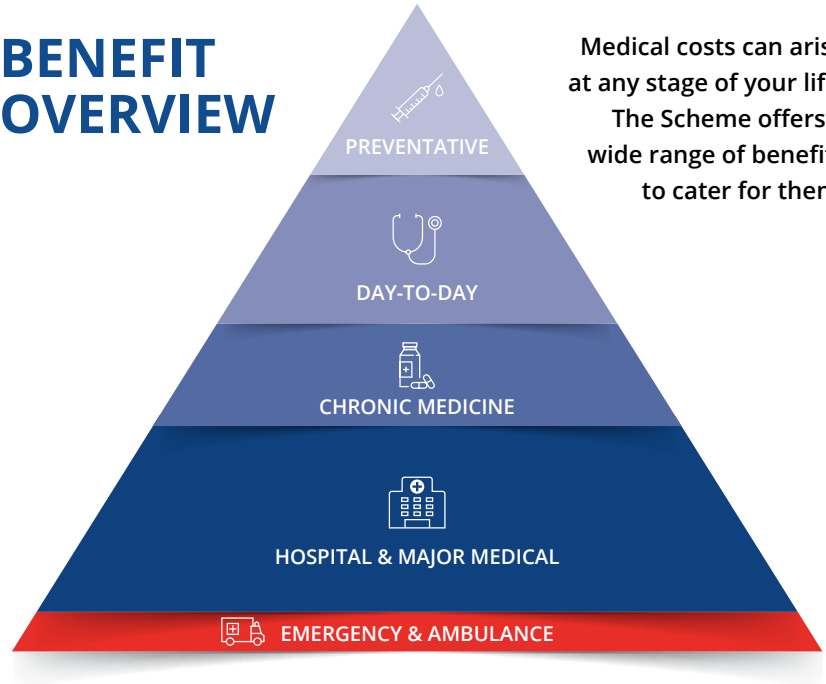
2026 BENEFITS

BENEFIT OVERVIEW

Medical costs can arise at any stage of your life. The Scheme offers a wide range of benefits to cater for them.



Preventative benefits include an annual health check, health screening tests and vaccines to help you manage your health pro-actively.

Day-to-day benefits typically cover expenses such as consultations with general and other healthcare professionals, optometry, dentistry, acute medicine and pharmacy advised treatment ("over the counter medication").

Chronic medicine benefits help members manage certain chronic conditions in a cost-effective way.

Hospital and major medical benefits cover in-room procedures to high-cost hospitalisation and treatment for emergencies, trauma, oncology and much more.

Emergency and ambulance benefits ensure that you and your beneficiaries can get emergency medical care when you urgently need it.

Unless otherwise specified, the benefits described in this guide apply to MBMed's benefit year, which runs from 1 January to 31 December. Benefits are not transferable from one benefit year to another.

PREVENTATIVE CARE BENEFITS

Annual Health Check

MBMed offers all beneficiaries an annual health check with their chosen preferred general practitioner (PGP). Your PGP will tailor your annual health check to your age and personal health risks. Even children can benefit from an annual health check.

Members are strongly encouraged to take advantage of this new benefit. Visit your doctor when you are well for an Annual Health Check - make your booking now.

The Annual Health Check is funded from your Preventative Care Benefits and will not reduce your Day-to-Day Benefits.

In addition to an Annual Health Check, MBMed pays for a range of Health Screening tests.

Health screenings are smart, preventative measures that can help to reduce the risk of chronic diseases like diabetes, heart disease, stroke and mental health conditions. Health screenings are covered by your Preventative Care Benefits and do not impact your Day-to-Day benefits.

Where can I have a Health Screening?

Please arrange your health screening tests with your PGP at your Annual Health Check. If that does not work for you, you can have many of the health screening tests with a qualified healthcare practitioner at your local pharmacy, onsite clinic or during a wellness event at your company. The results are specific and evidence-based, guiding you towards a healthier lifestyle with a reduced risk of disease.

The benefits of an Annual Health Check and Health Screening

- Access to a personalised health consultation when you are well
- Awareness of your current health status
- Early identification to prevent the onset of chronic diseases
- Review of any existing chronic conditions and chronic medicines that you are using
- Ability to make informed health decisions
- Improved health outcomes for a better quality of life

IMPORTANT: All payments are subject to Scheme tariffs and negotiated rates, unless specified otherwise.

PREVENTATIVE CARE BENEFITS

Annual Health Check with Preferred General Practitioner (PGP)	One health check per beneficiary per year by PGP. Tailored to the age of the beneficiary – your PGP is best qualified to advise and support. Cost or Scheme Rate, whichever is less.

VACCINES

Cost or Scheme Rate, whichever is less. Including pharmacist administration fee.

Influenza (flu)	One per beneficiary per year.
Pneumococcal (Strep. Pneumoniae infections including pneumonia and meningitis)	One per beneficiary 18 and older, every five years.
Human Papilloma Virus (HPV)	Cost or Scheme rate, whichever is less. Two doses per beneficiary between 9 and 14 years and 3 doses per beneficiary between 15 and 26 years.
Pertussis (whooping cough)	One vaccine per beneficiary between 4 and 64 years every 5 years.
Childhood immunisations	Limited to immunisations prescribed by the South African Expanded Programme of Immunisations plus Chicken Pox, Hepatitis B, Meningitis and Measles, Mumps and Rubella (MMR) vaccines available in the private health sector. Subject to managed care protocols.

HEALTH SCREENINGS

Cholesterol test (fasting lipogram)	One test per beneficiary per year. Additional tests are paid from out-of-hospital pathology benefits if available.
Colonoscopy	Referred by your PGP and subject to pre-authorisation.
Faecal occult blood test	One test per beneficiary per year.
HIV screening tests	Two tests per beneficiary per year.
Mammogram	One screening per adult female beneficiary per year. No referral is necessary.
Osteoporosis screening	One screening per adult beneficiary per year. No referral is necessary.
Pap smear or liquid based cytology	One screening per adult female beneficiary per year.
Prostate specific antigen test (PSA)	One test per adult male beneficiary per year.
HPV PCR Screening	One test per female beneficiary between 25 and 65 years of age every 5 years.

DAY-TO-DAY BENEFITS

CHOOSE AND REGISTER YOUR PREFERRED GENERAL PRACTITIONER/S (PGP)

It is important for a GP to be the coordinator of your care, so that a record of your medical history can be kept in one place and shared with specialists and other providers when necessary.

Visiting multiple GPs has major disadvantages, such as:

- Conflicting diagnoses and treatments;
- Additional costs being incurred where similar diagnostic tests are repeated, or where medicines are duplicated by different GPs.

MBMed has introduced the concept of a Preferred General Practitioner (PGP), to encourage you to consistently use one or two GPs of your choice. Each member of the family can have a different PGP.

How do I select a PGP?

New members should complete a PGP selection on their application form, visit a Medscheme walk-in centre or contact MBMed Customer Services on 0860 00 2109 to load their PGP(s). Changing or adding a PGP can also be done on the Member Portal. For children under the age of 6, a pediatrician can be the PGP.

What if my specific PGP is not available?

If a PGP is part of a group practice of general practitioners, you may visit any doctor who is part of the group practice, provided the account/claim is submitted under the group practice number.

When the PGP is not available, the doctor standing in (known as the locum) will be considered as the PGP. When you are on holiday and need to visit a doctor, these visits would be covered by the "Out of Area" benefit.

Each beneficiary can register a maximum of two PGPs.

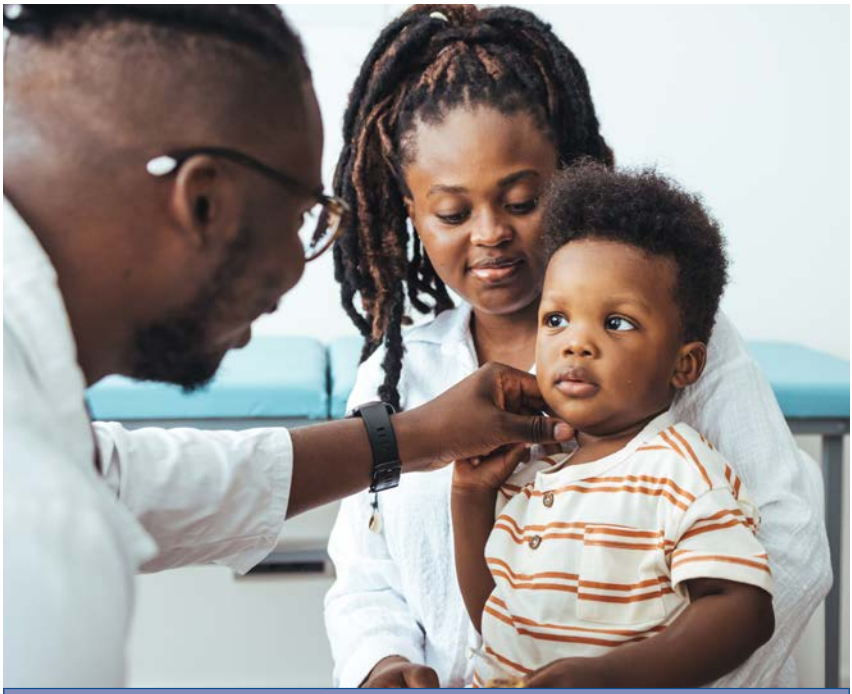
POOLED DAY-TO-DAY BENEFITS

POOLED DAY-TO-DAY BENEFIT LIMITS	
Member	R10 620
Member + 1	R16 510
Member + 2	R19 500
Member + 3	R23 310
Member + 4 or more	R26 420

The following services will be covered from the day-to-day benefit limits above:

SERVICE	NOTES
Preferred General Practitioner consultations	Consultations with your PGP.
Specialist consultations	Specialist consultations will only be covered by the Scheme if a PGP refers the member and a specialist referral number is obtained by the PGP's practice.
Acute medication	Acute medicines are routine, day-to-day medicines prescribed by a doctor, including immunisations, and which are not registered under the Chronic Medicine Management Programme. It excludes pharmacy-advised therapy (PAT).
Additional medical services	Additional medical services include alternative health, physical therapy, paramedical, chiropody, chiropractor, dietician, occupational therapy, physiotherapy, speech therapy, etc.
General radiology (out of hospital)	General radiology will only be covered by the Scheme if referred by a PGP or specialist.
Pathology (out of hospital)	A limit of **R6 920** per family per year applies.

Note: All payments are subject to Scheme tariffs and negotiated rates, unless otherwise specified.



ADDITIONAL DAY-TO-DAY BENEFITS

Limits are as specified below for each service.

OUT OF AREA CONSULTATIONS

Out of hospital 2 consultations per family if out of area or casualty – i.e. consultation/s with doctor not registered as a PGP	Cost or Scheme Rate, whichever is less.

BASIC DENTISTRY *(Subject to Medscheme Dental Management)*

Treatment by dental practitioner and therapist, including minor oral surgery, oral medical procedures and technical fees Plastic dentures	Limited to two dental check-up visits per beneficiary per year. 100% of the lower of the cost or Scheme Tariff or Uniform Patient Fee Schedule for public hospitals for basic dentistry.

OPTOMETRY *(Subject to Medscheme Optometry Management)*

Eye examinations, single, bifocal or multi-focal lenses Frames and lens enhancements Contact lenses	Limited to **R4 840** per beneficiary every 24 months. Cost or Scheme Rate, whichever is less.

SPECIALISED RADIOLOGY *(out of hospital)*

CT, MRI, PET scans and similar	**R14 900** per family per year. AUTHORISATION REQUIRED

CONTRACEPTIVES

100% of single exit price* plus the negotiated dispensing fee, to a maximum as dictated by legislation.

PHARMACY-ADVISED THERAPY

Medicines prescribed and dispensed by a pharmacist Often called "over the counter medicines"	100% of single exit price* plus the negotiated dispensing fee, to a maximum as dictated by legislation, limited to **R1 000** per beneficiary per year.

APPLIANCES

Medical and surgical appliances, including hearing aids, wheelchairs and foot orthotics	Cost or Scheme Rate, whichever is less, limited to **R29 800** per beneficiary per year.
Home oxygen cylinders, concentrators and ventilator expenses	Cost or Scheme Rate, whichever is less.

CHRONIC MEDICINE BENEFITS

CHRONIC MEDICINE BENEFITS

100% of the single exit price* plus the negotiated dispensing fee, to a maximum as dictated by legislation, limited to **R34 700** per beneficiary, and **R58 900** per family per year.

**The single exit price (SEP) is the maximum price at which a pharmaceutical manufacturer can sell a medicine to a wholesaler, including VAT and a logistics fee. This regulated price does not allow for discounts or rebates.*

What is a chronic condition?

A chronic condition is a condition that requires ongoing long-term or continuous medical treatment. However, not all these conditions are necessarily covered by the Scheme's Chronic Medicine Benefits. The Scheme specifies the chronic conditions that qualify for this benefit. Please visit the Member Portal to see what chronic conditions are covered by MBMed - mbmedmembers.medscheme.co.za and click on ***'Documents'*** and then ***'Guides/Rules'***.

When should I register on the Chronic Medicine Management Programme?

If you use medicine for a chronic condition without being registered on the Chronic Medicine Management Programme, it will be covered from your acute medicine benefit limit and you will probably exhaust this benefit limit quite quickly.

On the other hand, by registering on this programme (if you have a qualifying chronic condition as provided by MBMed), you have access to a far higher benefit limit for your chronic medicine.

Certain terms and conditions apply to the conditions covered, the medicine formularies available for those conditions, and the service provider from whom you must get the medicine. However, for most members, the financial benefit of registering for chronic medicine benefits far outweigh the restrictions.

Chronic medicine is indicated for prolonged illnesses that are often life-long. To access your chronic medicine benefits, you must apply and be authorised for a chronic medicine or condition through the Chronic Medicine Management (CMM) Programme, subject to the CMM Clinical Guidelines and Protocols.

How is my medicine approved?

When you apply for chronic medicine, and if you are approved for treatment of your chronic condition, you will have access to a list of pre-approved medicine, referred to as a basket. The quantity of each medicine in the basket is limited to the most appropriate monthly dose.

What if my medicine changes?

If you need to change or add a new medicine for your condition, you can do this quickly and easily at your pharmacy with your new prescription. Not all conditions are managed this way and you will need to contact the Scheme to update medicine telephonically or online if:

- you are joining the chronic programme for the first time;
- you are diagnosed with a new additional chronic condition;
- your medicine is not linked to one of your registered baskets; or
- you need a quantity or dosage of a medicine that is more than the quantity listed in the basket.

Pre-approved medicine in the basket may still be subject to the Medicine Price List (MPL) and formulary co-payments. The MPL is a reference pricing system used in conjunction with formularies and pre-authorisation, as a health risk management tool.

The reference pricing system does not restrict the choice of medicines but rather controls the cost of medication. The system uses a benchmark for generically similar products to limit the amount that will be paid in medicine prices. You are free to use any item which appears on the MPL. However, if the price is more than the reference price, you will be required to pay the difference.

You can find the MPL on the Member Portal under mbmedmembers.medscheme.co.za and click on *'Medicine Formularies'*.

How do I apply?

You, your doctor or pharmacist can register or update your chronic medicine telephonically or online. Ensure you have a copy of your current prescription with you. There is no need to send it to us, as you will need to give your original prescription to the pharmacy for the dispensing of your chronic medicine.

You will need to have the following information on hand:

- Your membership number
- The date of birth of the person applying
- The ICD10 code of your condition/s
- Doctor's practice number

To authorise certain medicines, you may also need to supply:

- Medicine details
- The clinical examination data, e.g. weight, height, BP readings, smoking status, allergy information
- Test results, e.g. lipogram results, Hba1c, lung function tests
- Motivation provided by your prescribing doctor

Register telephonically: Call CMM on 0860 002 109 between 08:30 and 16:00 and select the chronic medicine option.

Register online:

MBMed Member Portal → Log in → My Authorisations → My Chronic Application

Visit the MBMed website on mbmedmembers.medscheme.co.za and click ***'Login'***, top right. Log in with your username and password. (If you are a first- time user you will need to register – see *HOW TO REGISTER ON THE MEMBER PORTAL* on page 5). Go to ***'My Authorisations'*** and click on ***'My Chronic Application'***, click on the dependant code and follow the prompts on the system. Where more clinical information is required, members of the clinical team will review the information supplied and correspond with you and your doctor either telephonically or in writing on the status of the medicine request. You can follow up on the progress of your application at any time by contacting CMM.

TIP: If you or one of your accompanying dependants uses chronic medicine, you must remember to apply for advance supplies if you are travelling for an extended period. The completed form, together with a copy of the airline tickets and travel itinerary must reach Chronic Medicine Management at least ten working days before you leave, to ensure that you receive your medication in time.

Contact details for Chronic Medicine Management (CMM)

Member Call Centre: 0860 002 109 (08:30 – 16:00, Mon-Fri)

Provider Call Centre: 0861 100 220

mbmedcmm@medscheme.co.za

PO Box 38632 Pinelands 7430

How do I know if my pharmacy is part of the MBMed Network?

- Ask your pharmacist if they're part of the Medscheme network.
- Contact the MBMed Call Centre on 0860 002 109 for network pharmacies in your area.

How do I appeal a decision made by CMM?

Your doctor should contact the Chronic Medicine Management Provider Call Centre on 0861 100 220 or submit a clinical motivation to mbmedcmm@medscheme.co.za.

Benefit from Prescribed Minimum Benefits

Regulations published in terms of the Medical Schemes Act No. 131 of 1998 stipulate the scope and level of the minimum benefits to which members of the Scheme are entitled. Prescribed Minimum Benefits (PMBs) are a set of defined benefits that ensure that all medical scheme members have access to certain minimum health services.

PMB conditions include any life-threatening emergency, 271 defined diagnoses and their associated treatments as well as 26 chronic conditions.

All medical schemes in South Africa must include the Prescribed Minimum Benefits in the benefit options being offered to members. There are, however, certain requirements that a member must meet before they benefit from the Prescribed Minimum Benefits and include:

- The condition must be part of the list of defined PMB conditions
- The treatment needed must match the treatments in the defined benefits
- Members must use the Scheme's designated healthcare service providers where applicable

Please visit the Council for Medical Scheme's website www.medicalschemes.com or contact the MBMed contact centre for more information on PMBs.

HOSPITAL AND MAJOR MEDICAL BENEFITS

HOSPITAL AND MAJOR MEDICAL COSTS

OVERALL ANNUAL LIMIT: UNLIMITED

HOSPITALISATION

Private and public hospitals, including step-down rehabilitation centres and hospice	Cost or Scheme Tariff, whichever is less. **AUTHORISATION REQUIRED** from Medscheme Hospital Management.
Nursing services including private nursing, nursing agencies	Cost or Scheme Tariff, whichever is less. **AUTHORISATION REQUIRED** from Medscheme Hospital Management.
Out-patient care and out-patient services, materials and medicines	Cost or Scheme Tariff, whichever is less.
Medicine on discharge from hospital (usually called TTO medicines)	Unlimited if included in hospital account or if obtained from pharmacy on day of discharge.

CONSULTATIONS AND VISITS

General practitioners and specialists in hospital Allied health professionals in hospital (e.g. physiotherapy, dietetics, etc.)	Cost or Scheme Tariff, whichever is less. **AUTHORISATION REQUIRED** from Medscheme Hospital Management.

NON-SURGICAL PROCEDURES AND TESTS

Procedures performed by general practitioners and medical specialists in and out of hospital	Cost or Scheme Tariff, whichever is less. **AUTHORISATION REQUIRED** from Medscheme Hospital Management.

SURGICAL PROCEDURES

Procedures performed by clinical technologists, general practitioners, and medical specialists, excluding services provided for refractive surgery and organ transplants	Cost or Scheme Rate, whichever is less. **AUTHORISATION REQUIRED** from Medscheme Hospital Management.

PATHOLOGY AND MEDICAL TECHNOLOGY *(in hospital)*

Tests performed by general practitioners, medical specialists, medical technologists and private nurse practitioners in hospital	Cost or Scheme Rate, whichever is less.

SPECIALISED RADIOLOGY *(in hospital)*

In hospital	No limit. **AUTHORISATION REQUIRED** from Medscheme Hospital Management.

PROSTHESES

External and internal prostheses	Cost or Scheme Rate, whichever is less limited to **R51 400** per family per year. **AUTHORISATION REQUIRED** from Medscheme Hospital Management.

ONCOLOGY

Treatment, medication, materials used in radiotherapy and chemotherapy, including consultations and visits, specialised and biological drugs	Cost or Scheme Rate, whichever is less. For oncology specialised drugs a sub-limit of **R326 000** per family per year applies. **AUTHORISATION REQUIRED** from Medscheme Oncology Management.

MATERNITY

OUT OF HOSPITAL Medical services including ante-natal consultations and post-natal services, pregnancy scans and amniocentesis	Cost or Scheme Rate, whichever is less limited to **R14 400** per beneficiary per event.
IN HOSPITAL (public or private hospitals) Accommodation, theatre fees, labour ward fees, dressings, medicines and materials in hospital, normal delivery by a general practitioner, medical specialist or midwife A letter of clinical motivation is required for a Caesarean section from the attending Obstetrician	Cost or Scheme Rate, whichever is less. **AUTHORISATION REQUIRED** from Medscheme Hospital Management.

Pregnant members receive an MBMed backpack filled with baby goodies!

BENEFITS FOR NEWBORNS	
Infant hearing screening	Unlimited in or out of hospital for all infant beneficiaries up to 8 weeks.
Neonatal Vision Screening for Retinopathy of prematurity (ROP)	Cost or Scheme Rate, whichever is less. Subject to the following Scheme protocols: • Neonates born prior to 32 weeks gestation • Preterm neonates weighing <1500g Screenings should be performed by an ophthalmologist 4 – 6 weeks chronological age or 31 – 33 weeks post- conceptional age (whichever comes later).
Thyroid function screening test (TSH)	One test per infant beneficiary up to the age of 1 month old.
ADVANCED DENTISTRY AND ORAL SURGERY *(Subject to Medscheme Dental Management)*	
Inlays, crowns, bridges, mounted study models, metal base dentures, treatment by periodontists and prosthodontists, dental technician fees Osseo-integrated implants and orthognathic surgery (functional corrections of malocclusions)	Cost or Scheme Rate, whichever is less, limited to **R19 390** per family per year and further limited to **R11 990** per beneficiary.
Oral surgery	Cost or Scheme Rate, whichever is less. **AUTHORISATION REQUIRED** from Medscheme Dental Management.
Consultations, visits, removal of teeth, para- orthodontic surgery, procedures and preparation of jaws for prosthesis performed by maxillo-facial specialists	Cost or Scheme Rate, whichever is less. **AUTHORISATION REQUIRED** from Medscheme Dental Management.
Maxillo-facial surgery and orthodontic treatment	Cost or Scheme Rate, whichever is less. **AUTHORISATION REQUIRED** from Medscheme Dental Management.

BLOOD & BLOOD EQUIVALENTS

In and out of hospital	Cost or Scheme Rate, whichever is less. **AUTHORISATION REQUIRED** from Medscheme Hospital Management.

MENTAL HEALTH

Hospitalisation (public or private hospital) Accommodation in a general ward, electro-convulsive treatment (ECT) fees, medicines, materials and hospital equipment Alcoholism and drug dependency	Cost or Scheme Rate, whichever is less. **AUTHORISATION REQUIRED** from Medscheme Hospital Management.
General practitioner and psychiatrist consultations	IN HOSPITAL: No limit. OUT OF HOSPITAL: Cost or Scheme Rate, whichever is less, limited to **R7 610** per beneficiary.
Psychologists, psychiatric nurse practitioners and social workers consultations, visits and procedures in and out of hospital	IN HOSPITAL: Limited to **R18 400** per beneficiary per year for non-Prescribed Minimum Benefits. OUT OF HOSPITAL: Limited to **R7 610** per beneficiary.

HIV & AIDS

Anti-retroviral and related medicines, related treatment including pathology and radiology services	Subject to the relevant managed healthcare pro gramme, and to registration and case management by the programme. **AUTHORISATION REQUIRED** from Aid for AIDS.

INFERTILITY

Limited to interventions and investigations as prescribed by the Medical Schemes Act. Subject to Medical Advisor approval and the relevant managed healthcare programme. Paid at cost or the Scheme Rate, whichever is less.

ORGAN TISSUE TRANSPLANTS	
Harvesting of organ or tissue and transplantation thereof, including consultations and visits and the cost of post-operative anti-rejection medicines	Cost or Scheme Rate, whichever is less. **AUTHORISATION REQUIRED** from Medscheme Hospital Management.
RENAL DIALYSIS *(Acute and Chronic)*	
All services and materials, including consultations and visits	Cost or Scheme Rate, whichever is less. **AUTHORISATION REQUIRED** from Medscheme Hospital Management.

GAP COVER

Members should consider a gap cover policy to provide insurance cover for above Scheme Rate expenses.

HOW TO GET A REFERRAL BEFORE YOU SEE A SPECIALIST

To ensure coordinated care and to minimise unnecessary costs, you must be referred to certain specialists by your PGP. Your PGP must contact the Medscheme Call Centre on 086 111 2666 to obtain a specialist referral number for you, before your consultation with the specialist.

If a specialist refers you to another specialist, you must contact your PGP or the Call Centre to update your referral. Without this number the Scheme will not pay for the consultation.

IMPORTANT: It is your responsibility to ensure that your PGP obtains the specialist referral number. However, a specialist referral number is not a guarantee of payment as claims will be processed from the available benefit limits.

HOW TO PRE-AUTHORISE HOSPITAL ADMISSIONS OR SPECIALISED RADIOLOGY

You need to pre-authorise any admission to hospital unless it is an emergency. The pre-authorisation process ensures added value for you by making sure the planned intervention is medically necessary and appropriate, before the event or admission. This process can be initiated by you, your medical practitioner, or the hospital.

Specific authorisations are also needed for the following specialised radiology procedures: CT scans, MUGA Scans, Radio isotope studies, CT colonography and MDCT coronary angiography.

How to pre-authorise

Via the website – click on the drop-down arrow in the Login box at the top right-hand corner of the MBMed website and select *'member'* to log into the secure area. Then click on the pre-authorisation button.

Via email – mbmed.authorisations@medscheme.co.za (please ensure that your request is accompanied by all the relevant information to finalise your request).

Via phone – Call centre number: 0860 002 109; 08:30 – 16:00, Mon to Fri, excluding public holidays. An automated system is available 24 hours a day, 7 days a week.

Healthcare professionals can also apply on your behalf by calling **0861 100 220** or logging in to the Provider Portal on the MBMed website by selecting *'Hospital'* in the drop-down box and using their UMS login details.

HOW TO PRE-AUTHORISE A KNEE OR HIP REPLACEMENT

Use the Scheme's Preferred Provider group for knee and hip replacements to ensure that you do not incur a co-payment for your surgery. These are orthopaedic surgeons who specialise in performing hip and knee replacements according to standardised clinical care pathways. These care pathways have been developed in accordance with evidence-based outcomes to ensure that the quality of the hip and/or knee replacement is of the highest standard, ensuring the best health outcomes. They use a multidisciplinary team dedicated to assist with rapid and successful recovery, keeping the patient as comfortable as possible during the healing period.

How to access a participating orthopaedic surgeon

Call the MBMed Call Centre on 0860 00 2109 and you will be given the details of a list of participating orthopaedic surgeons closest to you or discuss a referral to an orthopaedic surgeon with your PGP.

Following your consultation with the orthopaedic surgeon and, if the decision for surgery is made, an application for an authorisation number will be arranged on your behalf by the admin staff at the practice. This will allow you access to the programme and ensure payment in full (subject to your prosthesis benefit) with no co-payments for the surgical procedure. The surgeon will give you a booklet providing you with information on the programme.

The following will be covered as part of your hip or knee replacement:

- All hospital costs
- Surgeons and anaesthetist fees
- Prosthesis (subject to the prosthesis benefit)
- Physiotherapist (pre-, intra-, and post-operative)

EMERGENCY & AMBULANCE BENEFITS

EMERGENCY & AMBULANCE BENEFITS

Emergency road and air transport by **NETCARE 911** for patients only.

This service is paid at cost or Scheme Rate, whichever is less.

AUTHORISATION REQUIRED from NETCARE 911.

You and your registered dependants have access to emergency medical transportation in South Africa 24 hours a day, 7 days per week, **provided that it is authorised by NETCARE 911** (MBMed's emergency medical services provider).

In an emergency*, call or get someone to call **NETCARE 911** on **082 911**.

Tell the NETCARE 911 operator that you are a MBMed Medical Scheme member – they will prompt you or the caller to obtain all the information they need to get help to you.

In a poisoning emergency, call 0861 555 777 or NETCARE 911 on 082 911.

*WHAT IS AN EMERGENCY?

An emergency medical condition means the sudden and, at the time, unexpected onset of a health condition that requires immediate medical treatment and/or an operation. If the treatment is not available, the emergency could result in weakened bodily functions, serious and lasting damage to organs, limbs or other body parts, or even death.

4 PROGRAMMES

If you struggle with your **MENTAL HEALTH**

If you want to **MANAGE YOUR WEIGHT**

If you want to **STOP SMOKING**

If you are diagnosed with **CANCER**

If you are **HIV-POSITIVE** or have been exposed to HIV infection

Click icons to navigate

IF YOU STRUGGLE WITH YOUR MENTAL HEALTH

The Mental Health Programme aims to improve your quality of life and empowers you to manage your condition more effectively. Once you've enrolled in the programme, a dedicated Care Manager will be assigned to assist you and collaborate with your treating doctor to ensure you get the support you need.

What does the Programme offer?

- Access to a Care Manager who will work with you, your treating doctor and, where appropriate, other healthcare professionals to improve your condition.
- The Care Manager will help you to set up appointments with your doctor, obtain authorisation for healthcare services, guide you on understanding the importance of preventative care and the use of wellness benefits or resolve queries related to any other health conditions.
- Educational material about mental health which empowers you to manage your condition.

Is there any other support or information that I can access?

You can access HealthCloud, an informative tool on the Member Portal, to look up medical information and read articles on your condition and many others.

Who can join the Programme?

Members who live with mental health conditions such as depression, anxiety, PTSD and alcohol abuse may be assessed and registered on the Programme.

How can you access the Programme?

Step 1: Simply call 0860 106 155 to register your mental health condition.

Step 2: You will be assessed to determine your eligibility to enroll in the Mental Health Programme.

Step 3: Nominate the treating doctor you want to continue supporting your mental health. You must grant us informed consent – this will allow us to share information with your doctor and monitor the treatment and management of your mental health, so you get the best possible care.

For more information about the Mental Health Programme:

0860 106 155

@ mbmed@medscheme.co.za

IF YOU WANT TO MANAGE YOUR WEIGHT

Obesity is a complex disease that is dependent on many factors, including a person's genetics and lifestyle. It is important to implement a longer-term, sustainable plan that will lead to a healthier lifestyle, which is what the Scheme's Weight Management Programme aims to help members do.

How can you access the Programme?

If you are interested in joining the Programme and would like to confirm whether you qualify, contact Member Care for more information on:

0860 106 155

@ membercare@medscheme.co.za

IF YOU WANT TO STOP SMOKING

Stopping smoking is the single most important decision you can make for your health. The benefits of stopping smoking are almost immediate, but stopping smoking is not easy, as nicotine is highly addictive and smoking is associated with social activities such as drinking or eating and psychological factors such as work pressure, anxiety and body weight concerns.

This benefit covers **R3 590** per beneficiary for services, including medicine. The GoSmokeFree services are provided by trained clinical nurses at Dis-chem, Clicks, Pick & Pay and independent pharmacies. Virtual consultations are also available.

How can you access the programme?

Visit www.gosmokefree.co.za to find out more, locate your nearest pharmacy or find out how to access an online virtual consultation.

IF YOU ARE DIAGNOSED WITH CANCER

To make the most of your oncology benefits, you must register on the Oncology Management Programme as soon as possible after the diagnosis of cancer. Your treatment plan must then be forwarded to the clinical team, as all oncology treatment is subject to pre-authorisation and case management. After the treatment plan has been assessed and approved, an authorisation will be sent to your treating doctor.

Who should register on the Programme and how?

Patients who have been diagnosed with cancer and are actively receiving treatment as well as patients who are in remission.

On diagnosis, your treating doctor should email a copy of your treatment plan to cancerinfo@medscheme.co.za. An oncology case manager will then take the process forward.

For any queries, call 0860 100 572.

What about related treatment?

In addition to obtaining authorisation from the Oncology Management team for oncology treatment, you will need to get pre-authorisation from Hospital Benefit Management for any hospitalisation, specialised radiology (e.g. MRI scans, CT scan angiography) or private nursing/hospice services.

What if my treatment changes?

Please make sure that your doctor advises the Oncology Management team of any change in your treatment, as your authorisation will need to be re-assessed and updated.

IF YOU ARE HIV-POSITIVE OR HAVE BEEN EXPOSED TO HIV INFECTION

Aid for AIDS (AfA) is a complete HIV/AIDS disease management programme that offers both members and beneficiaries:

- Medicine to prevent HIV (pre-exposure prophylaxis (PrEP) and post exposure prophylaxis (PEP);
- Medicine to treat HIV (including drugs to prevent mother-to-child transmission and potential infection) at the most appropriate time;
- Treatment to prevent opportunistic infections (e.g. pneumonia or TB);
- Regular monitoring of disease progression and response to therapy;
- Regular monitoring tests to pick up possible side-effects of treatment;
- Ongoing patient support via the dedicated AfA Call Centre; and
- Help in finding a registered counsellor for emotional support.

If a test shows that you are HIV-positive

Register with AfA as soon as possible to make use of this benefit. Your doctor can also contact AfA on your behalf. After you receive the application form, you and your doctor must complete it and return it to AfA.

Once treatment has been agreed upon, you and your doctor will be sent a detailed treatment plan, which explains the approved medicine as well as the regular tests that need to be done to ensure that the drugs are working correctly and safely.

If you have potentially been exposed to HIV infection

If you have possibly been exposed to HIV infection through unprotected sex with a partner living with HIV, sexual assault or needle-stick injury, please ask your doctor to contact AfA to authorise special antiretroviral medicine to help prevent possible HIV infection.

Contact details

0860 100 646 / 083 410 9078, Mon – Fri, 08:00 – 17:00

SMS (call me): 083 410 9078

afa@afadm.co.za

www.aidforaids.co.za

5 CLAIMING MADE EASY

Tips on claiming

Check that prescriptions for medicine show all your details. Also check that the correct quantity of medication dispensed is shown on the claim.

Dental treatment often requires additional work by a dental technician. He or she bills the dentist, who adds this to your account and attaches a copy of the technician's account. Please submit both accounts and ensure that your name and membership number are reflected on each account.

When to expect payment

MBMed has a regular payment cycle: three payment runs per month to members and healthcare practitioners. If the month extends to five weeks, four payment runs will take place. All valid claims received by MBMed will be processed on this basis.

After we receive your claim, we will process it and refund either you or pay your healthcare practitioner by direct transfer to a bank account, depending on the payment method that has been chosen and the rate your healthcare practitioner charges.

You will receive an email confirming that we have received your claims and another email once the claim has been processed and is ready for payment in the next payment run. This email will also tell you if you will be refunded or if we will pay the healthcare practitioner. An SMS message indicating the amount that will be credited to your account (if relevant) will be sent to you after the payment run. The Remittance Advice showing these payments will be available on the Member Portal after the run.

Please ensure that all your personal details, including your bank account details, are correct for the electronic payment of refunds.

Don't forget to check your statements

The Medical Schemes Act requires that healthcare providers give full details on all accounts. Please check that your account shows:

- Your name and surname
- Your medical aid number
- The treatment date
- Name of patient (as indicated on the membership card, not a nickname)
- Amount charged
- Rate code where applicable
- ICD10 codes

CLAIMING FOR MEDICAL EXPENSES INCURRED OUTSIDE SOUTH AFRICA

You can claim from the Scheme for medical expenses incurred while travelling outside South Africa. However, you need to be aware of the following:

- You will be responsible for settling the account upfront. You can then submit the claim to the Scheme when you return. You may not be fully covered depending on your available benefit limits and the exchange rate on the date of service.
- If your account is in a foreign language, it must be fully translated into English and detailed before you submit it to the Scheme.

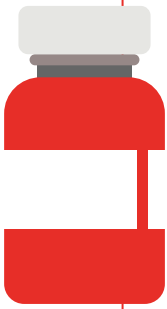
IMPORTANT! Medical care abroad can be very expensive (depending on the country you will be travelling to). MBMed recommends that you take out travel health insurance and not rely on the Scheme for health cover when you travel overseas. Your travel agent will be able to assist you with this.

1. When you send in foreign claims, please add a cover letter or email explaining the situation. The more detailed your cover letter and claim, the quicker the Scheme can process it. You need to clearly indicate the following details:
   - The name of the country in which you were treated
   - Treatment dates
   - Whether there was anaesthesia involved and if so, for how long
   - The medicine, materials, treatment, procedures and operations involved. These must all be clearly specified and charged individually.
   - The patient's name
   - The currency in which the claim was paid
2. Submit your claim to: foreign.hos@medscheme.co.za
3. Your claim will be subject to the Scheme's Rules as if the treatment was rendered in South Africa. In other words, the same exclusions, benefits and limits will apply.
4. Your claims will be paid according to the equivalent tariff and will be refunded to you in Rands, at the exchange rate that applied on the treatment date.
5. PMB rules do not apply outside the borders of South Africa.

PLEASE NOTE: In the event of the claim being covered under your travel insurance policy, you will not qualify for a refund from the Scheme. Should you claim from the Scheme and fail to disclose that you have been indemnified by your insurer for this claim, this will be regarded as fraud.

TIP: If you or one of your accompanying dependants uses chronic medicine, you must remember to apply for advance supplies. The completed form, together with a copy of the flight tickets and travel itinerary must reach Chronic Medicine Management at least ten working days before you leave, to ensure that you receive your medication in time.

Chronic Medicine Management:
0860 002 109 (08:30 – 16:00, Mon-Fri)



6 HOW TO APPLY FOR EX GRATIA COVER

An application for consideration of ex gratia benefits is available to all MBMed beneficiaries who have exhausted their current benefit limits.

Consideration for awarding of additional benefits on an ex gratia basis is based on medical necessity, assessment of financial impact on the beneficiary and a review of past benefit utilisation by the beneficiary.

Ex gratia application forms are available on the MBMed Member Portal. Once completed, applications with the necessary clinical motivation from your treating doctor should be submitted to corpexgratia@medscheme.co.za or handed in at the on-site East London MBMed office.

These requests are reviewed, where relevant, by the Fund's appointed Clinical Advisor and then prepared for submission to the Ex Gratia Committee, which consists of the MBMed Principal Officer and member- elected trustees.

For more information on how the ex gratia benefits process works please refer to the MBMed Ex Gratia Policy available on the MBMed Member Portal or from the Administrator.

7 ESCALATE A QUERY OR COMPLAINT

We understand that members expect reliable and efficient service from the Scheme at all times. To help you resolve medical scheme issues you may have, or if you have a complaint about service you received, please contact the Call Centre or send an email to mbmed@medscheme.co.za and provide the details of your complaint. The advantage of going through the Call Centre is that calls and emails are recorded and trends can be picked up, allowing the Scheme to identify specific communication needs.

If you are not satisfied with the outcome, you are requested to lodge a complaint in writing to the Principal Officer at mbmedpo@medscheme.co.za, detailing the nature of the dispute/complaint. The Principal Officer will try to resolve your query or may convene a Disputes Committee meeting to adjudicate your complaint and/or dispute. You have the right to be heard at these proceedings if you wish.

If, after following the procedures detailed above, you are still not satisfied with the outcome, you may contact the Council for Medical Schemes' Complaints Department:

www.medicalschemes.com
(follow the "Consumer Assistance – Complaints link")

information@medicalschemes.com

012 431 0500

012 431 0608