ENGEN | Medical Benefit Fund

Administered by Discovery Health

Maternity Benefit 2022

Who we are

Engen Medical Benefit Fund, registration number 1572, is a not-for-profit organisation, registered with the Council for Medical Schemes.

Discovery Health (Pty) Ltd, registration number 1997/013480/07, is a separate company, and an authorised financial services provider, and is responsible for the administration of your membership on behalf of the Fund.

About this document

This document tells you about how Engen Medical Benefit Fund covers pregnancy and childbirth. Read further to understand what is included in your benefits and how to get the most out of your Maternity Benefits.

Out-of-Hospital Maternity Benefits

These healthcare services are covered from the Maternity Benefit at the Fund Rate from the date of activation, and are paid from Insured Benefits.

Your cover includes:

Antenatal Basket:

- Twelve ante-natal consultations with a midwife, GP or gynaecologist. We will fund the GP, specialist and midwife at the Network rate for provider on the Network, or up to the Fund Rate for non-Network GPs, specialists and midwives.
- One non-invasive prenatal test (NIPT) or T21 Chromosome Test.
- A defined basket of pregnancy blood tests.
- Two 2D ultrasounds scans.

Antenatal and Post-natal Basket:

- Essential maternity-related external medical devices for you and your baby such as breast pumps or nebulisers. This is paid at 75% of the Fund rate and limited to R5 350 per member per pregnancy.

Post-natal mom and baby basket:

- One consultation with a midwife, GP or gyneacologist within 6 weeks of the delivery for any post-delivery complications.
- One consultation with a registered lactation specialist.
- One nutrition assessment with a dietician for the mother up to two years after the birth of your baby.
- Two consultations with a GP, gynaecologist, counsellor or psychologist for post-natal mental healthcare services.
- Two visits with a GP, paediatrician or ENT for children under the age of 2 years who are registered on the Fund.

If you are not registered on the Maternity Programme, or once you have used up your Maternity Benefit, we pay for out-of-hospital healthcare expenses related to your pregnancy from your available day-to-day benefits. If you do not have day-to-day benefits, or if you have run out of funds, you must pay for these costs yourself.

In-Hospital Maternity Benefits

We pay for the hospital account from the Hospital Benefit, subject to authorisation. All related accounts such as the gynaecologist, midwife, anaesthetist and other healthcare services will be paid at 100% of the Fund rate from the Hospital Benefit.

You have cover for 3 days and 2 nights for a normal delivery or 4 days and 3 nights for a caesarean section if approved. The day of the delivery is counted as day one.

If you need to stay in hospital longer than the number of days we have authorised, your doctor will need to send a letter with additional clinical information to support why you need to stay in hospital longer.

We cover home births with a registered midwife

Home births are covered from your Hospital Benefit. We will cover the cost of a midwife up to the maximum Fund rate for up to 2 days including the delivery. The midwife must be registered with a valid practice number.

We cover water births in-hospital or at home

If you choose to have a water birth in hospital, we will pay for up to 3 days and 2 nights, the cost of the birthing pool is included in your delivery. If you choose to hire one, you will be responsible for the payment of the birthing pool. If you choose to have a water birth at home, we will pay for the cost of the hire of a birthing pool from your Hospital Benefit. This must be hired from a provider who has a registered practice number.

If you choose to have a water birth or normal delivery at home, we will pay for up to 2 days midwifery care (including the delivery) from your Hospital Benefit up to the maximum Fund rate. The midwife must be registered with a valid practice number.

Home Nursing

If your doctor is comfortable to discharge you and your baby earlier, you both may qualify for the postnatal service in the comfort of your home. It includes up to a maximum of three-day visits for a normal delivery and four-day visits for a caesarean section by a midwife after giving birth. We will cover the days for which you receive home nursing up to the number of days we would have covered in hospital. This is three days for a normal delivery and four days for a caesarean section. The day of the delivery is counted as the first day.

This service will be provided by Discovery Home Care and will be covered from the Hospital Benefit, if approved. Please contact homecare@discovery.co.za if you are interested in this service.

You must discuss your discharge plan with your healthcare professional and advise us, to avoid possible short payments on claims.

Treatment for neonatal jaundice

If your baby needs phototherapy for neonatal jaundice, we will cover the phototherapy lights from the Insured Benefit, if authorisation is obtained.

We cover medically necessary circumcisions from the Hospital Benefit

Please pre-authorise the procedure with us if it is done in hospital. You do not require an authorisation if the circumcision is done in the doctors rooms and it is covered from your Risk Benefit.

There are certain items we do not cover

- Mother-and-baby packs supplied by the hospital.
- The bed booking fee that some hospitals may need you to pay.
- Your lodging or boarding fees if your baby needs to stay in-hospital for longer and you choose to stay on with the baby.
- The cost of a birthing pool for water births, if you choose to hire a birthing pool from a non-registered practitioner.

How to activate the Maternity Benefit

The maternity and early childhood benefits will be effective from the date of activation.

Activate your maternity and early childhood benefits:

- When you create your pregnancy or baby profile on the My Pregnancy or My Baby programmes on www.engenmed.co.za or on the Discovery app, or
- When you preauthorise your pregnancy and delivery or
- When you register your baby onto the Fund

You can also call us on 0800 001 615 or visit www.engenmed.co.za to activate your Maternity and early childhood benefits, to find out how you are covered and to authorise your hospital admission.

Getting the most out of your maternity benefits

Tell us about your pregnancy

Engen Medical Benefit Fund covers the birth of your baby either in hospital with a doctor or midwife or at home with the help of a midwife. It is important to call and notify us of your pregnancy as soon as you are 12 weeks pregnant or earlier, so that you always know how we cover you for your pregnancy-related healthcare services whether these are done in or out of hospital.

Make sure your baby is covered

Your baby will be covered for the calendar month of his or her birth. To continue cover, contributions for your baby must be paid from the first month following the baby's birth.

Example: A baby is born on the 3rd March. The mother is registered on the Fund. The baby is covered until the 31st March. If the baby needs cover from the 1st April onwards, the baby must be registered on the Fund.

To ensure all the necessary treatment for your baby is covered it is advisable to register your baby on the Fund as soon as possible after birth, within 30 days from the date of birth.
Your baby may be subject to underwriting if he or she is not registered within the 30-day period.
Your baby will be registered from their date of birth however contributions will only be charged from the first day of the month following the birth.

Understand your benefits

Prescribed Minimum Benefits (PMBs) are a set of conditions which all medical schemes must provide a basic level of cover for. The Prescribed Minimum Benefit (PMB) regulations include funding for antenatal care where it is necessary to hospitalise the mother before she gives birth.

We pay for confirmed PMBs in full from the hospital benefit subject to you meeting the requirements. Please refer to our PMB guide, visit www.engenmed.co.za or call us on **0800 001 615** for more details about the PMB requirements and how you are covered.

We pay for benefits not included in the PMBs from your appropriate and available hospital benefit and day-to-day benefits, according to the rules of the Fund.

How we cover In-Hospital claims

For confirmed PMBs we will cover the hospital account at 100% of the negotiated rate from the Insured Benefit and related accounts in full at the agreed rate if you receive treatment from a Designated Service Provider (DSP). Treatment received from a non-designated service provider (non-DSP) may be subject to a co-payment if the healthcare provider charges more than what we pay.

We pay for benefits not included in the PMBs from your appropriate and available insured and day-to-day benefits, according to the rules of the Fund.

Using the designated healthcare service providers

You have cover for healthcare providers up to 100% of the Fund Rate.

You can use www.engenmed.co.za or call us on **0800 001 615** to find healthcare service providers who we have an agreement with for the Fund.

All medical schemes must ensure that their members do not experience shortfalls when they use Desiganted Service Providers (DSPs). Members of the Fund should use healthcare providers who we have a payment agreement with so that they do not experience co-payments. Using a non-designated service provider (non-DSP) may result in a co-payment.

Some examples of DSPs you will have when admitted to hospital are:

- Specialists
- GPs
- Hospitals

There are some cases where it is not necessary to meet these requirements but you will still have full cover. An example of this is in a life-threatening emergency.

There are some circumstances where you do not have cover for PMBs

This can happen when you join a medical scheme for the first time, with no medical scheme membership before that. It can also happen if you join a medical scheme more than 90 days after leaving your previous medical scheme. In both these cases, the scheme would impose a waiting period, during which you and your dependants will not have access to the PMBs, no matter what conditions you might have. We will communicate with you at the time of applying for membership if waiting periods apply.

There are a few instances when the Fund will only pay a claim as a PMB

This happens when you have a waiting period or when you have treatments linked to conditions that are excluded by the Fund. This can be a three-month general waiting period or a 12-month condition-specific waiting period. But you might have cover in full, if you meet the requirements stipulated by the PMB regulations.

Contact us

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

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Complaints process

You may lodge a complaint or query with Engen Medical Benefit Fund directly on 0800 001 615, address a complaint in writing to the Principal Officer at the Fund's registered address. If your complaint remains unresolved, you may lodge a formal dispute by following the Fund's internal disputes process.

You may, as a last resort, approach the Council for Medical Schemes for assistance. Council for Medical Schemes Complaints Unit, Block A, Eco Glades 2 Office Park, 420 Witch-Hazel Avenue, Eco Park, Centurion, 0157 / 0861 123 267 / complaints@medicalschemes.co.za / www.medicalschemes.co.za

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