Administered by Discovery Health

ENGEN | Medical Benefit Fund

4TH EDITION

NEWSLETTER

2023

WHAT TO DO WHEN YOUR MEDICAL SAVINGS ACCOUNT IS DEPLETED

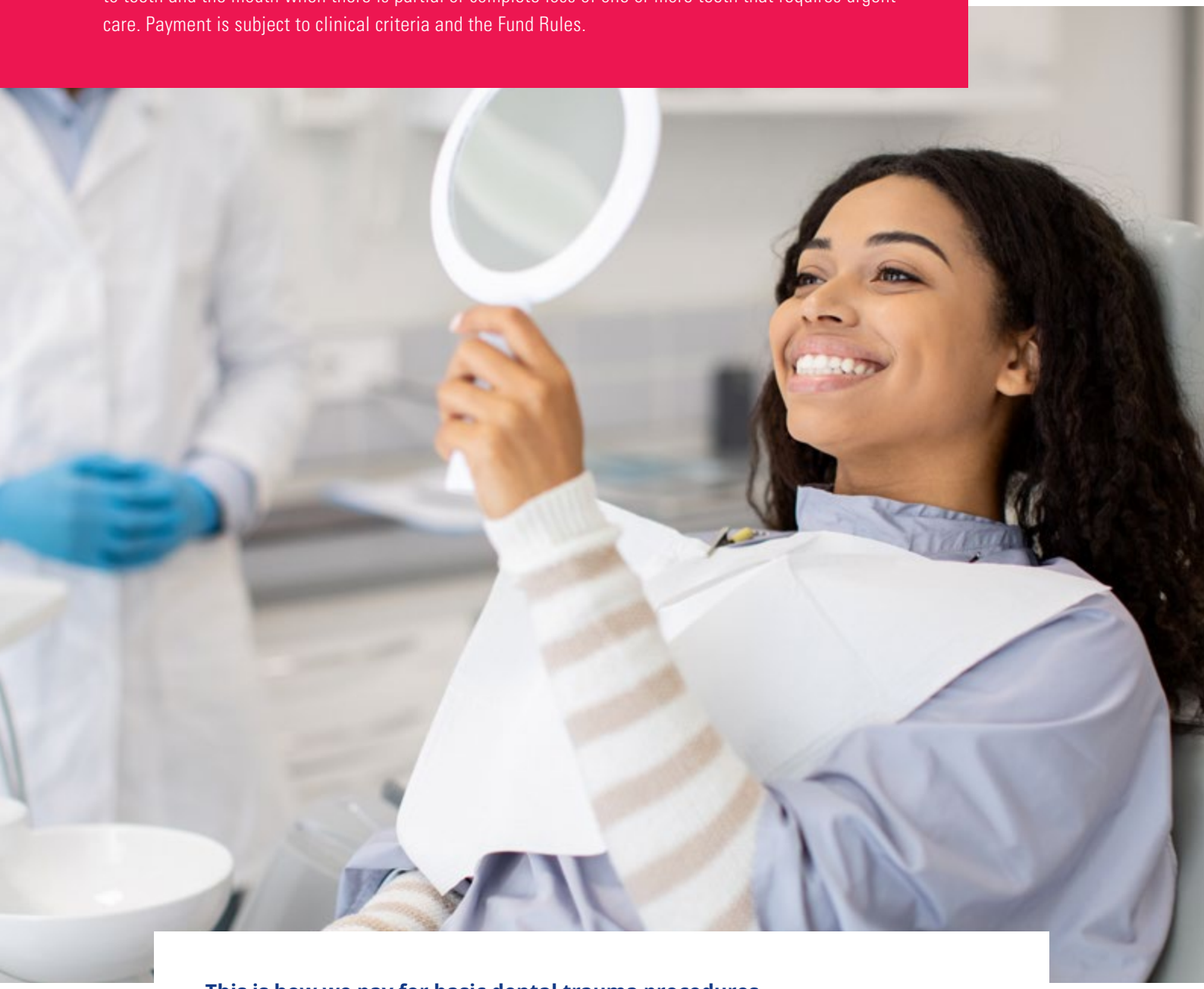
We calculate and allocate your Medical Savings Account (MSA) balance based on the number of dependants registered on your membership on 1 January of each year. This gives you yearly upfront medical funds that you can use to pay all day-to-day claims received from 1 January to 31 December of that year. Once your MSA is depleted, you have access to the Primary Care benefit with applicable limits.

Please read your member guide to learn more.

BASIC DENTAL TRAUMA BENEFIT

The Fund pays for basic dental trauma procedures from the Basic Dental Trauma Benefit.

This benefit covers you for sudden and unanticipated impact injuries because of an accident or injury to teeth and the mouth when there is partial or complete loss of one or more teeth that requires urgent care. Payment is subject to clinical criteria and the Fund Rules.



This is how we pay for basic dental trauma procedures

We pay claims for your authorised treatment up to 100% of the Fund Rate, up to a specific limit per beneficiary per year.

You must pay an upfront payment (deductible) to the facility if the procedure is done in a hospital or day clinic.

Read the member guide for more information.

THE NATIONAL HEALTH INSURANCE BILL

On 13 June 2023, the National Assembly passed the National Health Insurance (NHI) Bill. The objective of the NHI Bill is to provide access to affordable, quality healthcare for all South Africans. The Bill is now being processed by the National Council of Provinces (NCOP).

Because the Bill is a Section 76 Bill (an ordinary Bill that affect the provinces), it will be extensively analysed by the provincial legislatures. If the NCOP also passes the Bill, then it will be passed on to the office of the president for approval. However, if the NCOP does not agree with it, the Bill will be sent back for further amendments and processing.

In an interview, the Deputy President, Paul Mashatile, noted that further discussion is needed before the NHI Bill is signed into law. This suggests that there may be delays before the Bill is officially passed. We will share more information about the NHI Bill when it becomes available.

THE ROLE OF A CASE MANAGER IN A HOSPITAL

A hospital case manager is a professional who handles the hospital's discharge planning and utilisation reviews. The case manager is usually a registered nurse, but anyone with the right experience can be a case manager. They often collaborate with social workers, physicians, nurses and other medical staff to provide important medical care to patients.

A case manager's responsibilities include working with your doctor and the team providing services to you in:

- **Creating discharge plans for patients**

Discharge plans help case managers to determine if the patient will need further help or care after they leave the hospital. The case manager will communicate with the patient or their family about the steps to take to help them recover after they're discharged. This may include follow-up hospital visits or getting home-based care.

- **Completing utilisation reviews**

Utilisation reviews help to make sure that hospitals follow important protocols and that patients receive the highest care for their conditions or illnesses. These reviews help manage the cost of healthcare benefits by assessing and deciding the appropriate treatment for a patient's condition before treatment is provided, using evidence-based criteria or guidelines.

- **Compiling information for the patient's medical scheme**

Case managers compile the necessary information to give to the Fund. This can include the patient's current medical condition, information about their medical history and any information that is relevant to their hospital visit. This helps the case manager to get a better understanding of the patient's condition, help them negotiate with the Fund and do their best to prevent claim denials.

- **Creating rehabilitation plans**

If a patient needs rehabilitation after being discharged, the case manager will communicate with the patient, their family, and the Fund to create a suitable plan. The case manager will usually try to find a rehabilitation programme or specialist that provides the best care and is covered by the Fund.

- **Negotiating cover benefits**

If a patient needs specific treatment for their condition that the Fund doesn't cover, the case manager might arrange a meeting with the patient, the Fund and other medical professionals. Together they'll try to find a suitable solution. For example, the case manager might consult with doctors and pharmacists to see if there are other options or possible payment plans available.

In some of the large hospitals across the Country, you may meet a Discovery Health case manager when you are in hospital. The case manager is a member of the team looking after you when you are in hospital and focuses on ensuring you are receiving the right level of care and makes it easy for you to obtain the necessary authorisations from the Fund.

HEART HEALTH

Every year on 29 September, we celebrate World Heart Day. This is a global initiative of the World Heart Federation to raise awareness about heart health. It's a reminder that we should all make a promise to ourselves every day to take care of our hearts.

Cardiovascular disease is a leading cause of death globally. Those at risk of developing this disease may have high blood pressure, high blood sugar levels, high cholesterol or be overweight. The lifestyle factors that increase the risk of developing cardiovascular disease include tobacco use, physical inactivity, an unhealthy diet, and increased alcohol use.

The Cardio Care Programme

The Fund introduced the Cardio Care Programme to ensure you will have cover for quality care and outcomes. The Programme enables your Premier Plus GP to diagnose and start appropriate treatment while managing your risk factors with the support of a high functioning multidisciplinary care team.

How to access cover from the Cardio Care Programme

You must consult with a Premier Plus GP to access the Cardio Care Programme and be registered on the Chronic Illness Benefit (CIB) for at least one of the following conditions:

- Hypertension (high blood pressure)
- Ischaemia (coronary heart disease)
- Hyperlipidaemia (high cholesterol)

Please contact us on 0800 001 615 or visit our website at www.engenmed.co.za for more information.

COVER FOR PRESCRIBED MINIMUM BENEFITS

As an Engen Medical Benefit Fund member, you have cover for Prescribed Minimum Benefits (PMBs). They are a set of defined benefits to make sure that all medical scheme members in South Africa have access to certain minimum healthcare services. The aim is to give members access to cover for continuous care to improve their health and wellbeing and to make healthcare more affordable. PMBs are defined and governed by the Council for Medical Schemes (CMS) and the Medical Schemes Act 131, 1998.

What we pay for

The Prescribed Minimum Benefits (PMB) Chronic Disease List (CDL) is a list of conditions which all medical schemes must cover. Your cover includes funding for the diagnosis, treatment, and ongoing care for the listed conditions. These services include approved treatment, medicine, consultations, blood tests and other defined tests. We pay for these healthcare services as PMBs, and it will not affect your day-to-day benefits.

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

- Emergency medical conditions
- A defined list of 271 diagnoses
- 26 chronic conditions (Chronic Disease List conditions).

Click here to learn about what procedures, tests and consultations we cover for the diagnosis and ongoing management for each PMB condition. You can also learn more about the applicable medical conditions on the PMB list.

Keep in mind that we will only pay PMB claims if your condition has been registered and authorised on the Chronic Illness Benefit.

Use the Fund's designated service providers (DSPs) for full cover

Designated service providers (DSPs) are healthcare professionals with whom we have a payment arrangement. These healthcare professionals have agreed to provide treatment or services to our members at a contracted rate.

If you do not use a DSP, we will pay up to 100% of the Fund Rate. You will then be responsible for the difference between what we pay and the actual cost of your treatment, which means you will have to make a co payment.

To avoid co-payments when you use the services of a GP or Specialist, you must go to a GP or Specialist in the Fund's designated service provider (DSP) networks. In addition, you must be admitted to a hospital in the Fund's PMB network of hospitals to make sure all the costs for PMB treatment in a hospital are paid in full.

When you don't have time to look for a designated service provider (DSPs)

In a medical emergency, you can go directly to hospital and notify the Fund of your admission as soon as possible. You are covered in full for the first 24 hours or until you are stable enough to be transferred to a DSP if it is a medical emergency, i.e., your condition is life threatening and you need immediate care.

Keep in mind that we pay for treatment not included in the PMBs from your available benefits (where appropriate) and according to the rules of the Fund.

How to find designated service providers (DSPs)

To search for a service provider that is in our networks closest to you, click here.

What to do if there is no available designated service provider (DSP)

There are some instances when you will still have full cover if you use a healthcare provider who is not a designated service provider (DSP). In a medical emergency or when the use of a non designated service provider (non-DSP) is involuntary, or when there is no DSP available.

In cases where there are no services or beds available at a designated service provider (DSP) when you or one of your dependants need treatment, you can contact us on 0800 001 615. We will arrange for an appropriate facility or healthcare provider to accommodate you.

Your cover for chronic (long-lasting) conditions on the Chronic Illness Benefit

We want to help you to be as healthy as possible. The Chronic Illness Benefit (CIB) pays for specific medicine, tests and doctor's visits once you register your chronic condition with us. This means you get to keep your day to day medicine benefit for unexpected illnesses.

Keep in mind that you should go to one of the Fund's network providers for your treatment and care if you want the Fund to pay your claims in full. This includes network pharmacies.

How we pay for medicine from the Chronic Illness Benefit

The Chronic Illness Benefit covers authorised medicine for the 26 Prescribed Minimum Benefit (PMB) Chronic Disease List (CDL) conditions.

Authorised medicine for your approved PMB condition that appears on the Fund's formulary (list of medicines to treat the condition) will be funded in full up to the Fund Rate. Medicines that do not appear on the formulary will be funded up to the Maximum Medical Aid Price (MMAP) or Fund Rate in the absence of the MMAP.

For ADL conditions, there is no list of medicine. We pay for approved medicines for these conditions up to the MMAP or Fund Rate in the absence of MMAP.

The Fund uses the MMAP, a guide detailing the maximum price medical schemes will pay for an interchangeable multi-source pharmaceutical product (generic product).

You can get details of the Chronic Disease List on the Fund's website at www.engenmed.co.za.

If your condition is one of the CDL or if you use non-PMB medicine continuously for more than 3 months and you meet the clinical entry criteria, you can register on the Chronic Illness Benefit. You may have to get specific tests done and submit the results to us to prove that you have the condition to qualify.

How to register

You can register in one of three ways:

- If your treating doctor is part of our network, they can use HealthID (the healthcare professionals' platform) to register for the Chronic Illness Benefit on your behalf. You must give your consent before your doctor can start the process.
- You and your treating doctor can complete the Chronic Illness Benefit application form and send it to us. You can download the Chronic Illness Benefit application form from the Fund's website at www.engenmed.co.za.
- You can phone 0800 001 615 to register, or your doctor can phone 0860 44 55 66 to register your condition.

To avoid co-payments (additional payments which you must pay yourself) and get the most out of your benefits, make sure your doctor is one of our designated service providers.