



Medical Scheme
Administered by Discovery Health



NETCARE MEDICAL SCHEME

MEMBER BROCHURE
SAVINGS OPTION

20
25

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INTRODUCTION

Netcare Medical Scheme is pleased to present you with your 2025 Membership Brochure. We hope that you will find this document informative and helpful over the coming year, during which the Scheme remains as committed as ever to meeting your healthcare funding needs and those of your loved ones.

ABOUT THIS BENEFIT BROCHURE

This brochure serves as a guide to the Netcare Medical Scheme. It consists of information about your membership and benefits. This Benefit Brochure provides you with a summary of the benefits and features of the Netcare Medical Scheme, which is subject to approval by the Council for Medical Schemes on an annual basis, and is subject to the Rules of the Netcare Medical Scheme. The registered Scheme Rules are legally binding and always take precedence over the contents of this guide. Members who require further information should contact the Client Contact Centre on 0861 638 633.

SCHEME OVERVIEW

The Netcare Medical Scheme was established in 1999 to provide healthcare benefits that would truly make a difference in the lives of Netcare employees and their families.

The Netcare Medical Scheme is managed by a Board of Trustees, six of whom are appointed by the employer and six are elected by the members.

The Board of Trustees is responsible for setting the rules that govern the Scheme, for determining the benefits available to members and the contributions, while ensuring the financial stability of the Scheme and equitable access to benefits for all members.

The Board of Trustees conducts a thorough annual review of Scheme benefits and premiums, prioritising the alignment of members interests, with the benefits and premiums provided by the Scheme and the reality of an ever evolving industry.



IMPORTANT PRINCIPLES

- Familiarise yourself with the Rules of the Scheme.
- Understand your rights and responsibilities as a member.
- Obtain preauthorisation where necessary – even for follow-up visits.
- Remember that authorisation does not guarantee full settlement of a claim.
- Always make use of the Designated Service Providers or Preferred Providers available to you.
- If possible, negotiate rates with service providers to mitigate or reduce your payments.
- Make sure to access the wellness benefits offered by the Scheme.
- If you have any chronic conditions, enquire about the Scheme's specific treatment plans.
- **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 Scheme's website at www.netcaremedicalscheme.co.za.**
- Finally, if in doubt about anything, email or phone the Client Contact Centre.

MEMBERSHIP

WHO IS ELIGIBLE FOR MEMBERSHIP TO THE NETCARE MEDICAL SCHEME?

- The Netcare Medical Scheme is a restricted membership medical scheme and membership is restricted to permanent employees, pensioners, disability and continuation members of Netcare as defined in the Rules of the Scheme.
- Employees who join the Scheme may apply to have children and adults added to their membership as dependants. Dependants must qualify for Scheme membership in terms of the Rules of the Scheme.

WHO IS NOT ELIGIBLE FOR MEMBERSHIP TO THE NETCARE MEDICAL SCHEME?

- Members of the Scheme who resign from the employment of Netcare or a subsidiary of the Group, together with their dependants.
- Employees who were not members of the Scheme before retirement or the termination of their services on account of ill health or a disability are not eligible to become members of the Scheme.
- A continuation member who voluntarily resigns from the Scheme for any reason whatsoever, with their dependants, is not allowed to re-join as member/s once they have resigned.

- Dependants of deceased members, or members who are retirees or who suffer from ill health and disability, lose their membership to the Scheme if the Scheme terminates their membership as a result of non-payment of contributions. Kindly note that you will not be able to pay up the premiums and re-join the scheme as unpaid contributions result in a loss of continuation status.

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

- Members may retain their membership of the Scheme in the event of retirement or when their employment is terminated by Netcare or a subsidiary of the Group on account of ill health or a disability.
- Registered dependants may continue membership in the unfortunate event of the passing of the main member as long as they continue to pay all contributions that become due and are specifically required to advise the scheme of their intention to exercise this right to remain.





HOW TO APPLY FOR MEMBERSHIP

01

Obtain

You can get an application form from your HR department.

02

Complete

Complete your application and attach the required supporting documents.

03

Submit

Submit the completed application and supporting documents to your HR department.

The Scheme may terminate membership if the member does not disclose any and all relevant medical information. Your membership will not be active until the scheme has received all the required documents and information. Failure to supply the information within three months will result in your application being rejected.

INCOMPLETE AND OUTSTANDING SUPPORTING DOCUMENTS

All new applicants who join after two calendar months from the date of employment are required to complete the medical questionnaire. Applicants must disclose to the Medical Scheme 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 their dependants and includes, but is not limited to, medical conditions and diseases that:

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



WAITING PERIODS

Where an employee joins the Scheme two calendar months after commencing employment, the Scheme may impose the following waiting periods as stipulated by the Medical Schemes Act (131 of 1998):

| CATEGORY | THREE (3) MONTH GENERAL WAITING PERIOD | 12-MONTH CONDITION-SPECIFIC WAITING PERIOD | APPLICATION TO PRESCRIBED MINIMUM BENEFITS (PMBs) |
|---|--|--|---|
| New applicants, or persons who have not been members of a medical scheme for the preceding 90 days | Yes | Yes | Yes |
| Applicants who were members of another medical scheme for less than two years | No | Yes | No |
| Applicants who were members of another medical scheme for more than two years and who did not join within 30 days of employment | Yes | No | No |
| Child dependants born during a period of membership and registered within 30 days of birth/adoption | No | No | No |
| Addition of a spouse/life partner within 30 days of marriage/proof of common household | No | No | No |

Welcome Packs and membership cards are couriered to the relevant Human Resources (HR) departments. It is therefore essential that the correct workplace or work site is clearly indicated on all application forms.

MEMBERSHIP CARDS

The Scheme provides members with a Welcome Pack, which includes a membership card for the main member and all of the adult dependants on their membership.

Membership cards may **ONLY** be used by the registered member and dependants.

It is fraudulent to permit someone else to use your medical scheme card and benefits. Please note that the scheme will proceed with civil and criminal action should you be found doing so.

Netcare Medical Schemes has introduced improved communication through a dedicated website and mobile application, providing members with enhanced functionality and convenience.

Key features include:

- Modern Design: A refreshed look and enhanced screen design for ease of use.
- Eco-Friendly Approach: Supporting environmental sustainability by reducing reliance on printed materials.
- Digital Accessibility: Access information and resources anytime, anywhere through the website or mobile app.
- Electronic Membership Card: Immediate access to a digital membership card.
- These enhancements aim to provide a streamlined and user-friendly experience for all members.

CHANGE OF PERSONAL DETAILS

In order for the Scheme to effectively communicate with you, it is important for you to notify us of changes to your contact details.

In compliance with the Protection of Personal Information Act (POPIA), HR departments do not inform the Scheme of any changes made to personal details. Therefore, members must directly notify the Scheme of any changes to personal details.

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



UPDATE YOUR INFORMATION

To update your personal information, log in to the Scheme's website at www.netcaremedicalscheme.co.za and go to the '**YOUR DETAILS**' section. You can also phone our Client Contact Centre on 0861 638 633 for assistance. You may also request a copy from your Human Resources (HR) Department.



MONTHLY CONTRIBUTIONS

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

Pensioners, dependants of deceased members and disability claimants must make payment directly to the Scheme and will be liable for the full contribution unless they qualify for the post retirement subsidy after age 65.

Late payments will result in suspended benefits or cancellation of membership.

The Scheme calculates your contribution using the contribution table based on:

- The income (rate-of-pay (ROP)) of the principal (main) 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. Additional adult dependants must be financially dependent on the member and evidence to this effect is required for acceptance on to the Scheme. Spouses, life partners and any immediate family for whom the principal member is financially responsible may apply to become a dependant, including children from the age of 21.
- All dependants younger than 21 are considered to be child dependants. Children age 21 to 25 who are, registered as bona fide students at an educational institution, subject to providing proof of current registration at a tertiary institution to the Scheme annually, are also considered to be child dependants.
- The contribution table is included as Annexure A.

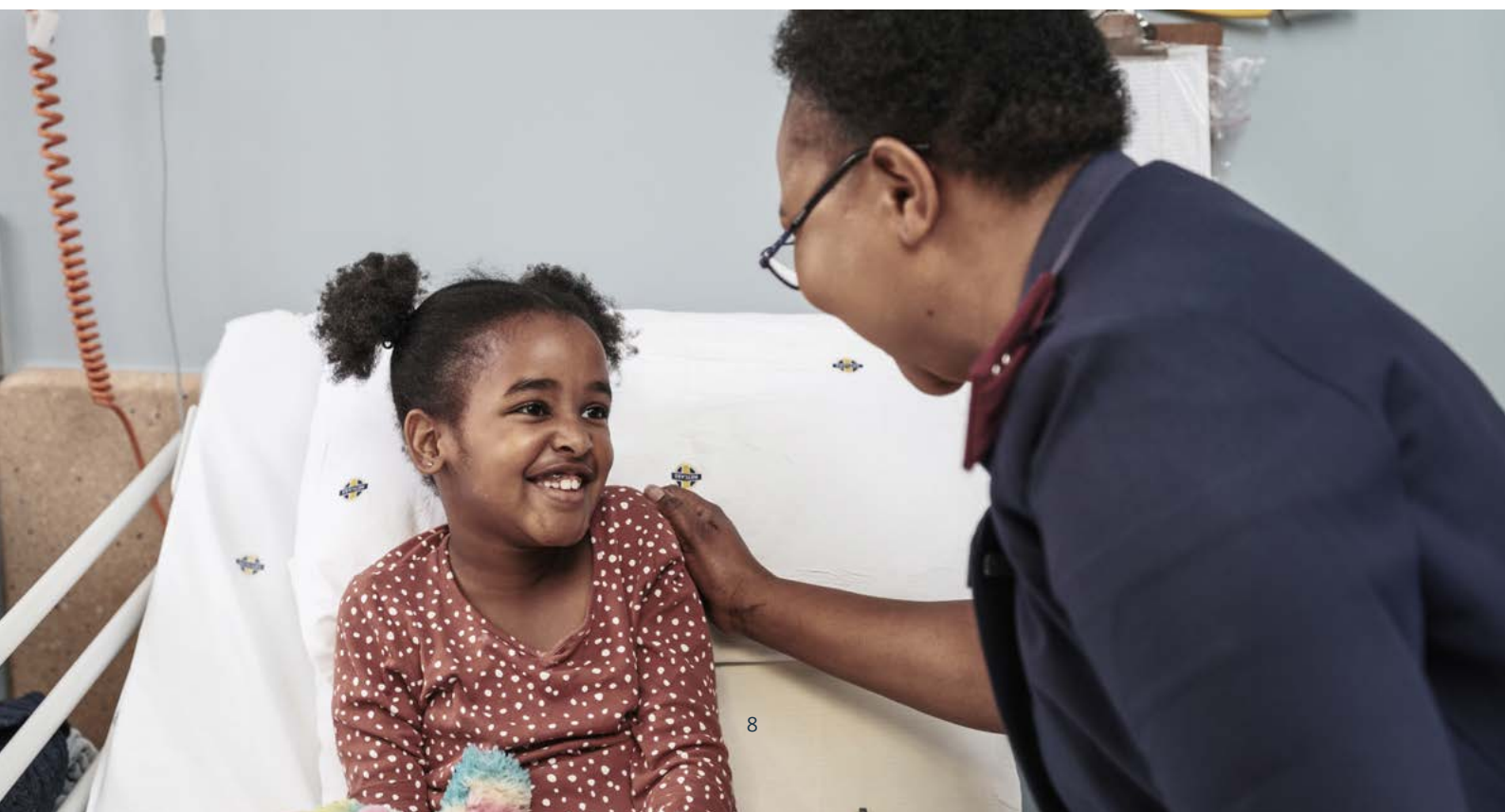
LATE JOINER PENALTIES

Late joiner contribution penalties for people over the age of 35 will be imposed as per the Medical Schemes Act and the membership rules noted in this guide. Please take the time to ensure you clearly understand the premium due by you.

REMOVING A DEPENDANT OR TERMINATING YOUR MEMBERSHIP

You may terminate the membership of any of your dependants by notifying your Human Resources (HR) department using the documents provided by the Scheme, giving one (1) calendar month's written notice to the Scheme.

Principal members may only terminate membership if they resign from employment with Netcare or provide proof of alternative medical scheme cover (as a dependant). One (1) calendar month's notice is required using the required Scheme documentation.



Structure of benefits

The benefit structure of the Netcare Medical Scheme includes a 15% Member Savings Account (MSA) component for day-to-day expenses. Preventative benefits and high-cost items are paid by the Scheme from the insured or risk portion.

EXPENSES PAYABLE FROM THE SCHEME'S INSURED OR RISK PORTION

Note that payment may be subject to:

- Preauthorisation
- Managed Care Protocols and Clinical Guidelines generally accepted in the industry as best practice principles
- Co-payments
- Sub-limits

EXPENSES PAYABLE FROM YOUR MEMBER SAVINGS ACCOUNT (MSA)

The following day-to-day expenses are covered from your MSA:

- General practitioner (GP) services out of hospital
- Non-emergency consultations at any Netcare emergency department
- All optical services (note: one optometry consultation per beneficiary per year is payable from the insured risk portion of your benefits and is deducted from your specialist consultation limit)
- Prescribed acute medicine
- Medical appliances i.e. nebulisers, glucometers and blood pressure monitors with motivation
- Self-medication or over-the-counter (OTC) medicine
- Vitamins
- Homeopathic formulations
- Physiotherapy and bio-kinetics out of hospital
- Psychology and social services

Treatment for the services above will be paid from your MSA only if there is an **available** balance.



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)
- A seven-day supply of medicine on discharge from hospital (To-take-out (TTO))
- General practitioners, specialist 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 a legal undertaking in favour of the Scheme
- Routine diagnostic endoscopic procedures
- Outpatient or emergency department visits with a final diagnosis of a Prescribed Minimum Benefit (PMB) or Priority Emergency or leading to an immediate admission
- Specialist consultations out of hospital (full cover for Preferred Provider specialists)
- Pathology (using a Preferred Provider will ensure full cover)
- Prescribed Minimum Benefits in and out of hospital
- In-hospital dentistry – theatre and anaesthetist accounts will fund from the unlimited hospital benefit. Dentists or dental surgeons will pay from the combined in hospital and out of hospital family limit for dentistry
- Unlimited specialised radiology such as CT, PET and MRI scans and radio isotope studies
- Basic radiology, subject to annual limits out of hospital
- Maternity benefits (including home births), subject to registration on the Maternity Care Programme
- PMB Chronic Disease List chronic medicine, subject to registration on the Chronic Illness Benefit
- Prostheses
- Hearing aids (including repairs)
- Ambulance and emergency services through Netcare 911
- Home care, step-down facilities, physical rehabilitation and hospice services as an alternative to hospitalisation immediately following an event (excluding day-to-day care)
- HIV management
- Infertility interventions and investigations in line with PMBs
- Conservative and specialised dentistry including orthodontics. Subject to annual limits where applicable
- Maxillo-facial and oral surgery where approved with preauthorisation
- Some preventative care benefits. Subject to annual limits where applicable
- World Health Organisation recognised disease outbreaks, subject to Prescribed Minimum Benefit guidelines or as otherwise legislated

IMPORTANT THINGS YOU SHOULD KNOW BEFORE USING YOUR BENEFITS

Network arrangements

The Scheme has Designated Service Provider (DSP) and Preferred Provider arrangements in place. You should make sure that you use these appointed DSPs and Preferred Providers to minimise your co-payments and to prevent claims from being rejected. Visit the Scheme's website at www.netcaremedicalscheme.co.za and log in to the MaPS tool through the 'Doctor visits' tab for a complete list.

Scheme appointed DSPs

- For all hospital admissions:
 - Any Netcare Hospital or Akeso Clinic
- Chronic medicine – register first:
 - Any Netcare Retail Pharmacy or pharmacies located inside a Medicross facility
- For ambulance services:
 - Netcare 911
- National Renal Care facilities
- Netcare Oncology Units
- Medicross and Netcare Day Theatres

For Oncology

- Oncologists registered with the South African Oncology Consortium (SAOC)
- Oncology medicine – refer to the benefit summary for the list of DSP pharmacies

Please note:

- Exceptions are only allowed in an emergency as defined in the Medical Schemes Act, 131 of 1998.
- Voluntary use of a non-DSP hospital or failure to preauthorise any hospital admission will result in a 25% co-payment (including PMBs), unless it is a defined emergency.

Preferred Provider arrangements

- Specialist Network
- Pathology laboratories: Netcare Diagnostics, Ampath, Pathcare and Lancet.
- Radiology Network
- Medicross Dentists

PREAUTHORISATION IS REQUIRED TO ACCESS THE FOLLOWING BENEFITS

- Hospital admissions/step-down/sub-acute/rehabilitation/hospice and home care in lieu of hospitalisation (subject to managed care protocols and clinical entry criteria)
- Specialist visits (including follow up visits) out of hospital
- Some radiology scans: IVP tomography, contrast studies, bone densitometry, MRI, PET and CT scans and mammograms

- All appliances and prosthesis
- All chronic medicine
- Outpatient procedures

Please obtain preauthorisation at least 72 hours before a planned event and within 72 hours after an emergency. Failure to preauthorise will result in a 25% co-payment on the entire account.

BENEFITS THAT HAVE LIMITS

ANNUAL LIMITS APPLICABLE PER BENEFICIARY

| | |
|---|---|
| Out of hospital pathology including consumables and materials | R4,000 per beneficiary per year |
| Psychiatric hospitalisation | 21 days per beneficiary |
| Specialist consultations | Five (5) visits per beneficiary per year |
| Alcohol and drug rehabilitation | 21 days per beneficiary |
| External and internal prostheses | R97,200 per beneficiary per year. Refer to the benefit summary to view applicable sub-limits. |
| Hearing aids and hearing aid repairs | R21,350 per beneficiary per ear every two years |

ANNUAL FAMILY LIMITS

| | | |
|--|--|-----------|
| Dentistry (overall limit applicable to basic and specialised, in and out of hospital) Includes orthodontic (braces) treatment | Combined in-hospital and out-of-hospital dentistry limit | |
| | M | – R5,700 |
| | M+1 | – R8,900 |
| | M+2 | – R11,400 |
| Basic radiology (black and white X-rays and ultrasonography) | M | – R3,600 |
| | M+1 | – R5,400 |
| | M+2 | – R6,300 |
| | M+3+ | – R6,750 |

MATERNITY LIMITS (SUBJECT TO REGISTRATION ON THE MATERNITY PROGRAMME)

| | |
|---|--|
| Ultrasound scans | Two (2) ultrasound scans per pregnancy |
| Antenatal consultations at a gynaecologist, general practitioner or midwife units | Six consultations per pregnancy |
| Antenatal classes | R1,000 per pregnancy at any registered clinic. |

Benefits

The benefit table shows the expenses that are covered by the Scheme and limits, co-payments, authorisation requirements and DSP or Preferred Provider arrangements that may apply.

HOSPITAL ADMISSION AND TREATMENT WHILE IN HOSPITAL

A copy of the authorisation, including possible exclusions, will be emailed to you (if we have your email address), your treating doctor and the hospital. Make sure to clarify any uncertainty you may have with your treating practitioner or the Scheme before your admission as some procedures, items and medicine may not be covered. Should the treating practitioner disregard the terms and conditions of the authorisation, you will be responsible for the cost.

- Members are advised to, where possible, use specialists and other medical service providers on the Preferred Provider lists to optimise benefits and minimise co-payments for treatment while in hospital. Please visit the Scheme's website at www.netcaremedicalscheme.co.za for a list of DSPs and Preferred Providers of the Scheme.
- Accommodation in a private ward is subject to a motivation from the attending practitioner.
- CT, MRI and PET scans in hospital require a separate authorisation but have no co-payment.

AUTHORISATION IS A CLINICAL CONFIRMATION, NOT A GUARANTEE OF PAYMENT

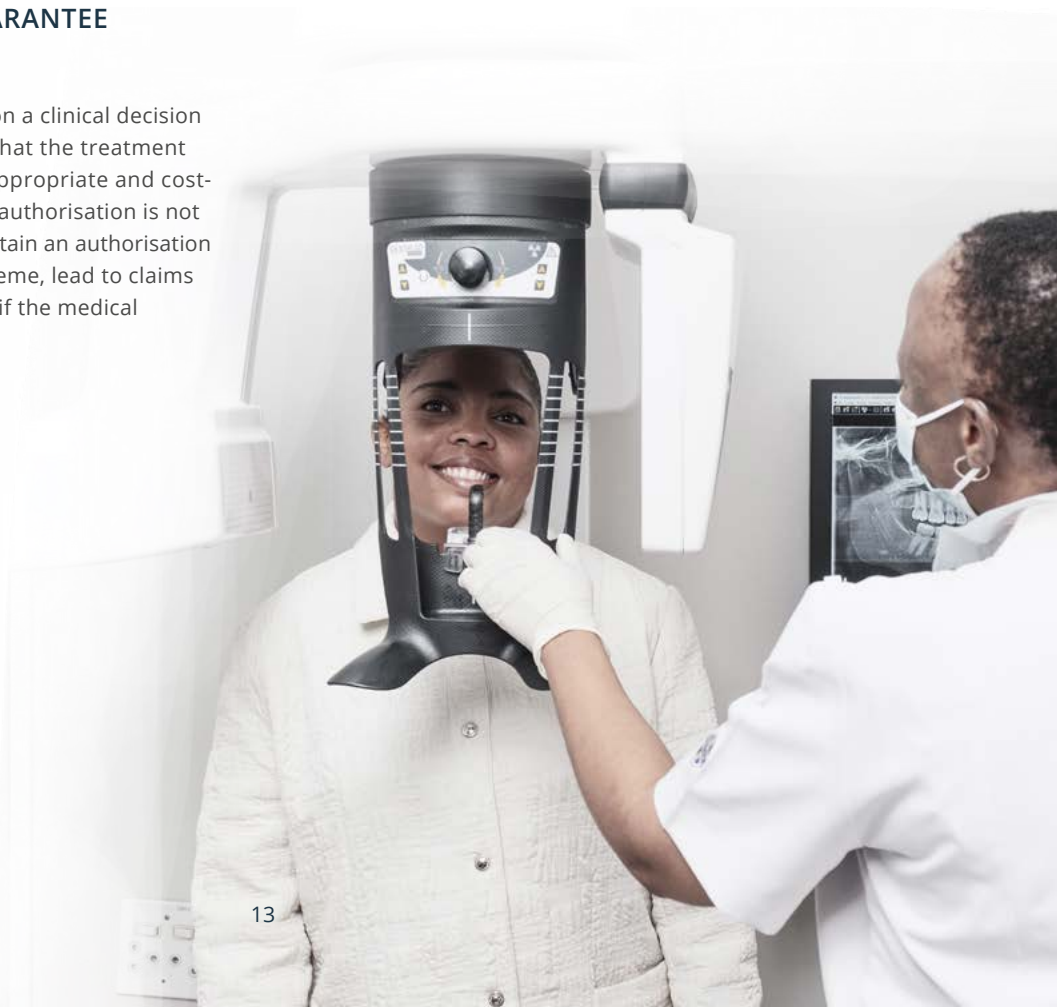
Preauthorisation is provided based on a clinical decision and enables the Scheme to ensure that the treatment that is provided to you is clinically appropriate and cost-effective. It should be noted that preauthorisation is not a guarantee of payment. Failing to obtain an authorisation may, in terms of the rules of the Scheme, lead to claims not being paid or co-payments even if the medical condition is a PMB.

IN-THEATRE DENTISTRY

- It is important to note that dentist and dental surgeon accounts in-theatre **are not paid from the unlimited hospital benefit but from the annual family dentistry limit**. The theatre and anaesthetist accounts will be paid from the unlimited hospital benefit and a co-payment will apply. All in-hospital dentistry requires preauthorisation.
- When a maxillo-facial surgeon performs a standard dental procedure in theatre, the event is still payable from your annual family dentistry limit. Only when a maxillo-facial surgeon performs surgery pertaining to the jaw and face that is specialised and preauthorised, will services be paid from the unlimited risk portion of the Scheme's benefits.

DENTISTRY

It is important to note that all dental work in and out of hospital, as well as orthodontic work, forms part of the dental benefit and is covered by the annual family dentistry limit. This excludes theatre and anaesthetist costs for children under the age of 8 years, which will be paid from the unlimited hospital benefit.



COVER FOR CHRONIC CONDITIONS

- The Scheme covers approved chronic medicine for the 26 Prescribed Minimum Benefit (PMB) Chronic Disease List (CDL) conditions and two additional conditions.
- A medicine list (formulary) applies to the Chronic Disease List (CDL) conditions. Approved medicine on the medicine list for CDL conditions will be funded in full up to the Scheme Rate. Approved medicine not on the medicine list will fund up to the Chronic Drug Amount (CDA). The CDA is a set monthly amount the Scheme will fund up to for each medicine category.
- You also have cover for two Additional Disease List (ADL) conditions, namely depression and attention deficit hyperactivity disorder (ADHD).
- For depression, we pay for approved medicine in full up to the Scheme Rate if it is on the Scheme's medicine list (formulary). If your approved medicine is not on the medicine list, we will pay your medicine up to the monthly Chronic Drug Amount (CDA). A medicine list (formulary) does not apply to ADHD. For this condition, we pay for approved medicine up to 80% of the Scheme rate.
- You must apply for cover by completing a Chronic Illness Benefit application form with 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.
- There is a DSP arrangement with a number of pharmacies, including Netcare Retail pharmacies, so please check the pharmacy network list.
- Use of a non-DSP pharmacy will require upfront payment from the member and the claim needs to be submitted to the Scheme in order for the member to be reimbursed. The Scheme will refund the member at the fee that would have been payable if the medicine was obtained from a DSP. In other words, you may be liable for a co-payment if you do not use a DSP.
- If your Chronic Disease List (CDL) condition is approved, 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.



Out-of-pocket expenses can be avoided by using alternative products which have been shown to be clinically effective and cost less. Discuss your options with your treating provider or pharmacist.

PRESCRIBED MINIMUM BENEFIT (PMB) CHRONIC DISEASE LIST (CDL) CONDITIONS:

| | |
|---------------------------------------|------------------------------|
| Addison's disease | Dysrhythmia |
| Asthma | Epilepsy |
| Bipolar mood disorder | Glaucoma |
| Bronchiectasis | Haemophilia |
| Cardiac failure | Hyperlipidaemia [#] |
| Cardiomyopathy | Hypertension [#] |
| Chronic obstructive pulmonary disease | Hypothyroidism |
| Chronic renal failure | Multiple sclerosis |
| Coronary artery disease [#] | Parkinson's disease |
| Crohn's disease | Rheumatoid arthritis |
| Diabetes insipidus [#] | Schizophrenia |
| Diabetes mellitus type 1 [#] | Systemic lupus erythematosus |
| Diabetes mellitus type 2 | Ulcerative colitis |

NON-CHRONIC DISEASE LIST CONDITIONS

| | |
|---|------------|
| Attention deficit hyperactivity disorder (ADHD) | Depression |
|---|------------|

[#] We have condition-specific care programmes that help you to manage your diabetes or heart-related medical conditions. You must be registered on these condition-specific care programmes to access additional benefits and services. You can read more about these programmes in the care programmes section of this brochure.

01

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

02

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

03

Use a Netcare hospital. If you choose to use any other hospital in a non-emergency situation, it will result in a 25% co-payment on the entire cost associated with the event.

04

Use a Preferred Provider (a contracted doctor) as the Scheme has negotiated fees with them and they are not allowed to charge more than has been agreed with them by the Scheme. 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.

05

Obtain a preauthorisation for any specialist follow-up consultations that may be related to your hospital admission, as follow-up consultations do not form part of the hospital authorisation process.

06

Few anaesthetists charge 'Scheme Rates'. It is therefore a good idea to ask your doctor which anaesthetist they use and negotiate fees with them upfront.

PREVENTATIVE HEALTHCARE

Preventative care is an important part of maintaining good health. We encourage our members to make use of this special benefit as it can assist you in ensuring that you maintain your good health. These benefits are paid from the insured risk portion subject to the terms and conditions of the rules of the Scheme.

THE SCHEME PROVIDES COVER FOR THE FOLLOWING:

Flu immunisations

- Flu vaccination – one (1) per beneficiary per year.

Baby and child immunisations

- Standard immunisations for beneficiaries up to the age of twelve (12) years in accordance with the Department of Health protocols (excluding the HPV vaccine). These immunisations may be obtained at your nearest Clicks Clinic.
- MMR vaccine for measles, mumps and rubella (also called German measles).

Health tests

- Blood sugar test
- Cholesterol test
- HIV test
- Pap smear
- Prostate test

Scans

- Bone densitometry scan (women and men 50 years and older)
- Mammogram

For expecting mothers

- Six (6) antenatal consultations at a gynaecologist or general practitioner
- Two (2) ultrasound scans per pregnancy
- 1 Non-invasive Prenatal Test (NIPT) limited to high-risk pregnancies as defined by clinically qualifying criteria
- Cyclogest – limited to high-risk pregnancies as defined by clinical qualifying criteria (not for the treatment of infertility)

Netcare Medical Scheme

Savings Option Benefit Summary

A list of the Designated Service Providers (DSPs) and Preferred Providers is available at www.netcaremedicalscheme.co.za or by calling the Client Contact Centre on **0861 638 633**

| SERVICE | BENEFIT | LIMITS (SUBJECT TO MANAGED CARE RULES AND PROTOCOLS) | AUTHORISATION REQUIREMENTS | DESIGNATED SERVICE PROVIDER (DSP)/ PREFERRED PROVIDER |
|--|--------------------|--|---|--|
| IN-HOSPITAL COVER | | | | |
| LIMITS DO NOT APPLY TO PRESCRIBED MINIMUM BENEFITS (PMBs). PMBs ARE PAID IN FULL WHEN USING A DESIGNATED SERVICE PROVIDER (DSP). ADMISSION TO NETCARE HOSPITAL (DSP) – FAILURE TO USE A DSP OR FAILURE TO PREAUTHORISE ANY HOSPITAL ADMISSION WILL RESULT IN A 25% CO-PAYMENT (INCLUDING PMBs) | | | | |
| Hospital stay | 100% of NMS tariff | Unlimited cover | Yes, at least 72 hours prior to admission or within 72 hours of an emergency admission | At DSP |
| Psychiatric hospitalisation | 100% of NMS tariff | 21 days per beneficiary per year or 15 outpatient psychotherapy sessions | Yes, at least 72 hours prior to admission or within 72 hours of an emergency admission | At DSP |
| Gender Affirming Surgery Clinical and benefit entry criteria and treatment guidelines apply | 100% of NMS tariff | Up to R200,000 | Yes, email clinicalhelp@netcaremedicalscheme.co.za | At DSP |
| Day clinic or day theatre admission | 100% of NMS tariff | Unlimited cover | Yes, at least 72 hours prior to admission or within 72 hours of an emergency admission | At DSP |
| To-take-out (TTO) drugs | 100% of NMS tariff | Seven-day supply | Forms part of the related hospitalisation | At DSP |
| TREATMENT WHILE IN HOSPITAL | | | | |
| Consultations, surgical procedures, physiotherapy, medicine and blood transfusions | 100% of NMS tariff | Unlimited cover | Forms part of the related hospitalisation | At DSP |
| Anaesthetics | 100% of NMS tariff | Unlimited cover | Forms part of the related hospitalisation | At DSP |
| Pathology | 100% of NMS tariff | Unlimited cover | Forms part of the related hospitalisation | At DSP |
| Organ transplants (including donor cost and immunosuppressant medicine) | 100% of NMS tariff | Unlimited cover | Yes, at least 72 hours prior to admission or within 72 hours of an emergency admission | At DSP |
| Peritoneal dialysis and haemodialysis (kidney dialysis) including renal unit and technicians | 100% of NMS tariff | Unlimited cover | Yes, registration on the renal treatment plan required | At DSP |
| Dentistry hospitalisation | 100% of NMS tariff | Unlimited cover for theatre and anaesthetist Combined in-hospital and out-of-hospital dentistry limit applies for dentist/dental surgeon M – R5,700 M+1 – R8,900 M+2 – R11,400 M+3+ – R14,000 | Yes, at least 72 hours prior to admission or within 72 hours of an emergency admission | Preferred Provider use recommended to minimise co-payments |
| Dentistry: maxillo-facial surgery | 100% of NMS tariff | Related to certain treatment | Yes, at least 72 hours prior to admission or within 72 hours of an emergency admission | Preferred Provider use recommended to avoid co-payments |
| ADMISSION TO A NON-DSP HOSPITAL (A NON-DSP HOSPITAL IS DEFINED AS A PROVINCIAL OR PRIVATE HOSPITAL OTHER THAN A NETCARE HOSPITAL OR AN AKESO CLINIC) | | | | |
| Hospital (voluntary admission) stay and all related services including consultations, surgical procedures, treatment, medicine, physiotherapy, anaesthetics, etc. | 75% of NMS tariff | 25% co-payment will apply on the entire admission | Yes, at least 72 hours prior to admission or within 72 hours of an emergency admission | - |
| Hospital (#emergency/involuntary non-DSP admission) will qualify for the same benefits as for a DSP hospital admission #emergency as defined in the Medical Schemes Act, No. 131 of 1998 | 100% of NMS tariff | Unlimited cover | Yes, at least 72 hours prior to admission or within 72 hours of an emergency admission | - |
| MOTOR VEHICLE ACCIDENTS AND THIRD-PARTY CLAIMS | | | | |
| Payment is subject to a legal undertaking and completion of an accident injury form and report by the member | 100% of NMS tariff | Unlimited cover | Yes, at least 72 hours prior to admission or within 72 hours of an emergency admission | At DSP |
| WORLD HEALTH ORGANISATIONS (WHO) GLOBAL OUTBREAK BENEFIT | | | | |
| Benefits will be subject to PMBs. Includes a basket of care to manage the disease and provide supportive treatment of Global WHO recognised disease outbreaks | | | | At DSP |

| SERVICE | BENEFIT | LIMITS (SUBJECT TO MANAGED CARE RULES AND PROTOCOLS) | AUTHORISATION REQUIREMENTS | DESIGNATED SERVICE PROVIDER (DSP)/ PREFERRED PROVIDER |
|--|---|---|--|--|
| OUT-OF-HOSPITAL COVER | | | | |
| CHRONIC MEDICINE | | | | |
| The chronic medicine benefit is applicable to members and dependants registered on the Chronic Illness Benefit Medicine for the Chronic Disease List (CDL) conditions Medicine for additional chronic conditions listed by the Scheme (ADLs): Depression Attention deficit hyperactivity disorder (ADHD) | 100% of NMS tariff | Approved medicine on the medicine list (formulary) will be funded in full up to the Scheme Rate. Approved medicine not on the medicine list (formulary) will be funded up to the monthly Chronic Drug Amount (CDA). 20% co-payment will apply | Yes, once diagnosed | At DSP (failure to use the services of a DSP will require upfront payment by the member and the submission of the claim to the Scheme for reimbursement) |
| OUTPATIENT PROCEDURES AND EMERGENCY VISITS | | | | |
| Gastrosopies and colonoscopies | 100% of NMS tariff | Unlimited cover At DSP R500 co-payment at non-DSP | Yes, at least 72 hours prior to procedure | At DSP |
| Sigmoidoscopy, direct laryngoscopy, biopsy of breast lumps, excision of nail bed, surgical removal of plantar warts, non-cosmetic varicose vein injections or drainage and wound care | 100% of NMS tariff | Unlimited cover | Yes, at least 72 hours prior to procedure | At DSP |
| Removal of wisdom or impacted teeth, removal of retained dental roots in lieu of hospitalisation | 100% of NMS tariff | Combined in- and out-of-hospital dentistry limit M - R5,700 M+1 - R8,900 M+2 - R11,400 M+3+ - R14,000 | Yes, at least 72 hours prior to procedure | At DSP |
| Outpatient or casualty procedure that results from a procedure previously requiring hospital admission (within 72 hours post-event) | 100% of NMS tariff | Unlimited cover | Yes, at least 72 hours prior to procedure or within 72 hours of an emergency admission | At DSP |
| Outpatient or casualty consultations, procedures, medicine and treatment defined as an emergency or a priority emergency | 100% of NMS tariff | Unlimited cover | None | At DSP |
| SPECIALIST CONSULTATIONS AND TREATMENT OUT OF HOSPITAL – FAILURE TO PREAUTHORISE WILL RESULT IN PAYMENT BEING MADE FROM SAVINGS FOR NON-PMB CONDITIONS OR A CO-PAYMENT ON PMB CONDITIONS | | | | |
| Consultations, procedures in room, material and visits (including outpatient visits) | NMS negotiated tariff at contracted Preferred Provider 100% of NMS tariff at non-contracted provider | Five (5) consultations per beneficiary per year | Yes, at least 72 hours prior to consultation or procedure or within 72 hours of an emergency | Preferred Provider use recommended to avoid co-payments Use of a non-Preferred Provider may lead to co-payments |
| One specialist consultation per beneficiary per year may be used for an optometry consultation | | | None | - |
| ONCOLOGY | | | | |
| Oncology treatment including chemotherapy and radiation in hospital and out of hospital | 100% of NMS tariff At DSP | Unlimited cover | Yes, registration on oncology programme required and submission of a treatment plan | At DSP |
| Oncology medicine in-rooms Treatment administered in the doctor's rooms such as injectable and infusional chemotherapy | 100% of NMS tariff | Unlimited cover 20% co-payment out of DSP | Yes, registration on oncology programme required and submission of a treatment plan | Oncology Pharmacy DSP - Dis-Chem's Oncology Courier Pharmacy - Medipost Pharmacy - Qestmed - Olsens Pharmacy - Southern Rx |
| Oncology and oncology-related medicine scripted for dispensing Such as supportive medicine, oral chemotherapy and hormonal therapy | 100% of NMS tariff | Unlimited cover 20% co-payment out of DSP | Yes, registration on oncology programme required and submission of a treatment plan | Oncology Pharmacy DSP - Dis-Chem's Oncology Courier Pharmacy - Medipost Pharmacy - Qestmed - Olsens Pharmacy - Southern Rx |

| SERVICE | BENEFIT | LIMITS (SUBJECT TO MANAGED CARE RULES AND PROTOCOLS) | AUTHORISATION REQUIREMENTS | DESIGNATED SERVICE PROVIDER (DSP)/ PREFERRED PROVIDER |
|---|--------------------------|--|---|---|
| Cover for a specific list of innovative cancer treatment subject to clinical entry criteria | 75% of NMS tariff | A 25% co-payment applies | Yes, registration on oncology programme required and submission of a treatment plan | Oncology Pharmacy DSP – Dis-Chem's Oncology Courier Pharmacy – Medipost Pharmacy – Qestmed – Olsens Pharmacy – Southern Rx |
| PATHOLOGY | | | | |
| Pathology including consumables and materials Point of care pathology testing is subject to meeting the Scheme's Treatment guidelines and Managed Health Care criteria | 100% of NMS tariff | R4,000 per beneficiary per year | None | Preferred Provider use recommended to avoid co-payments: Ampath, Lancet, Pathcare and Netcare Diagnostics. |
| SPECIALISED RADIOLOGY | | | | |
| IVP tomography, contrast studies, MRI, bone densitometry for men and women younger than 50, CT scans, PET scans and related consumables | 100% of NMS tariff | Unlimited cover R500 co-payment applicable to out-of-hospital non-PMB conditions and not applicable to PET scans | Yes, at least 72 hours prior to procedure | – |
| Bone densitometry for men and women older than 50 | 100% of NMS tariff | One per beneficiary per year No co-payment for out-of-hospital non-PMB conditions | Yes, at least 72 hours prior to procedure | – |
| Mammogram | 100% of NMS tariff | One per beneficiary per year | Yes, at least 72 hours prior to procedure | – |
| Any other specialised radiology | 100% of NMS tariff | Unlimited cover | None | – |
| BASIC RADIOLOGY | | | | |
| Black and white X-rays and ultrasonography | 100% of NMS tariff | M – R3,600 M+1 – R5,400 M+2 – R6,300 M+3+ – R6,750 | None (maternity ultrasounds require registration on the Maternity Care Programme) | – |
| MATERNITY BENEFIT | | | | |
| Hospital and home confinements | 100% of NMS tariff | Unlimited cover | Yes, registration on Maternity Care Programme | At DSP |
| Ultrasound scans | 100% of NMS tariff | Two (2) ultrasounds | Yes, registration on Maternity Care Programme | – |
| Non-invasive Prenatal Test (NIPT) | 100% of NMS tariff | 1 NIPT limited to high-risk pregnancies as defined by clinically qualifying criteria | Yes | Preferred Provider |
| Cyclogest | 100% of NMS tariff | Limited to high-risk pregnancies as defined by clinical qualifying criteria | Yes | At DSP |
| Antenatal consultations at a gynaecologist or general practitioner | 100% of NMS tariff | 6 consultations | Yes, registration on Maternity Care Programme | Preferred Provider use recommended to avoid co-payments |
| Antenatal classes | R1,000 per pregnancy | | Yes, registration on Maternity Care Programme | At any registered clinic. |
| IMMUNISATIONS – FAILURE TO USE A DSP WILL RESULT IN PAYMENT FROM MSA | | | | |
| Baby and child immunisations (up to 12 years) | 100% of NMS tariff | Unlimited cover. According to Department of Health protocol including MMR vaccine but excluding HPV vaccine | None | Vaccine – At DSP Pharmacy Administered at a Clicks Clinic. |
| DENTISTRY | | | | |
| Basic dentistry (fillings, extractions, X-rays and prophylaxis) and specialised dentistry (periodontics, bridgework, crowns, dentures and dental implants) | 100% of NMS tariff | Combined in- and out-of-hospital dentistry limit, subject to Dental Managed Care Protocols. | None | Preferred Provider use recommended to minimise co-payments |
| Orthodontics (under 21 years of age) | 100% of NMS tariff | M – R5,700 M+1 – R8,900 M+2 – R11,400 M+3+ – R14,000 | None | Preferred Provider use recommended to minimise co-payments |
| Maxillo-facial and oral surgeons performing specialised dental procedures | 100% of NMS tariff | Subject to Managed Care Rules and Protocols | Yes | Preferred Provider use recommended to minimise co-payments |
| In-hospital dentistry and maxillo-facial surgery: refer to in-hospital cover above | | | | |
| PROSTHESES | | | | |
| External and internal prostheses | 100% of approved benefit | R97,200 per beneficiary per year, and the following sub-limits: Hip & knee replacements – R34,400 Shoulder replacements – R47,800 Prosthetic devices used in spinal surgery – R29,200 for the first level and R58,400 for two or more levels. Sub-limits will not apply if a preferred provider is used | Yes | Unlimited where preferred provider is used |

| SERVICE | BENEFIT | LIMITS (SUBJECT TO MANAGED CARE RULES AND PROTOCOLS) | AUTHORISATION REQUIREMENTS | DESIGNATED SERVICE PROVIDER (DSP)/ PREFERRED PROVIDER |
|--|--|--|---|---|
| APPLIANCES | | | | |
| Hearing aids and hearing aid repairs | 100% of approved benefit | R21,350 per beneficiary per ear every two (2) years | Yes | - |
| Continuous Glucose Monitoring devices (transmitters and readers): Freestyle Libre (Abbot), MediLink and Enlite (Medtronic) and Dexcom G6 (Ethitec) devices or as amended from time to time | 100% of NMS tariff | Limited to 1 per year per beneficiary Subject to protocols and clinical entry criteria No increase, subject to change. | Only for beneficiaries approved and registered on the Chronic Illness Benefit (CIB) for type 1 diabetes and enrolled onto the diabetes care programme | Preferred Provider |
| Continuous Glucose Monitoring sensors for use with Freestyle Libre (Abbot) and Enlite (Medtronic) and Dexcom G6 (Ethitec) devices or as amended from time to time | 100% of NMS tariff | Limited to R1,640 per beneficiary per month Subject to protocols and clinical entry criteria | Only for beneficiaries approved and registered on the Chronic Illness Benefit (CIB) for type 1 diabetes and enrolled onto the diabetes care programme | At DSP |
| AMBULANCE SERVICES | | | | |
| Air and road emergency services | 100% of cost At DSP | None | No authorisation required if DSP is utilised | Through DSP, Netcare 911 |
| A 25% co-payment will apply for voluntary, non-emergency use of any other service provider. | | | | |
| HOME NURSING, STEP-DOWN/SUB-ACUTE, REHABILITATION | | | | |
| Home nursing, step-down, sub-acute (physical) rehabilitation | 100% of NMS tariff | Subject to Managed Care Rules and Protocols | Yes | As authorised |
| Home-based acute care - in lieu of hospitalisation - after early discharge - as a continuation of care after discharge from hospital - home-based readmission prevention | Unlimited cover 100% of NMS tariff at approved provider | Subject to clinical criteria and the Scheme's Basket of Care (BOC) Includes devices for home-monitoring (based on clinical need) for qualifying members | Yes | As authorised |
| HOSPICE, END OF LIFE CARE | | | | |
| Advanced Illness Benefit for members with terminal illnesses | 100% of NMS tariff at approved provider | Subject to Managed Care Rules and Protocols | Yes | As authorised |
| HIV MANAGEMENT | | | | |
| HIV Treatment – Prescribed antiretroviral medication for HIV/AIDS and medication to treat opportunistic infections such as tuberculosis and pneumonia | 100% of NMS tariff | Approved medicine on the medicine list (formulary) will be funded in full up to the Scheme Rate. Approved medicine not on the medicine list (formulary) will be funded up to the monthly Chronic Drug Amount (CDA). | Yes | - |
| POST-EXPOSURE PROPHYLAXIS | | | | |
| Post-exposure HIV prophylaxis following occupational exposure, traumatic exposure or sexual assault | 100% of NMS tariff | 1 claim within 182 days. Should additional medicine be needed, this must be authorised | Second request within 182 days will require authorisation | - |
| HIV prophylaxis to prevent mother-to-child transmission | 100% of NMS tariff | Maximum of R440 per month and a maximum of R2,460 per six months subject to formulary. Maximum quantity of 1.8kg of infant formula per infant per month for a maximum duration of six months is allowed. We approve the first month upfront; however, the infant needs to be registered on your health plan in order to qualify for the remaining five months. | Yes | - |
| MEMBER SAVINGS ACCOUNT (MSA) | | | | |
| GENERAL PRACTITIONERS | | | | |
| Consultations and all visits and procedures performed out of hospital or in the emergency department | 100% of NMS tariff | Subject to MSA balance | - | - |
| PRESCRIBED ACUTE MEDICINE | | | | |
| Acute medicine prescribed or dispensed by medical practitioners or specialists | 100% of NMS tariff | Subject to MSA balance | - | - |
| Self-medication or over-the-counter (OTC) medicine | 100% of NMS tariff | Subject to MSA balance | - | - |
| Homeopathic medicines, multi-vitamins, calcium, magnesium, tonics, stimulant laxatives, contact lens preparations | 100% of NMS tariff | Subject to MSA balance | - | - |
| Medical Appliances | 100% of NMS tariff | Subject to MSA | - | - |

| SERVICE | BENEFIT | LIMITS (SUBJECT TO MANAGED CARE RULES AND PROTOCOLS) | AUTHORISATION REQUIREMENTS | DESIGNATED SERVICE PROVIDER (DSP)/ PREFERRED PROVIDER |
|---|--------------------|--|----------------------------|--|
| OPTICAL | | | | |
| First optometry consultation will automatically be paid from specialist benefit | 100% of NMS tariff | One consultation per beneficiary per year | None | Preferred Provider use recommended to minimise co-payments |
| Subsequent optometry consultations | 100% of NMS tariff | Subject to MSA balance | - | Preferred Provider use recommended to minimise co-payments |
| Spectacle lenses and frames, readers and contact lenses | 100% of NMS tariff | Subject to MSA balance | - | Preferred Provider use recommended to minimise co-payments |
| HOSPITAL OUT-PATIENT VISITS | | | | |
| Out-patient visits to the emergency department with non-PMB and non-priority emergency diagnoses | 100% of NMS tariff | Subject to MSA balance | - | - |
| AUXILIARY SERVICES | | | | |
| Psychology and social services: consultations, therapy, treatment and social workers | 100% of NMS tariff | Subject to MSA balance | - | - |
| Out-of-hospital physiotherapy and biokinetics | 100% of NMS tariff | Subject to MSA balance | - | - |
| Homeopathy, naturopathy, chiropractic, speech therapy, audiology, occupational therapy, acupuncture, podiatry and dietetics (excluding X-rays and appliances) | 100% of NMS tariff | Subject to MSA balance | - | - |
| Educational, remedial and marriage counselling | No benefit | No benefit | - | - |

Care Programmes

ADVANCED ILLNESS BENEFIT (AIB)

Through the Advanced Illness Benefit (AIB), Netcare Medical Scheme provides comprehensive out-of-hospital palliative care for members who are terminally ill. This is a unique home-based service that offers you quality care in the comfort of your own home, with minimum disruption to your normal routine and family life. Supportive care is provided by nurses or care workers in partnership with the Hospice Palliative Care Association of South Africa. Registration is required to access this benefit.

ONCOLOGY MANAGEMENT

What you need to do before your treatment can start

If you are diagnosed with cancer, you need to register on the Netcare Medical Scheme Oncology programme. To register, you or your treating doctor must send us a copy of your histology results that confirm your diagnosis to oncology@netcaremedicalscheme.co.za. Please make sure your doctor advises you of any change to your treatment, as your authorisation will need to be evaluated and updated. If this is not done, claims could be rejected for payment or paid from the incorrect benefit.

ONCOLOGY INNOVATION BENEFIT

You are eligible for cover for a select list of cutting-edge oncology medications through our Oncology Benefit. To utilise this benefit, it is necessary to enroll in the Oncology Programme and meet the clinical entry criteria established by the Scheme. Upon approval of your treatment, the Scheme will contribute 75% of the NMS tariff at the Designated Service Provider (DSP) for the specified oncology medications. These medications are to be obtained exclusively from the Scheme's designated Oncology Pharmacy DSP.

| INDICATION | PRODUCT NAME | CLINICAL CRITERIA |
|---|--------------|--|
| Locally advanced or metastatic non-small cell lung cancer | Keytruda | Metastatic non-small cell lung carcinoma (NSCLC) and as first line therapy and whose tumours express PD-L1 with a $\geq 50\%$ and with no EGFR or ALK genomic tumour aberrations |
| | Keytruda | Metastatic Squamous non-small cell lung carcinoma (NSCLC) and in combination with carboplatin and either paclitaxel or nab-paclitaxel and as first line therapy |
| | Keytruda | Metastatic non-squamous non-small cell lung carcinoma (NSCLC) and in combination with pemetrexed and platinum chemotherapy and as first line therapy and with no EGFR or ALK genomic tumour aberrations |
| | Keytruda | Advanced non-small cell lung carcinoma (NSCLC) as second line therapy after platinum-containing chemotherapy and whose tumours express PD-L1 with a $\geq 1\%$ TPS IF EGFR or ALK genomic tumour aberration. After one line of targeted therapy |
| | Tagrisso | Locally advanced or metastatic non-small cell lung cancer (NSCLC) as second line therapy (after EGFR TKI therapy) and EGFR T790M mutation-positive |
| | Tagrisso | Non-small cell lung cancer adjuvant therapy after tumor resection in adult patients with tumors having (EGFR) exon 19 deletions or exon 21 L858R mutations. |
| | Tagrisso | Locally advanced or metastatic non-small cell lung cancer (NSCLC) as second line therapy (after EGFR TKI therapy) and EGFR T790M mutation-positive |
| | Xalkori | Advanced non-small cell lung carcinoma (NSCLC) whose tumours are ALK positive and as first line therapy or second line therapy after failure of systemic chemotherapy |
| Malignant melanoma | Yervoy | Advanced (unresectable or metastatic) malignant melanoma |
| | Keytruda | Adjuvant malignant melanoma and with lymph node involvement and following complete resection |
| | Keytruda | Advanced (unresectable or metastatic) malignant melanoma |
| Multiple myeloma | Darzalex | Multiple myeloma and after at least three prior lines of therapy (including a proteasome inhibitor and immunomodulatory agent) or who are double refractory to PI and immunomodulatory agent |
| | Darzalex | Newly diagnosed myeloma, and ineligible for autologous stem cell transplant (ASCT), in combination with bortezomib, melphalan and prednisone |
| | Darzalex | Newly diagnosed myeloma, and ineligible for autologous stem cell transplant (ASCT), in combination with lenalidomide and dexamethasone |
| | Darzalex | Newly diagnosed myeloma, and ineligible for autologous stem cell transplant (ASCT), in combination with bortezomib, thalidomide and dexamethasone |
| | Darzalex | Multiple myeloma, treatment of relapsed/refractory disease, in combination with bortezomib and dexamethasone in adult patients |
| | Darzalex | Multiple myeloma, treatment of relapsed/refractory disease, in combination with lenalidomide and dexamethasone in adult patients |
| Chronic lymphocytic leukemia | Brukina® | Chronic Lymphocytic Leukemia or Small Lymphocytic Lymphoma, without Del 17p mutation as first line therapy |
| | Calquence | Relapsed or Refractory Chronic Lymphocytic Leukemia |
| | Calquence® | Chronic Lymphocytic Leukaemia and as first line therapy or treatment for relapsed (refractory) disease |
| | Imbruvica | Chronic lymphocytic leukaemia and as first line therapy or treatment for relapsed (refractory) disease |
| | Venclexta | Chronic lymphocytic leukemia in combination with obinituzumab and as first line therapy |
| | Venclexta | Chronic lymphocytic leukemia in combination with rituximab and after at least one prior therapy |
| Waldenstrom macroglobulinemia | Imbruvica | Waldenstrom macroglobulinemia and as first line therapy or relapsed disease and after treatment with a rituximab-containing regimen |
| Mantle cell lymphoma | Imbruvica | Mantle cell lymphoma (MCL) and after treatment with at least one prior therapy |
| WT-cell lymphoma | Adcetris | Cutaneous T-cell lymphoma and in combination with Doxorubicin, Cyclophosphamide and Prednisone and previously treated (relapsed disease) and CD-30 positive |
| | Adcetris | Cutaneous T-cell lymphoma and in combination with Doxorubicin, Cyclophosphamide and Prednisone and as first line therapy and CD-30 positive |
| | Adcetris | Systemic anaplastic large cell lymphoma (SALCL) |
| Hodgkin's Lymphoma | Adcetris | Hodgkin's lymphoma and as consolidation therapy after autologous stem-cell transplantation and at risk of relapse or progression |
| | Keytruda | Classical Hodgkin lymphoma, and failed autologous stem cell transplant (ASCT), or following at least two prior therapies when ASCT is not a treatment option |
| Thyroid cancer | Lenvima | Progressive locally advanced or metastatic differentiated thyroid cancer (DTC) and radioactive iodine (RAI) refractory |
| Renal cell carcinoma | Lenvima | Advanced renal cell carcinoma (RCC) and in combination with everolimus and after one prior antiangiogenic therapy |
| | Keytruda | Advanced renal cell carcinoma (RCC) as first line treatment, and in combination with axitinib |
| | Keytruda | Advanced renal cell carcinoma, and as first line therapy, and in combination with lenvatinib |
| | Keytruda | Adjuvant treatment in Renal Cell Carcinoma as monotherapy, at intermediate-high or high risk of recurrence following nephrectomy |
| Metastatic head and neck squamous cell carcinoma | Keytruda | Head and neck squamous cell carcinoma (HNSCC), as first line treatment, and monotherapy, or in combination with platinum and 5-fluorouracil (5-FU) CPS ≥ 20 |
| | Keytruda | HNSCC with disease progression on or after platinum containing chemotherapy, as monotherapy in adults whose tumours express PD-L1 with a $\geq 50\%$ TPS |
| | Keytruda | Head and neck squamous cell carcinoma (HNSCC), as first line treatment, and in combination with platinum and 5-fluorouracil (5-FU) CPS ≥ 1 |
| Metastatic colorectal cancer | Keytruda | Unresectable or metastatic colorectal cancer, with microsatellite instability-high (MSI-H) or mismatch repair deficient (dMMR), and as first line treatment |
| | Lynparza | Epithelial ovarian, fallopian tube or primary peritoneal cancer, platinum sensitive relapsed, with a mutation in BRCA1, BRCA2, or both complete response or partial response, to first line platinum-based chemotherapy as monotherapy |
| Acute myeloid leukemia | Venclexta | Acute Myeloid Leukemia ≥ 75 or not eligible for intensive chemotherapy in combination with LDAC in combination with Azacitidine |
| | Venclexta | Acute Myeloid Leukemia ≥ 18 previously untreated patients, and ineligible for intensive chemotherapy |
| Sickle cell disease | Ryverna | Sickle cell disease, in patients, aged 16 years and over |
| Oesophageal and gastro-oesophageal junction cancer | Keytruda | Locally advanced unresectable or metastatic carcinoma of the oesophagus, or HER2-negative gastro-oesophageal junction adenocarcinoma, previously untreated patients, and in combination with platinum and 5-fluorouracil (5-FU) in adults whose tumours express PD-L1 with a CPS ≥ 10 |
| Metastatic triple-negative breast cancer | Keytruda | Locally recurrent unresectable or metastatic triple-negative breast cancer, in adults whose tumours express PD-L1 with a CPS ≥ 10 . |

USE THE ONCOLOGY DESIGNATED SERVICE PROVIDERS (DSPS)

It is important that you use the Scheme's Oncology DSP to prevent unnecessary co-payments. If you are unsure, contact us or ask your treating doctor if they are using our oncology pharmacy DSP for your medicine received for treatment in-rooms or in a treatment facility.

For approved oncology-related medicine where the doctor provides you with a prescription, you should use:

- MedXpress Network Pharmacy
- Dis-Chem's Oncology Courier Pharmacy
- Medipost Pharmacy
- Qestmed
- Olsens Pharmacy
- Southern Rx

DESIGNATED SERVICE PROVIDER (DSP):

Our DSP Pharmacy Network specialises in providing oncology and oncology-related medications. It is imperative that you obtain your oncology medicines exclusively through our DSP Pharmacy Network. Should you opt for a pharmacy outside of this network, a 20% co-payment will be applicable.

Within the DSP arrangement, we primarily cater to two service settings:

MEDICATION ADMINISTERED IN-ROOMS:

Medication administered in a doctor's office, such as injectable and infusional chemotherapy, should be acquired from a courier pharmacy contracted as a DSP. In-room treatment services are facilitated through a network of courier pharmacies. Typically, your treating oncologist will have a pre-established arrangement with a courier pharmacy to dispense and deliver treatment to their practice or treatment facility. The DSP network includes the following courier pharmacies, which specialise in oncology services:

- Dis-Chem's Oncology Courier Pharmacy
- Medipost Pharmacy
- Qestmed
- Olsens Pharmacy
- Southern Rx

Certain providers who self-dispense and bill the Scheme directly for in-room treatment are exempt from the DSP arrangement. The DSP arrangement also does not apply to chemotherapy administered in a hospital.

MEDICATION SCRIPTED AND DISPENSED AT A RETAIL PHARMACY:

For oncology and oncology-related medicine, such as supportive medication, oral chemotherapy, and hormonal therapy, your treating doctor typically provides a prescription for you to obtain from your local retail or courier pharmacy. Medications prescribed and dispensed through this process will be fully covered at the following pharmacies:

- MedXpress Network Pharmacy
- Dis-Chem's Oncology Courier Pharmacy
- Medipost Pharmacy
- Qestmed
- Olsens Pharmacy
- Southern Rx

By adhering to our DSP Pharmacy Network, you can ensure seamless access to your oncology medications and related services while enjoying the benefits of coverage for these essential treatments.

MATERNITY CARE BENEFIT

The Maternity Care benefit has been specially designed to enhance the Scheme's maternity benefit for expectant mothers, helping to ensure a healthy, happy pregnancy. Expectant mothers are required to register on this programme from the 12th week of their pregnancy. At registration, we will provide you with a list of benefits available as well as any other information you may require.

SUBSTANCE ABUSE FOCUS

All Netcare Medical Scheme members have access to South African National Council on Alcoholism and Drug Dependence (SANCA) approved facilities as in-patients for drug and alcohol addiction. Please contact the Client Contact Centre for confidential support and a referral to an appropriate treatment facility should you need assistance. Daily and yearly limits apply and preauthorisation is required.

HIV/AIDS PROGRAMME

It has been demonstrated that by proactively managing HIV, those who have HIV can live a healthy and fulfilling life. When you register for our HIVCare Programme, you are covered for the care that you need. You can be assured of confidentiality at all times. Call us on **0861 638 633** or email hiv@netcaremedicalscheme.co.za to register.



COVER FOR HIV PROPHYLACTICS

If you, as a Netcare member, need HIV prophylactics to prevent HIV infection from mother-to-child transmission, occupational and traumatic exposure to HIV or sexual assault, please call Netcare Medical Scheme immediately on **0861 638 633** as treatment must start as soon as possible.

This treatment is paid for by the Netcare Medical Scheme at 100% of the NMS tariff.

DIABETES CARE PROGRAMME

The Diabetes Care programme, together with your Premier Plus GP, will help you, and your dependants actively manage diabetes. A Premier Plus GP is a network GP who has contracted with us on a set of diabetes focused quality-based metrics.

This programme also unlocks cover for valuable healthcare services from healthcare providers like dietitians and biokineticists. Members with diabetes who have registered on the Chronic Illness Benefit (CIB) will be eligible to enrol on the Diabetes Care Programme, but you must make use of a Premier Plus GP so please check if your GP is listed.

CARDIO CARE PROGRAMME

The Cardio Care Programme is designed to offer members with certain heart-related conditions who have registered on the Chronic Illness Benefit (CIB) optimal care from the best service providers in a coordinated network, thereby ensuring 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 (CIB) with hypertension, hyperlipidaemia or ischaemic heart disease. A GP in the Premier Plus GP network can enrol you onto the programme.

HEALTH AT HOME BENEFIT

Health at Home comprise of several sub-programmes providing members access to a full spectrum of quality healthcare across all levels of acuity, from home. Health at Home brings together both new and existing benefits and service offerings, thereby offering our members an end-to-end, integrated at-home care experience.

HOSPITAL AT HOME

Hospital at Home provides qualifying members with the option to receive hospital level home-based care instead of being admitted to a traditional hospital or after an early discharge from hospital for continuation of care in the home. Scheme members admitted to Hospital at Home have access to enhanced benefits and services, delivered through their personalised care team. Together, these benefits and services ensure a seamless healthcare experience for patients, making them healthier, and enhancing and protecting their lives.

Members may qualify for Hospital at Home if their treating doctor deems home-based care appropriate for their medical condition. The medical conditions include but are not limited to, chronic obstructive pulmonary disease (COPD), congestive cardiac failure (CCF), community acquired pneumonia, complicated urinary tract infection (UTI), deep vein thrombosis (DVT), cellulitis, diabetes, COVID-19, pneumonia, etc. Where approved, cover will be from your Hospital Benefit if you have a valid preauthorisation for hospital level home-based care and will not affect your day-to-day benefits.

Care delivery within a home setting will be facilitated by a dedicated care team who will provide clinical support and monitoring of your condition using remote monitoring devices. While receiving care at home, members have 24/7 access to an in-person and a virtual care team. This real-time connection ensures that patients can always reach a clinician if they have questions or concerns. Depending on a patient's specific needs, consultations with allied healthcare professionals may be incorporated into their personalised care plan.

Clinical oversight

While receiving care at home, you will have access to in-person and virtual care from a dedicated care team including doctors, nurses and allied healthcare professionals. The care team will provide you with 24-hour clinical oversight and qualifying members will have access to additional Hospital at Home services to support a seamless home care delivery experience, such as:

- Discharge planning and care coordination
 - A personalised plan, which includes delivery of discharge medications, collection of oxygen concentrators, scheduling follow-up diagnostic tests and doctor appointments, navigation of Scheme benefits, and enrolment on any relevant programmes.
- 24-hour carer*
 - If additional support is required, access to a full-time carer may be provided to assist with activities of daily living.

* Individual member qualification criteria apply

Remote monitoring

Enabled by the Home Monitoring Device Benefit, you will get access to a remote monitoring device that will automatically transmit your physiological information to the hospital-based care team, 24 hours a day, 7 days a week. A member companion app will be available to you, which will not only allow for the transferring of information from your remote monitoring device but also enable you to receive reminders of upcoming visits with the care team, conduct virtual consultations, and view your treatment plan. This companion device allows your care team to directly communicate with you throughout your admissions as well as send you prompts when it is time to take your medications or perform certain tasks that will contribute towards optimising your health and aid in faster recovery.

It is important that you have constant active connection to the Internet to enable the transmission of both your physiological parameters as well as check-up responses sent via your companion app. Medical providers will be able to continually assess your health status, monitor your medical stability and recommend interventions when necessary by accessing the provider dashboard. It is important that you are in your home until you are discharged.

Hospital care

An enhanced range of clinical diagnostic procedures and interventions will be available to manage your medical or postsurgical hospital-level care requirements in the home, supported by additional risk-funded benefits to enhance your experience while receiving care in the home.

- **Interventions**
 - Medicine
 - Home oxygen
 - Phlebotomy
 - Emergency services
 - Intravenous therapy
 - Wound care
 - Suture and staple removals after surgery
 - Stoma care
 - Urinary catheter care
 - Tracheostomy care
 - Total Parenteral Nutrition (TPN)
- **Diagnostics**
 - ECG in the home
 - Ultrasound in the home
- **Value-added benefits and services**
 - Vaccinations
 - Spirometry
 - Urinalysis POC
 - Urine culture sample
 - COVID-19 testing
 - Pap smear
 - Clinically appropriate screening service

How you are covered

You can receive home-based care when recommended by your treating doctor. The programme is available on all plans, with a defined basket of care for clinically appropriate conditions that require treatment.

Where approved by the Scheme, cover includes:

- **Assessment**
 - Initial assessment by your treating doctor to determine eligibility for treatment at home
- **Supportive care at home**
 - Physical nurse visits for the duration of treatment
 - Online virtual consultations with your treating doctor
 - 24-hour virtual monitoring and oversight from a network of experienced healthcare providers
 - 24-hour caregiver (for qualifying members)
- **Devices**
 - Access to condition-specific remote-monitoring biosensor devices to measure key physiological parameters
- **Pathology services, if required**
- **Three meals a day (for qualifying members)**
- **In-person visits by allied healthcare professionals**
- **Discharge planning and care coordination**
- **Access to any other clinically appropriate at-home treatment required, as prescribed by your treating doctor**



Continuation of care after discharge (readmission prevention)

Hospital readmissions are increasing worldwide and equally noticeable within our Scheme. Internationally, up to 20% of patients admitted have a readmission within 30 days and mainly occurs within the first week of being discharged.

While efforts have been concentrated on preparing patients for good discharge during their admission, there are still gains to be made from focusing on managing patients considered high risk for a readmission within the immediate acute stages following a discharge. This benefit is aimed to achieve improvements in readmission rates based on international literature showing that a 27% reduction in readmissions can occur with a home health initiative. When integrated into the continuum of care, home health ensures that patients discharged from acute care do not suffer a relapse or deterioration that may require readmission to hospital.

This benefit has three components:

- Home care (one in-person visit, three virtual consultations, and a care coordination aspect)
- A doctor follow-up consultation
- A medicine reconciliation done at the point of discharge by the treating doctor

These components will occur intensely within the first 10 - 14 days of the patient leaving the hospital.

The benefit is targeted at only those considered high risk for a readmission. A predictive model, built for this purpose, will identify those considered highest risks for a readmission for benefit eligibility.

Special features

EMERGENCY MEDICAL EVACUATIONS

If you ever find yourself in a situation where you require emergency transport for medical reasons, you are in safe hands. The Netcare Medical Scheme ambulance benefits, which are covered under insured benefits, include medically appropriate air and road response services provided by Netcare 911. This benefit is available by contacting **082 911**.

SELF-SERVICE FACILITIES

The Netcare Medical Scheme 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 online.

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



Administrative requirements

CLAIMS ADMINISTRATION

To qualify for benefits, a claim must be submitted to the Scheme 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. If you don't follow this process, the claim will be classified as stale.

As a member of the Scheme, you are responsible for monitoring and reviewing your monthly statement 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 Scheme (in line with Regulation 6 of the Medical Schemes Act 131 of 1998).

This can only be done if your MSA reflects a positive balance.

Members are responsible for ensuring that the Scheme is informed of any changes to their banking details. Please note that changing your banking details with your Human Resources (HR) department does not update your banking details with the Scheme.

Members who pay cash for any services received should remember to submit the claim with the receipt as proof of payment using the appropriate contact details of the Scheme as provided in this Membership Brochure or communicated by the Scheme from time to time.

Members will be reimbursed at the relevant Scheme Rate and you may request the Scheme, in writing, for differences between claimed amounts and benefit amounts to be settled from your Member Savings Account (MSA).

Payment of claims is always subject to Scheme rules, tariffs and limits, and Managed Care Protocols and Guidelines may apply.

Remember to obtain preauthorisation at least 72 hours prior to a planned event or within 72 hours following an emergency.



MEMBERSHIP STATEMENTS

Claims notification will be sent electronically where email details are available. Member statements will also be available on the Scheme's website at www.netcaremedicalscheme.co.za.

MEMBER SAVINGS ACCOUNT (MSA)

- All members contribute 15% of their total monthly contribution into their Member Savings Account. For example, if your total Scheme contribution is R1,000, an amount of R150 (15% of R1,000) will be allocated to your savings and R850 towards the risk pool.
- If you have a positive savings balance in your MSA at the end of the month, you will receive interest on that amount.
- If you resign from the Scheme, your savings balance will be kept for four (4) months to settle any claims that were incurred before resignation. After the four (4) months, in compliance with the Medical Schemes Act 131 of 1998, the balance will be paid out to you or transferred to your new medical scheme. If this pay out occurs before month-end, you will not receive interest on the part-month. Please note that it is your responsibility to declare this payment to SARS and pay any tax which may be due by you as a result of this payout.
- On termination of membership, the Scheme may use your savings to offset any debt owed by the member, which may include outstanding contributions.
- The Scheme advances six (6) months of savings to members effective 1 January and 1 July of each year. Overdrawn savings (i.e. if you have used an amount from your advanced savings that exceeds the amount you have contributed at the time of your resignation) will have to be repaid if you resign from the Scheme.
- Payments from your MSA will be done at 100% of the NMS rate subject to funds being available at the date on which a claim is processed.
- You may give written instruction to the Scheme to fund any co-payments or shortfalls from your accrued MSA. Accrued savings means the portion of savings that you have already contributed for, and exclude any savings that the Scheme has advanced to you but has not yet been paid for by you.
- If you have savings available at the end of the calendar year (31 December), your savings will be carried over to the next year.
- In the unfortunate event of your passing, the savings balance due to you will be transferred to your dependants if they decide to continue membership of the Scheme or, in the absence of such dependants, paid into your estate.

Exclusions

Unless prescribed as a minimum benefit or otherwise provided for or decided by the Netcare Medical Scheme Board of Trustees, expenses incurred in connection with any of the following will not be paid by the Scheme:

- Wilful self-inflicted injury except for PMBs
- Holidays for recuperative purposes
- Accommodation and services provided in a geriatric hospital, old age home, frail care facility, or the like
- All costs of whatsoever nature incurred for treatment of sickness, conditions or injuries sustained by a member or a dependant and for which any other party is liable. The member is, however, entitled to such benefits as would have applied under normal conditions, provided that on receipt of payment in respect of medical expenses, the member will reimburse the Scheme any money paid out in respect of this benefit by the Scheme
- Treatment consequential to medical procedures for which the Scheme does not pay
- Expenses relating to or incurred in a research environment
- Medical examinations and tests for insurance or fitness purposes and overseas visits
- Treatment of injuries arising from members and beneficiaries professionally participating in any sport or speed contests
- Treatment required as a result of members' or dependants' use of any dependence-producing drugs or intoxicating liquor or the member being under the influence of any dependence-producing drugs except for PMBs
- Treatment of obesity and slimming preparations
- The treatment of infertility and artificial insemination, including all costs relating to sperm count tests, in vitro fertilisation, gamete intrafallopian transfer, GIFT procedures, zygote intrafallopian transfer (ZIFT) procedures, embryo transport, surrogate parenting, donor semen (and related costs including collection and preparation), and non-medically necessary amniocentesis other than PMBs stipulated in the Regulations to the Medical Schemes Act 131 of 1998
- Costs incurred for treatment received outside the borders of South Africa.

- Interest and legal fees relating to overdue medical accounts
- Domestic and biochemical remedies
- Exceeded annual or pro-rated limits
- Patent foods or baby food, bandages, cotton wool or similar aids, sunscreen, shampoos and skin-cleansing remedies
- Sterility and impotence examinations
- Cosmetic procedures including but not limited to gastroplasty, bat ears, blepharoplasty, dermabrasion, lipectomy, breast augmentation and reduction, liposuction, nasal reconstruction, revision of scars and face lifts
- Vitamins, tonics and mineral supplements not prescribed in conjunction with an antibiotic or forming part of the maternity and HIV programmes. Some vitamins that have a NAPPI code may be procured from positive savings at a member's discretion
- Illness, injury or disease arising from war, unrest or riots except for PMBs
- Appointments not kept
- Injury or sickness caused by treatment of alcohol or drug abuse, unless registered with a SANCA approved programme or a PMB
- Antenatal and post-natal classes or post-natal care at home unless registered on the maternity programme
- Sunglasses and tinted lenses, unless the member requests this to be paid from positive savings account balances
- Charges for services relating to preventative healthcare not explicitly listed under the Preventative Care benefit
- Boarders in respect of patient's stay in hospital
- Fees charged by persons not legally registered with the relevant authority
- Any sexually transmitted diseases except for PMBs
- Travel expenses (other than ambulance costs, where the use of an ambulance is certified as necessary by a medical practitioner and transport is provided by Netcare 911)
- Accommodation in retirement villages
- Treatment not set out in the benefit structures and rules except for PMBs
- Treatment relating to pre-existing sickness conditions subject to waiting periods when the member joined the Scheme
- Limitation of benefits
 - The maximum benefits to which a member and their dependants are entitled in any financial year are limited as set out in Annexure B of the official Scheme rules.
 - Members admitted during the course of a financial year are entitled to the benefits set out in Annexure B of the official Scheme rules, with the maximum benefits being adjusted in proportion to the period of membership calculated from the date of admission to the end of the particular financial year.
- Unless otherwise decided by the Board, benefits in respect of medicines obtained on a prescription are limited to one (1) month's supply for each such prescription or repeat thereof
- Laparoscopic approach procedures except if specifically authorised
- Any services which are not mentioned in the rules that are not rendered in terms of accepted protocols or that are not aimed at the treatment of an actual or supposed condition or deficiency, disadvantaging or endangering essential bodily functions



Important terminology

CO-PAYMENT

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

EMERGENCY MEDICAL CONDITION

An emergency medical condition means 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.

CHRONIC DRUG AMOUNT (CDA)

If you are registered for a chronic condition, NMS will fund your chronic medicine on the Scheme's medicine list (formulary) in full. If your approved medication is not on the Scheme's medicine list, your chronic medicine will be funded up to a set monthly amount (Chronic Drug Amount).

NETCARE MEDICAL SCHEME TARIFF (NMS TARIFF)

The NMS Tariff is the tariff for medical services as approved by the Board of Trustees on an annual basis.

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 Scheme will pay for such emergencies from the insured (risk) benefit and not from your MSA.

PREFERRED PROVIDER

Preferred Providers are those healthcare providers with whom the Scheme has made special arrangements to provide members with effective and cost-efficient services. These providers will not request upfront payment from members. Unlike in the case of DSP arrangements, the Scheme does not restrict members to utilise the services of Preferred Providers.

Rather, we recommend their use where they are available in order to optimise benefits and minimise co-payments.

PRESCRIBED MINIMUM BENEFITS (PMBs)

Prescribed Minimum Benefits are defined in the regulations of the Medical Schemes Act 131 of 1998 as 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 treatment plans and conditions. Members are required to utilise Designated Service Providers for PMBs. A total of 271 diagnoses and 26 chronic conditions are listed as PMBs.

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 therefore 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 Scheme as an Ex Gratia award. Ex Gratia awards are not registered benefits, but are awarded at the discretion of the Board of Trustees. The Board has appointed an Ex Gratia committee who review the applications received and this committee is mandated to act on behalf of the Board in making decisions on behalf of the Trustees and the Scheme in this regard. 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:

01. Contact the Scheme's call centre during office hours and try to resolve your query with the call centre.
02. If the result is not considered to be satisfactory by you, you can contact the Principal Officer. The contact details are available in the, Contact details' section of this brochure.
03. Lodge your complaint in writing, for the attention of the 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.

04. 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 (CMS) 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

E mail address: complaints@medicalschemes.co.za



Contact details

CLIENT CONTACT CENTRE

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

Phone: **0861 638 633**

member@netcaremedicalscheme.co.za

AMBULANCE AND EMERGENCY SERVICES

Phone: **082 911**

MEMBER CLAIM SUBMISSION

Postal address:

Claims Department

PO Box 652509

Benmore 2010

claims@netcaremedicalscheme.co.za

Fax: **0860 329 252**

MATERNITY REGISTRATION

maternity@netcaremedicalscheme.co.za

APPLIANCE AND PROSTHESES AUTHORISATIONS

preauthorisations@netcaremedicalscheme.co.za

ONCOLOGY REGISTRATIONS AND AUTHORISATION

oncology@netcaremedicalscheme.co.za

CHRONIC MEDICATION QUERIES AND RENAL DIALYSIS REGISTRATIONS AND QUERIES

chronics@netcaremedicalscheme.co.za

CHRONIC ILLNESS BENEFIT APPLICATIONS

chronicapplications@netcaremedicalscheme.co.za

SPECIALIST AUTHORISATION

member@netcaremedicalscheme.co.za

HIV REGISTRATION AND AUTHORISATION

hiv@netcaremedicalscheme.co.za

HOSPITAL AUTHORISATION

preauthorisations@netcaremedicalscheme.co.za

ESCALATED COMPLAINTS

complaints@netcaremedicalscheme.co.za

PRINCIPAL OFFICER

Craig Taylor

craig.taylor@netcare.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 mail

member@netcaremedicalscheme.co.za.

*This Member Brochure is intended to summarise the Rules of Netcare Medical Scheme applicable to the principal member and their dependants registered with the Scheme. A copy of the full set of Rules can be obtained from the Scheme's website at **www.netcaremedicalscheme.co.za**. Should a discrepancy arise between this Member Brochure and the rules of the Scheme, the rules of the Scheme will take precedence. Subject to CMS approval.*

Annexure A

CONTRIBUTION TABLE

The contribution table below applies from 1 May 2025.

| | SALARY BANDS | | TOTAL PREMIUM | | | RISK | | | SAVINGS | | |
|---|--------------|--------|---------------|-------|-------|-----------|-------|-------|-----------|-------|-------|
| | FROM | TO | PRINCIPAL | ADULT | CHILD | PRINCIPAL | ADULT | CHILD | PRINCIPAL | ADULT | CHILD |
| A | - | 2,847 | 3,191 | 1,606 | 645 | 2,710 | 1,365 | 548 | 481 | 241 | 97 |
| B | 2,848 | 3,796 | 3,274 | 1,654 | 654 | 2,780 | 1,407 | 555 | 494 | 247 | 99 |
| C | 3,797 | 4,743 | 3,360 | 1,707 | 683 | 2,856 | 1,450 | 581 | 504 | 257 | 102 |
| D | 4,744 | 6,867 | 3,503 | 1,827 | 725 | 2,980 | 1,552 | 616 | 523 | 275 | 109 |
| E | 6,868 | 7,592 | 3,736 | 1,958 | 782 | 3,176 | 1,665 | 664 | 560 | 293 | 118 |
| F | 7,593 | 9,493 | 4,067 | 2,236 | 861 | 3,457 | 1,904 | 731 | 610 | 332 | 130 |
| G | 9,494 | 11,387 | 4,337 | 2,551 | 989 | 3,687 | 2,166 | 841 | 650 | 385 | 148 |
| H | 11,388 | 13,284 | 4,471 | 2,784 | 1,075 | 3,800 | 2,367 | 916 | 671 | 417 | 159 |
| I | 13,285 | 15,182 | 4,569 | 2,897 | 1,140 | 3,883 | 2,466 | 970 | 686 | 431 | 170 |
| J | 15,183 | 17,081 | 4,695 | 3,123 | 1,178 | 3,988 | 2,658 | 1,003 | 707 | 465 | 175 |
| K | 17,082 | 18,979 | 4,796 | 3,318 | 1,286 | 4,082 | 2,823 | 1,094 | 714 | 495 | 192 |
| L | 18,980 | 20,876 | 4,832 | 3,351 | 1,293 | 4,110 | 2,846 | 1,101 | 722 | 505 | 192 |
| M | 20,877 | 22,777 | 4,857 | 3,374 | 1,305 | 4,132 | 2,864 | 1,110 | 725 | 510 | 195 |
| N | 22,778 | 24,673 | 4,901 | 3,443 | 1,321 | 4,167 | 2,930 | 1,124 | 734 | 513 | 197 |
| O | 24,674 | 26,571 | 4,956 | 3,562 | 1,339 | 4,209 | 3,029 | 1,137 | 747 | 533 | 202 |
| P | 26,572 | 28,469 | 5,093 | 3,656 | 1,368 | 4,328 | 3,109 | 1,164 | 765 | 547 | 204 |
| Q | 28,470 | 30,367 | 5,132 | 3,689 | 1,385 | 4,363 | 3,136 | 1,176 | 769 | 553 | 209 |
| R | 30,368 | 32,264 | 5,174 | 3,737 | 1,398 | 4,401 | 3,176 | 1,188 | 773 | 561 | 210 |
| S | 32,265 | 34,161 | 5,288 | 3,805 | 1,430 | 4,494 | 3,233 | 1,217 | 794 | 572 | 213 |
| T | 34,162 | 36,061 | 5,394 | 3,881 | 1,452 | 4,588 | 3,300 | 1,235 | 806 | 581 | 217 |
| U | 36,062 | 37,960 | 5,394 | 3,881 | 1,452 | 4,588 | 3,300 | 1,235 | 806 | 581 | 217 |
| V | 37,961 | 47,447 | 5,512 | 3,970 | 1,482 | 4,685 | 3,374 | 1,259 | 827 | 596 | 223 |
| W | 47,448 | 56,937 | 5,628 | 4,060 | 1,518 | 4,787 | 3,453 | 1,290 | 841 | 607 | 228 |
| X | 56,938 | 99,999 | 5,752 | 4,146 | 1,545 | 4,890 | 3,522 | 1,314 | 862 | 624 | 231 |

Netcare Medical Scheme, registration number 1584, is administered by Discovery Health (Pty) Ltd, registration number 1997/013480/07. Discovery Health (Pty) Ltd is an authorised financial services provider.