moto HEALTH CARE

taking care of our own

2026 MEMBER GUIDE

Taking care of our own at every stage of their health journey

Contents

Moto Health Care (MHC) Key Features

For the people in the motor industry.

Cover created especially for you
7 options to choose from, catering for various needs.

Managed Care programmes/services
A holistic approach to the patient accessing benefits.

Day-to-day benefits
Including general practitioner (GP) and specialist visits, dentistry, optical services and radiology. Private and State hospital cover plus take home medications.

High quality and world class service
Dedicated services from our healthcare providers through care driven benefits. Networks of doctors, hospitals and pharmacies.

Virtual advice via Hello Doctor
Talk to a doctor on your phone for free - anytime, anywhere, in any of our official languages.

Best value for money in terms of benefit versus cost
A value-based healthcare system that lowers healthcare costs, resulting in lower contributions.

Comprehensive Cover At Affordable Rates

'Taking care of our own' means you get quality medical cover inclusive of many value adding innovative products such as free virtual advice and tips via Hello Doctor, the MHC mobile app, free preventative care benefits, a maternity programme tailored for all expectant parents, as well as free patient care programmes with dedicated wellness coaches and innovative products. You get even more with comprehensive hospital and day-to-day cover for complete peace of mind.

The Scheme rules are available on request and available on the website. Benefits are subject to approval from the Council for Medical Schemes (CMS).

PLEASE NOTE: Product rules, limits, terms and conditions apply. Where there is a discrepancy between the content provided in this member guide, the website and the Scheme rules, the Scheme rules will prevail.

Wellness Programme

Preventative benefits available

MHC offers wellness and preventative care benefits to help all members lead healthier and happier lives. Preventative screening is an important way to detect medical conditions early. Having these specific tests (up to the specified number) does not affect your day-to-day benefits. The healthcare professional will guide you when you receive your test results, where necessary.

Information will be shared on measures you can take to prevent or reduce your health risks. You can also receive health tips on topics of your choice by downloading the Hello Doctor app. You may be contacted by one of our wellness or lifestyle coaches should you be classified as a high-risk member.

Download the Hello Doctor App

GET IT ON Google Play | Download on the App Store | EXPLORE IT ON AppGallery

hello doctor
Powered by momentum

Wellness Programme Benefits

What is covered under the wellness benefit?

ESSENTIAL OPTION				
What does the programme cover?	**Age**	**Frequency**	**Tariff code**	**Comment**
Baby and child immunisations		In line with the Department of Health protocols		Subject to use of a network provider
Flu vaccines		One flu vaccine per beneficiary per year	731826 300826	Subject to use of a network provider
Pneumococcal vaccines	High risk and beneficiaries older than 60 years		755826 715858 705032 714999	Subject to use of a network provider
Blood pressure testing	All beneficiaries			Use a network provider
Blood glucose testing (pathologist)	All beneficiaries	Once a year	4057	Use a network provider
Cholesterol test (pathologist)	All beneficiaries	Once a year	4026 4027 4028 4147	Use a network provider
Clinical breast screening	High risk members			Subject to pre-authorisation and use of a network provider
Pap smear (GP)	Female15 years and older	Once a year	4566 4559	Use a network provider
Prostate specific antigen (PSA) testing	Males 40 to 49 years Males 50 to 59 years Males 60 to 69 years Males 70 years and older	Once every five years Once every three years Once every two years Once a year	4519	Use a network provider
TB screening (pathologist)	All beneficiaries		3916	Use a network provider
Tetanus diphtheria injection	All beneficiaries	As needed		Subject to pre-authorisation and use of a network provider
Human Papilloma Virus (HPV) Vaccination	All females between ages 9 and 26 years All males between 9 and 18 years All high-risk females (after discussion with their physicians) between the ages 26 and 45 years	Two vaccines per beneficiary per lifetime	3006049 710249 710020	Subject to pre-authorisation and use of a network provider
Colorectal Screening	High risk lives of 50 years and over	Once a year	4352	No authorisation required

ESSENTIAL OPTION				
Antenatal care (GP)	Subject to the specialist limit and use of a network provider			
Paediatric visit	One paediatric visit per family subject to the use of a network provider and specialist limit			
Pregnancy vitamins	Subject to medication formulary and registration onto the maternity programme			
Scans	Two 2D scans per pregnancy 3D and 4D scans will be paid at 2D scan rates			
Certain blood tests				
CUSTOM OPTION: EARLY DETECTION TESTS				
Baby and child immunisations	In line with the Department of Health protocols			Subject to use of a network provider
Flu vaccines		One flu vaccine per beneficiary per year	731826 300826	Subject to use of a network provider
Pneumococcal vaccines	High risk and beneficiaries older than 60 years		755826 715858 705032 714999	Subject to use of a network provider
Blood pressure testing	All beneficiaries	As required		Use a network provider
Blood glucose testing (pathologist)	All beneficiaries	Once a year	4057	Use a network provider
Cholesterol test (pathologist)	All beneficiaries	Once a year	4026 4027 4028 4147	Use a network provider
Mammogram	Females 38 years and older	Once every two years	34100 34101	Subject to pre-authorisation and use of a network provider
Pap smear (GP and gynaecologist)	Females 15 years and older	Once a year	4566 4559	Subject to use of a network provider
Human Papilloma Virus (HPV) Vaccination	All females between ages 9 and 26 years All males between 9 and 18 years All high-risk females (after discussion with their physicians) between the ages 26 and 45 years	Two vaccines per beneficiary per lifetime	3006049 710249 710020	Subject to pre-authorisation and use of a network provider
Prostate specific antigen (PSA) testing	Males 40 to 49 years Males 50 to 59 years Males 60 to 69 years Males 70 years and older	Once every five years Once every three years Once every two years Once a year	4519	Subject to use of a network provider
TB screening (pathologist)	All beneficiaries		3916	Subject to use of a network provider
Colorectal Screening	High risk lives 50 years and older	Once a year	4352	Subject to use of a network provider

CUSTOM OPTION : SUBJECT TO THE SPECIALIST LIMIT AND USE OF A NETWORK PROVIDER	
Antenatal care (GP)	Subject to registration on the Maternity Management Programme between 12 and 20 weeks 4 visits subject to registration onto the programme
Paediatric visit	Subject to GP referral and Specialist Limit
Pregnancy vitamins	Subject to medication formulary and registration onto the programme
Scans	Two 2D scans per pregnancy 3D and 4D scans will be paid at 2D scan rates
Urine tests	4 tests subject to registration onto the programme
Blood tests	Certain tests are available subject to GP referral

PATIENT CARE PROGRAMMES
Includes disease management for conditions such as diabetes, hypertension and HIV/AIDS. Please call **0861 000 300** for more information.

CLASSIC + CLASSIC NETWORK OPTIONS : PLEASE CALL 0861 000 300 FOR MORE INFORMATION				
What is covered?	**Age**	**Frequency**	**Tariff code**	**Comment**
One basic dental consult	All beneficiaries	Once a year	8101 8109 8110	
Fissure sealants	Children under the age of 16		8163	
Fluoride treatment	Children under the age of 16	Once a year	8161	
CLASSIC + CLASSIC NETWORK AND OPTIMUM OPTIONS				
Baby and child immunisations		In line with the Department of Health protocols		
Flu vaccines	High risk and beneficiaries older than 65 years	Once per beneficiary per year	732826 300826	Subject to pre-authorisation
Pneumococcal vaccines	High risk and beneficiaries older than 60 years	Once per beneficiary per year	755826 714999 715858 705032	Subject to pre-authorisation
EARLY DETECTION TESTS				
Dexa bone density scan	Beneficiaries 50 years and older	Once every 3 years	3604 50120	
Health risk assessment at a pharmacy network provider – includes a finger prick test and glucose test, blood pressure check and measurement of waist, height and weight (BMI)	Principal members and adult beneficiaries	Once a year	NAPPI 711326001	

EARLY DETECTION TESTS				
What is covered?	**Age**	**Frequency**	**Tariff code**	**Comment**
Glaucoma screening	All beneficiaries 40 to 49 years and older All beneficiaries 50 years and older	Once every two years at a PPN network provider Once a year		Included in the PPN annual composite consultation if a PPN network provider is utilised
Mammogram	Females 38 years and older	Once every two years	34100 34101	
Pap smear (GP)	Females 15 years and older	Once a year	4559	
Prostate specific antigen (PSA) testing	Males 40 to 49 years Males 50 to 59 years Males 60 to 69 years Males 70 years and older	Once every five years Once every three years Once every two years Once a year	4519 4524	
TB screening (pathologist)	All beneficiaries	3916		
Tetanus diphtheria injection	All beneficiaries	As needed		
Human Papilloma Virus (HPV) Vaccination	All females between ages 9 and 26 years All males between 9 and 18 years All high-risk females (after discussion with their physicians) between the ages 26 and 45 years	Two vaccines per beneficiary per lifetime	3006049 710249 710020	
Contraceptives	For female beneficiaries up to the age of 45	R1 600 annual limit	Pill (oral), devices and injectables	In formulary medication only Subject to pre-authorisation
Colorectal Screening	High risk lives 50 years and older	Once a year	4352	
Dental benefits for children	Children under the age of 16	Once a year	8161 8163	
HOSPICARE + HOSPICARE NETWORK OPTIONS				
Pap smear (GP)	Females 15 years and older	Once a year	4559	
Prostate specific antigen (PSA) testing	Males 40 to 49 years Males 50 to 59 years Males 60 to 69 years Males 70 years and older	Once every five years Once every three years Once every two years Once a year	4519 4524	
Flu vaccines	High risk and beneficiaries older than 65 years	Once per beneficiary per year	732826 300826	Subject to pre-authorisation
Mammogram	Females 38 years and older	Once every two years	34100 34101	

HOSPICARE + HOSPICARE NETWORK OPTIONS				
What is covered?	**Age**	**Frequency**	**Tariff code**	**Comment**
Health risk assessment at a pharmacy network provider – includes a finger prick test and glucose test, blood pressure check and measurement of waist, height and weight (BMI)	Principal members and adult beneficiaries	Once a year	NAPPI 711326001	

HOSPICARE + HOSPICARE NETWORK, CLASSIC + CLASSIC NETWORK, OPTIMUM OPTIONS	
Subject to registration on the Maternity Management Programme between 12 and 20 weeks	
Antenatal visits (Midwives, GP or Gynaecologists)	12 visits per pregnancy (excludes exercises)
Paediatric visit	2 per pregnancy
Pregnancy vitamins	Subject to formulary
Pathology tests	1 test per pregnancy: Full blood count, blood group, rhesus (Rh antigen), IgG (specific antibody titer), VDRL (Venereal Disease Research Laboratory), glucose strip test Urine test - microscopic culture and sensitivity test
Scans	Two 2D scans per pregnancy at 20-24 weeks (growth scan) At 24 weeks (pregnancy scan) 3D and 4D scans will be paid at 2D scan rates
Urine test (dipstick)	12 per pregnancy

PATIENT CARE PROGRAMMES
Includes disease management for conditions such as diabetes, hypertension, HIV/AIDS, oncology, chronic renal failure, organ transplants and alcohol and drug rehabilitation. Please call **0861 000 300** for more information.

momentum multiply

Why Momentum Multiply?

Your health is worth investing in and the sooner you start, the more your body will thank you. It's the small, everyday actions that make the biggest difference, and Multiply is here to support you every step of the way.

As a Moto Health Care member, you have access to Multiply Engage for FREE.

Multiply Engage isn't just about rewards. It's about a commitment to yourself, your future, and the life you were meant to live. When you choose Multiply Engage, you're choosing to thrive. You're joining a movement that believes health is a celebration of how we were supposed to live!

Score even more when you upgrade to Multiply Engage Plus.

PLUS, you get rewarded for every step you take toward a healthier you.

Getting rewarded is easy

Know your health

1. Do a health assessment
2. Do a fitness assessment

+

Improve your health

3. Achieve weekly and monthly activity and recharge goals
4. Boost your Wins by adding recharge goals

=

Get rewarded

Up to **60%** from **BIG brands**

Plus vouchers for achieving your activity and recharge goals!

Rewards from day one

Log in and create a profile. Do a quick digital health assessment and that's all you need to access partners rewards immediately.

Rewards on your whole basket

WOOLWORTHS

Pick n Pay

CLICKS

Maximise your rewards with a fitness assessment.

Up to 60% back from big brands

NuMetro

GARMIN

planet fitness

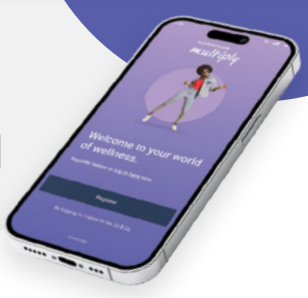
Virgin active

FlySafair

Checkers

Download the Multiply app to get started.

GET IT ON Google Play | Download on the App Store | EXPLORE IT ON AppGallery



Moto Health Care members may choose to make use of additional products available from Momentum Group Limited and its subsidiaries as well as Momentum Multiply (herein collectively referred to as Momentum). Momentum is not a medical scheme and is a separate entity to Moto Health Care. Momentum products are not medical scheme benefits. You may be a member of Moto Health Care without taking any of the products offered by Momentum.

Welcome To Hello Doctor!

Request a call or send your question via text

Hello Doctor lets you talk to your doctor on your phone, any time, any where.

hello doctor
Powered by momentum

DIAL *120*1019#

Submit your enquiry online via the App.
Works on all phones.

Download the App

GET IT ON Google Play

Download on the App Store

EXPLORE IT ON AppGallery

Log in via our website

www.hellodoctor.co.za

Trusted help is just a tap away

Get access to quality healthcare without leaving home or wherever you are. Talk to a doctor on your phone, anytime, anywhere, in any of our official languages – for free.

Hello Doctor is a free, voluntary, mobile-based service that gives you access to doctors within minutes. You can get expert health advice through your phone, tablet or computer at no cost to you. Simply download the Hello Doctor app and log in with a one-time password (OTP) and enjoy instant access to the full suite of convenient, easy to use health services. You can also access Hello Doctor through your MHC app – just tap on the icon, confirm your contact number and a doctor will call you back.

Hello Doctor does not charge any service fees. All you need is data or a Wi-Fi connection to use the app and as our doctors call you, you won't need to use your airtime.

Hello Doctor offers

DOCTOR ACCESS

Speak to a doctor over the phone, or chat via text message. All information shared is completely private and confidential.

HEALTH EDUCATION

Get free daily advice with Hello Doctor's health tips and health coaching. Subscribe to any category that interests you and walk the journey to better health.

MONTHLY EMAILS

Emails give you the latest health trends and advice.

UNSTRUCTURED SUPPLEMENTARY SERVICE DATA (USSD)

You can dial ***120*1019#** from your mobile phone and follow the menu prompts to request a call back from a doctor or send a text message to the number that they provide. Just enter your ID/Passport number and you'll receive a one-time password (OTP) via SMS. **OTP not arriving?**

Call us on 087 230 0002 to confirm your details or **WhatsApp us on 073 778 4632**.

NO WAITING IN QUEUES, NO DELAYS, NO WORRIES.

Download the app and get relevant and reliable health advice at the touch of a button.

The MHC Healthcare App

Access your healthcare any where, any time

As the digital transformation of healthcare gains momentum, you can benefit from continuously enhanced state-of-the-art technology and services when you join Moto Health Care.

DIGITAL HEALTH TECHNOLOGY SUPPORTING YOU 24/7

Click on your preferred operating system icon below to download the App or log onto the website **www.mhcmf.co.za** for more information.

MHC mobile app key features

- Track your claims and medical expenditure
- Submit your enquiry online via the App
- Download key documents – tax certificates and claims statements
- View your monthly contributions and track your payment history
- Understand and manage your health risk
- Access your digital membership card

GET IT ON Google Play | Download on the App Store | EXPLORE IT ON AppGallery

You can get the following paid from your annual savings limit:

- Slimming preparations
- Treatment for sexual dysfunction
- Treatment that assists with smoking cessation
- Vitamins
- Oral contraception, injectables and approved devices once your contraceptive limit has been reached

Remember to ask your GP for a prescription and hand it in at your pharmacy

ER made easy

ER made EASY for Classic, Classic Network and Optimum members, is an initiative that offers all beneficiaries, regardless of their age, free emergency medical cover when you need it the most. Each beneficiary will have direct access to a hospital's Emergency Room (ER) for medical treatment in emergency situations.

Even if the member doesn't have normal benefits available, the cost of the ER visit will be covered up to a maximum of R1 050. MHC offers one emergency visit per beneficiary per annum to a maximum of R1 050.

Emergency circumstances include:

- Sport injuries
- Car accidents
- Playground accidents
- Assault

Complement Your Cover With HealthSaver

You can use additional complementary products to seamlessly enhance your medical scheme. Save for additional medical expenses with HealthSaver. HealthSaver lets you save for additional day-to-day medical expenses, such as co-payments, exclusions and more.

PLEASE NOTE: All MHC members qualify for this product, which is regulated outside the Scheme benefits and rules. The cost for this product is excluded from the MHC monthly contribution. Members interested in the product must sign up directly.

DISCLAIMER: As a MHC member, you can choose to make use of additional products available from Momentum, part of Momentum Health, to seamlessly enhance your medical cover. Momentum is not a medical scheme, and is a separate entity to your medical scheme. These voluntary complementary products range from a world-class lifestyle rewards programme, to the HealthSaver account. These complementary products are not medical scheme benefits. You can be a member of MHC without taking any of the complementary products.

Prescribed Minimum Benefit Conditions

TO ACCESS PRESCRIBED MINIMUM BENEFITS, THERE ARE RULES THAT APPLY

In terms of the Medical Schemes Act 131 of 1998 and its Regulations, all medical schemes have to cover the costs related to the diagnosis, treatment and care of:

- An emergency medical condition
- A defined list of 271 medical conditions which are specified in the Diagnostic Treatment Pairs (DTP)
- A list of 26 chronic conditions

To qualify for Prescribed Minimum Benefits (PMBs); the treatment must match the treatment in the defined PMB benefits. You must use designated service providers (DSPs) in our network if applicable to your Option being Essential, Custom, Hospicare Network and Classic Network Options.

In the case of an emergency (as defined below), you will be taken to the nearest hospital. Once stabilised the Scheme may transfer you to a hospital or another service provider (in our network). Should your treatment not meet the emergency criteria, co-payments can be applied or the event may be paid at Scheme rates.

To register your PMB condition, your service provider must complete a PMB application form which is available on the Scheme website:

For more information on PMBs visit the Council for Medical Schemes website at **https://www.medicalschemes.co.za/resources/pmb/**

What is an emergency?

An emergency medical condition, also referred to as an emergency, is the sudden and, at the time unexpected, onset of a health condition that requires immediate medical and surgical treatment, where failure to provide medical or surgical 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.

An emergency does not necessarily require a hospital admission. We may ask you for additional information to confirm the emergency.

PLEASE REMEMBER: The Essential and Custom options are exempt from paying PMB conditions at cost, this means that PMBs are covered at the **Scheme rate up to your benefit limit**.

Chronic Disease List Conditions Covered

Members with chronic conditions need to register on the Chronic Care Programme. The programme covers all or some of the chronic conditions on the Chronic Disease List (CDL). Registering on the programme gives you benefits relating to your condition that do not affect your day-to-day or savings limits.

ESSENTIAL OPTION	CUSTOM OPTION	OPTIMUM OPTION CLASSIC OPTION & CLASSIC NETWORK OPTION HOSPICARE & HOSPICARE NETWORK OPTION
• Addison's Disease • Asthma • Bronchiectasis • Cardiac Failure • Cardiomyopathy • Chronic Obstructive Pulmonary Disease • Coronary Artery Disease • Diabetes Insipidus • Diabetes Mellitus Type I • Diabetes Mellitus Type II • Dysrhythmias • Epilepsy • Glaucoma • Hyperlipidaemia • Hypertension • Hypothyroidism • Menopause	• Addison's Disease • Asthma • Bronchiectasis • Cardiac Failure • Cardiomyopathy • Chronic Obstructive Pulmonary Disease • Coronary Artery Disease • Crohn's Disease • Diabetes Insipidus • Diabetes Mellitus Type I • Diabetes Mellitus Type II • Dysrhythmias (PMB) • Epilepsy • Glaucoma • Hyperlipidaemia • Hypertension • Hypothyroidism • Multiple Sclerosis • Parkinson's Disease • Rheumatoid Arthritis • Schizophrenia • Systemic Lupus Erythematosus • Ulcerative Colitis	• Addison's Disease • Asthma • Bipolar Mood Disorder • Bronchiectasis • Cardiac Failure • Cardiomyopathy • Chronic Obstructive Pulmonary Disease • Chronic Renal Disease • Coronary Artery Disease • Crohn's Disease • Diabetes Insipidus • Diabetes Mellitus Type I • Diabetes Mellitus Type II • Dysrhythmias • Epilepsy • Glaucoma • Haemophilia • Hyperlipidaemia • Hypertension • Hypothyroidism • Multiple Sclerosis • Parkinson's Disease • Rheumatoid Arthritis • Schizophrenia • Systemic Lupus Erythematosus • Ulcerative Colitis

Where To Obtain Your Medication

THE PLANS LISTED BELOW HAVE PREFERRED SERVICE PROVIDERS FOR CHRONIC MEDICATION.

ESSENTIAL CUSTOM OPTIONS	HOSPICARE OPTION	HOSPICARE NETWORK OPTION	CLASSIC OPTION	CLASSIC NETWORK OPTION
You must use a network pharmacy or Network GP	Scheme pharmacy network	Medipost	Scheme pharmacy network	Medipost

Avoid a 30% co-payment by using these Providers.

How are co-payments applied?

OPTION	CHRONIC MEDICATION NETWORK	MEDICATION OUT-OF-NETWORK CO-PAYMENT	OUT-OF-FORMULARY CO-PAYMENT	ACUTE MEDICATION NETWORK	OUT-OF-NETWORK HOSPITALISATION
ESSENTIAL	Subject to network pharmacy	N/A	Subject to protocols	Subject to network pharmacy	No benefit unless it is an emergency admission
CUSTOM	Subject to network pharmacy	N/A	Subject to protocols	Subject to network pharmacy	30%
HOSPICARE NETWORK	Medipost Pharmacy	30%	20%	N/A	30%
HOSPICARE	Scheme pharmacy network	30%	20%	N/A	N/A
CLASSIC NETWORK	Medipost Pharmacy	30%	20%	Scheme pharmacy network	30%
CLASSIC	Scheme pharmacy network	30%	20%	Scheme pharmacy network	N/A
OPTIMUM	Any	N/A	20%	Any	N/A

Pharmacy, doctor and hospital networks: Use the networks to ensure no co-payments are applied.
Pharmacies (generic versus original, brand-name medicine): Where possible, ask your doctor or pharmacist to prescribe and dispense generic medicine instead of original, brand-name medicine.

How To Register For Chronic Medication?

ESSENTIAL/CUSTOM OPTIONS	
Ask your network doctor to complete the chronic application form	Your network doctor will submit the form, together with a copy of the prescription, to the chronic department on your behalf
Notification of the outcome will be sent to both you and your doctor	Take your original prescription to the approved network pharmacy to obtain your medication

HOSPICARE + HOSPICARE NETWORK, CLASSIC + CLASSIC NETWORK, OPTIMUM OPTIONS		
Send the prescription, inclusive of the diagnosis codes (ICD-10 codes), to the chronic department via: Email: chronic@mhcmf.co.za	Your pharmacist/healthcare provider may call the chronic team on **0861 000 300** to register you telephonically for your chronic conditions/medication	Notification of the outcome will be sent to both you and your doctor
HOSPICARE & CLASSIC Take your original prescription to a network pharmacy to obtain your chronic medication	**HOSPICARE NETWORK & CLASSIC NETWORK** Send your prescription to Medipost Courier Pharmacy via: Email: info@medipost.co.za	**OPTIMUM** Collect your medication from the pharmacy. Remember, if you use a network pharmacy, co-payments may be avoided

REMEMBER: Chronic medicines approved from the additional non-PMB chronic condition benefit on the Classic, Classic Network and Optimum options are paid subject to an annual limit.

To ensure that you continue to obtain your chronic medication and as per the pharmacy requirements, a new prescription and ICD-10 (diagnosis code) must be submitted every six months.

Getting The Most Out Of Your Chronic Medication Benefits

DO	OR YOU MAY
Enquire about your specific condition's chronic formulary (on **www.mhcmf.co.za** or the call centre on **0861 000 300**).	Be required to contribute towards your medication cost.
Opt for generic versions of your medication as far as possible to stretch every Rand.	Deplete your chronic medication benefit before the end of the year.
Double check that your doctor or pharmacy has registered your chronic condition with the Scheme.	Face out-of-pocket expenses.
Make sure that your prescription includes the ICD-10 code.	Have your medication declined.

Integrated Care

These programmes assist our at-risk members to manage their health and benefits better so that they are able to get the care they need when they need it. Members will be assigned a personal wellness coach, who will assist them every step of the way. Wellness coaches will develop a tailor-made care plan in conjunction with your treating doctor, which can include unlocking additional benefits.

NOTE: If your treatment plan changes or additional benefits are required, please ensure that your Doctor or Specialist notifies the oncology management team.

Who qualifies for the care management programmes?

- Chronic patients (depending on the severity of your condition) for example members who have been diagnosed with diabetes, hypertension, HIV and cancer.
- Patients with an increased risk of having an adverse health event that may, for example, result in hospitalisation.
- Patients who have had severe in-hospital or other acute health events.
- Patients with rare conditions who require constant monitoring.

It's important to remember that Integrated Care is a health management programme; where members who could benefit from the programme are identified. Once, identified, we start helping you to use your specific option's benefits better.

Once identified, a wellness or lifestyle coach will be allocated to you. These coaches are there to assist and advise you during every step of your healthcare journey.

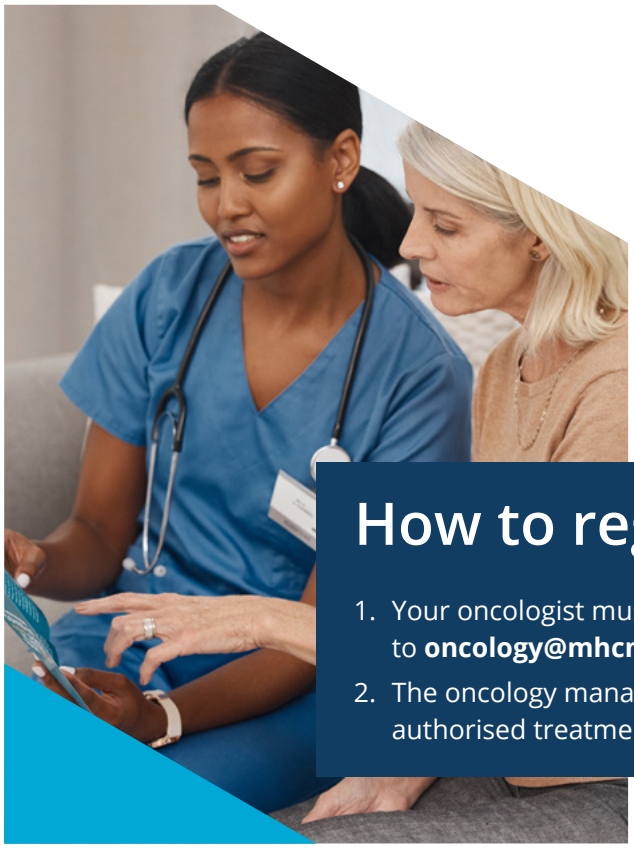
Our HIV/Your Life care programme

We ensure your privacy and confidentiality is maintained, including the way in which your medication is delivered.

- Contact **0860 109 793** or download the registration form from **www.mhcmf.co.za**
- Email the completed form to **ha@mhcmf.co.za**
- A care coach from the HIV/Your Life programme will contact you.

Palliative care

Holistic home-based end of life care and services are provided via our Palliative care programme, assisting members and their families. This benefit is subject to Scheme rules and clinical protocols.



Oncology care

If you are diagnosed with cancer, register on the oncology programme as soon as possible. Once your treatment has been approved you are covered for additional benefits offered. Approved treatment will include chemotherapy, radiotherapy, visits to Oncologists and cancer related blood tests.

How to register

1. Your oncologist must email your histology report and treatment plan to **oncology@mhcmf.co.za**.
2. The oncology management team will call your doctor to discuss the authorised treatment plan.

Emergency Services

Call **0861 009 353** for the emergency operations centre to assign an ambulance to the incident/emergency.

Emergency medical services include:

- Access to a 24-hour emergency medical assistance contact centre.
- Assisted by medically trained and registered agents with the Health Professions Council of South Africa (HPCSA).
- Immediate dispatch of emergency medical services in order to provide lifesaving assistance.
- Constant monitoring of the incident until the ambulance provider has transferred the member to the hospital.
- Emergency pre-arrival instructions provided by the registered agents e.g. CPR.

EMERGENCY TRANSPORTATION BY AIR OR ROAD AMBULANCE DEPENDING ON THE OPTION YOU CHOOSE

The procedure you should follow is:

1. Dial **0861 009 353**.
2. Provide your name, the telephone number you are calling from and the ID of the patient (if available).
3. Provide a brief description of what has happened and how serious the situation is.
4. Provide the address or location of the incident to help paramedics get there.
5. Do not put down the phone until the person on the other side has disconnected the call.
6. The person phoning for the ambulance will receive an SMS asking to provide the exact location of the patient
7. An SMS/ WhatsApp will be sent with your reference number.

IMPORTANT POINTS: Please tell all your registered dependants about this service; including your child's school!

How To Apply For Membership

Any person who is employed in the retail motor industry may join the Scheme.

How to apply in five easy steps

	ACTIVE EMPLOYEE MEMBERSHIP	CONTINUATION MEMBERSHIP
1	Visit your Human Resources (HR) Department to obtain a copy of the membership application form **OR**	Dial **0861 000 300** to confirm if you meet the requirements for continuation membership on the Scheme
2	**The application form can also be obtained from:** The Contact Centre: **0861 000 300** or website **www.mhcmf.co.za**	**If YES complete the continuation form, which can be obtained from:** The Contact Centre: **0861 000 300** or website **www.mhcmf.co.za**
3	Ensure that all the required documentation is submitted together with the fully completed application form to your HR Department. **Remember to complete the inception date.**	Ensure that all the required documentation is submitted together with the fully completed application form. **Remember to complete the inception date.**
4	Request your HR representative to sign your application form.	A bank confirmation letter is available on your banking APP or at some ATM machines.
5	The **completed application form** must be submitted to **membership@mhcmf.co.za**. The reference number provided can be used to follow up on the progress of your application.	

Membership

Continuation of membership

Active members who leave for one of the following reasons can continue as continuation members:

- If you are retrenched
- When you retire
- If you are unable to work due to ill health
- Where the principal member passes away, the surviving spouse and/or children may continue as beneficiaries, provided that one of the beneficiaries (spouse/eldest child) is converted to the principal member
- Should you become disabled
- If you resign from your company and are employed by another company in the industry, which does not offer medical cover on MHC
- If you leave your employer to start your own business in the industry.

Each month a contribution statement is sent to members who pay contributions directly to the Scheme.

Update your membership details should the following changes occur:

Make sure that MHC has the email address and contact information of dependants 18 years and older.

Contribution statements

A monthly contribution statement is sent to all employers and continuation members. The contribution statement sets out the monthly contribution due.

If you need help with paying your contributions, please contact the Scheme or speak to your employer for assistance.

WAITING PERIODS when applying for membership waiting periods may be applied when:

CATEGORY	THREE-MONTH GENERAL WAITING PERIOD	12-MONTH CONDITION-SPECIFIC WAITING PERIOD	APPLICATION FOR PMBS
New applicants or persons who have not been members of a medical scheme for more than 90 days before joining	Yes	Yes	Yes
Applicants who were members of a medical scheme for less than two years	No	Yes	No
Change of benefit option	No	No	No
Child dependant born during period of membership	No	No	Not applicable
Involuntary transfers due to change in employment or employer changing to another medical scheme	No	No	Not applicable

Register your new baby in time!

- Complete the registration form available on the website: **www.mhcmf.co.za** and enclose a certified copy of the birth certificate/confirmation of birth from the hospital.
- Forward it to the Scheme via email at **membership@mhcmf.co.za** within 30 days of the birth of your child.

- Registration of adults older than 35 years may be subject to late-joiner penalties. For more information contact **membership@mhcmf.co.za** or contact the call centre on **0861 000 300**

You will retain the same Scheme membership number for life, even if you change employment in the motor industry. Notify the Scheme when you change employment in the industry in order for us to keep track of your movements and contribution payments. In this way you will avoid having your benefits suspended.

Changing Your Benefit Option

Choose the right option for your family

What is important when choosing a benefit option for you, your family or your employees? Choose the option that best suits your unique situation including the amount you can afford.

Ask yourself:

- What is your health status?
- How often do you visit a doctor?
- Do you have any chronic ailments?
- Do you need specialist visits?
- Are you planning to start or expand your family in the near future?
- What is your budget?

Compare the different benefits and contributions and how they are structured.

You can change your benefit option once a year by 31 December

The member guide, containing benefit information, and an option selection form will be sent to you in the last quarter of each year, so that you can make an informed decision in time for the following year. If you change your option, benefits on the new option will be available on 1 January of the following year. Once your option change has been done, an SMS to confirm this will be sent.

NOTE: When choosing to move from Moto Health Care to another Scheme, the new Scheme may impose a waiting period.

HOW DO I INFORM MOTO HEALTH CARE OF MY CHANGE OF OPTION?

Complete an option selection form available from the call centre – **0861 000 300** OR download the form: **www.mhcmf.co.za**

HOW DO I SUBMIT THE OPTION CHANGE FORM?

Email:
Optionchange@mhcmf.co.za

HOW DO I FOLLOW UP?

When you have emailed your form, a reference number will be provided, which can be used to follow-up with the Call Centre: **0861 000 300** or email **info@mhcmf.co.za**.

Claims Procedure

What information must be included on all claims?

- Your membership number
- The Scheme name
- Your option (for example Optimum, Custom, etc.)
- Your surname and initials
- Patients name, initials, date of birth and beneficiary code, as it appears on your membership card
- The name and practice number of the service provider
- The date of service
- The nature and cost of treatment
- The pre-authorisation number (if applicable)
- The tariff code
- The ICD-10 code
- If you paid for the service, attach the proof of payment and highlight it clearly. Proof of payment can be a receipt from the healthcare provider, an electronic fund transfer (EFT) slip or a bank deposit slip

IMPORTANT: To ensure that we process your refund to the correct bank account, call **0861 000 300** to verify or change your banking details. Claims can be submitted via email to **claims@mhcmf.co.za** for processing.

Reasons why claims are rejected

- Incorrect membership number quoted
- Incorrect member or dependant information
- Dependants are not registered or their details do not appear on the claim
- No pre-authorisation number was obtained for treatment that required pre-authorisation
- Benefits not available on that option/or if the claim pertains to a Scheme exclusion
- Claims will not be paid if the benefit category you are claiming from has been depleted

Claims received after the claiming period has expired

Claims must reach the Scheme within 4 months (i.e. 120 days) of the treatment date.

The Scheme will not pay claims that are older than 4 months. You will be responsible for paying the claim if it is submitted after this time period, unless you can prove that you resubmitted the claim before 4 months have lapsed.

Claims received after you have resigned from the scheme

If you resign from your employer, your membership ends and you cannot access healthcare services. If you or your healthcare provider claims for healthcare services after you resigned from the Scheme, the claim will not be paid. Remember that contributions are paid at the end of the month for the month and not in advance.

Scheme exclusions

Where a service rendered is an exclusion, the service will be rejected. Exclusions may be viewed further on in this guide as well as on the Scheme's website at **www.mhcmf.co.za**.

Fraud, Waste And Abuse – Be Vigilant

Fraud, waste and abuse

FRAUD

- Submitting claims for services not rendered
- Provider/member collusion
- Product substitution
- Allowing a non-dependant access to benefits

WASTE

- Over-utilisation of benefits
- Ordering of unnecessary tests
- Dispensing generic medication but claiming for branded medication

ABUSE

- Up-coding of services
- Providing unnecessary services
- Improper billing practices

Member Consequences

- Loss of membership
- Criminal prosecution
- Loss of employment
- Recovery of irregular benefits

Pre-Authorisation Process

The pre-authorisation process ensures that the treatment or procedure is both necessary and appropriate. Pre-authorisation must be obtained 48 hours before any planned hospital admission.

Pre-authorisation is required for the following, among others:

- All hospital admissions
- Outpatient treatment in a hospital, i.e. when you do not stay overnight at the hospital
- Admission to a day hospital
- MRI, CT or PET scans or radio-isotope studies
- To get access to patient care programmes
- Emergency ambulance transportation
- Specialised and surgical dentistry in hospital
- Visits to a specialist for the Custom and Essential options
- Additional GP consultations on the Classic and Classic Network options once your savings are depleted
- To access certain preventative care benefits

Ask your healthcare practitioner for a full description of:

- All the tariff and ICD-10 codes that the doctor intends to claim
- Your membership number
- Name and date of birth of the patient
- Date of admission
- Name and practice number of the treating practitioner
- Name and practice number of the hospital
- Additional information may be requested by the pre-authorisation department, when necessary

2026 OPTION BENEFITS

Taking care of our own at every stage of their health journey

Essential Option

This network option is suitable for first time medical scheme members.

Brief description of the benefits offered on the Essential option:

Medicine Benefit

- Unlimited acute medicines within formulary and dispensing GP or pharmacy on the network
- Over-the-counter medicine from a network pharmacy within formulary
- Chronic medication obtained from a network pharmacy or GP within formulary

In-Hospital Benefits

- Unlimited access to State facilities
- Stabilisation in a Private hospital
- **AMBULANCE SERVICES:** 24-hour access to road ambulance by calling **0861 009 353**

Out-Of-Hospital Benefits

- GP consults, Optical, Dentistry, Pathology and Radiology benefits
- Access to network specialists
- Free access to telephonic advice via Hello Doctor
- 11 additional procedures available from network providers

Maternity Benefits

- Maternity benefits subject to registration onto the maternity programme
- Antenatal care via the network provider
- Monthly pregnancy vitamins within formulary
- Paediatric visits at a network provider

Chronic Benefits

When you register on the Chronic Medicine programme you are covered for 17 CDL conditions as well as:

- Menopause
- HIV/AIDS
- Oncology

Wellness Benefits

The wellness benefit allows for early detection and pro-active management of your health. **You are covered when referred by a Network Provider for:**

- Blood glucose test
- Blood pressure test
- Cholesterol test
- Pap smear
- Flu vaccines
- Pneumococcal vaccination – high-risk members
- Prostate specific antigen (PSA) testing
- TB screening
- Clinical Breast Screening (ultrasound) for high-risk members
- Colorectal Screening
- HPV Vaccine

Benefits may be subject to clinical protocols.

MONTHLY CONTRIBUTIONS

SALARY BAND	MEMBER	ADULT	CHILD
R0 - R3 800	R508	R305	R204
R3 801 - R8 154	R541	R325	R204
R8 155 - R11 952	R774	R469	R305
R11 953+	R894	R541	R363

OUT-OF-HOSPITAL BENEFITS

Not sure what we mean? Refer to glossary at the end of this guide

PRIMARY CARE NETWORK	
General Practitioners (GPs)	Unlimited at the primary care network service provider
Specialist Limit	M R1 950 M+ R3 900 Subject to network GP referral, pre-authorisation and managed care/Scheme protocols
Antenatal care	Antenatal care available from a primary care network provider for the first 20 weeks, thereafter referral to a State facility for confinement
Pathology	Pathology out of hospital — subject to network GP referral and formulary tests
Radiology	Out of hospital — subject to network GP referral and formulary
PRESCRIBED MEDICINES AT A PRIMARY CARE NETWORK SERVICE PROVIDER	
Acute	Unlimited at the primary care network provider – subject to network formulary
Over-the-counter (OTC)	Single member = 3 prescriptions Family = 5 prescriptions
Chronic	17 conditions covered subject to formulary which can be viewed on the website or earlier in the guide) Subject to use of a primary care network provider and protocols

THIS OPTION IS EXEMPT FROM PMB'S.

Claims on this option are paid at the Scheme rate, up to limits and/or sub limits in accordance with the exemption received from the Council for Medical Schemes. Exclusions including option specific exclusions can be viewed on the Schemes website at **www.mhcmf.co.za**

PRIMARY CARE NETWORK ONLY	
Optometry Optical benefit available per beneficiary every 24 months	1 optical test per beneficiary per year 1 pair of clear, standard mono- or bifocal lenses in a standard frame **OR** Contact lenses to the value of R668 towards a frame outside the standard range Subject to use of primary care network provider and protocols
Basic dentistry Subject to use of primary network provider and protocols	**Per beneficiary per annum:** • one dental examination • scaling • 4 extractions thereafter must be pre-authorised • 4 fillings thereafter must be pre-authorised • polishing
External prostheses	Per family = R7 450

Out-of-hospital procedures covered on the Essential Benefit Option subject to use of a network provider and clinical protocols	
TARIFF	**TARIFF DESCRIPTION**
0300	Stitching of soft-tissue injuries: Stitching of wound (with or without local anaesthesia). Including normal after-care.
0301	Stitching of soft-tissue injuries: Additional wounds stitched at same session (each).
0307	Excision and repair by direct suture. Excision nail fold or other minor procedures of similar magnitude.
0308	Each additional small procedure done at the same time.
0255	Drainage of subcutaneous abscess onychia, paronychia, pulp space or avulsion of nail.
0259	Removal of foreign body in muscle or tendon sheath: simple (not to be used for post-operative removal of Kirschner wires or Steinmann pins).
2133	Circumcision: Clamp procedure.
0887	Limb cast (excluding after-care).
1232	Electrocardiogram: Without effort for high risk patients 5 years and over.
1233	Electrocardiogram: With and without effort for high risk patients 5 years and over.
1136	Up to 2 nebulisations (in rooms) per family.

PRIMARY CARE NETWORK ONLY	
Medical and surgical appliances (in- and out-of-hospital)	The following appliances are subject to the annual limit of R3 250 per family subject to motivation and pre-authorisation
Glucometers	R960 per beneficiary every 2 years
Nebulisers	R960 per family every 3 years
Other appliances – once every	Subject to clinical protocols and submission of a motivation/quote
4 years	Please note that hearing aids are not covered on the Essential option

ADDITIONAL BENEFITS	
Out-of-Hospital Procedures subject to use of a network provider	11 procedures covered out of hospital. Refer to the list on the previous page.
Free Hello Doctor advice	Telephonic advice via Hello Doctor. Talk or text a doctor on your phone, anytime, anywhere, in any of our official languages – for free.
Out-of-area or emergency visits	Per family = three visits to a maximum of R1 150. **Now payable directly to the provider.**
Paedriatric visits	1 visit per family subject to the Specialist benefit limit and authorisation
Wellness Benefit	Refer to the beginning of the guide for detailed benefits on free early detection, preventative and antenatal care.

IMPORTANT: Treatment performed in-hospital needs to be pre-authorised prior to commencement of treatment. Some conditions require you to register onto the Patient Care Programme to access benefits. MHC will pay benefits in accordance with the Scheme Rules and clinical protocols per condition. The sub-limits specified below apply per year. If you join the Scheme after January, your limits will be pro-rated.

IN-HOSPITAL BENEFITS	
State hospital	Unlimited treatment in accordance with Scheme protocols and authorisation
Private hospital	Stabilisation only
GPs and specialists	Unlimited treatment in a state facility in accordance with Scheme protocols
To-take-out medicine	Up to 7 days
Internal prostheses	Per family = R11 550, where approved during hospital admission
Oncology	Where approved during hospital admission. Subject to state and managed care protocols
Pathology	Subject to state and managed care protocols
Radiology	Where approved during hospital admission. Subject to state and managed care protocols
Confinement	Treatment in accordance with Scheme and state protocols Patient will be referred to a state facility for specialist care and the confinement
Ambulance	Emergency road transport only Subject to use of a network provider, clinical protocols and authorisation

THIS OPTION IS EXEMPT FROM PMB'S.

Claims on this option are paid at the Scheme rate, up to limits and/or sub limits in accordance with the exemption received from the Council for Medical Schemes. Exclusions including option specific exclusions can be viewed on the Schemes website at **www.mhcmf.co.za**

Custom Option

Targeted at young and healthy members. The Custom Option provides you and your dependants an opportunity to make health part of your journey.

Brief description of benefits offered on the Custom option:

Medicine Benefit

- Unlimited acute medicines within formulary and dispensing GP or network pharmacy
- Over-the-counter medicine from a network pharmacy within formulary
- Chronic medication obtained from a network pharmacy or GP within formulary

In-Hospital Benefits

- Unlimited access to State facilities
- Private hospitalisation up to an annual an annual limit
- **AMBULANCE SERVICES:** 24-hour access to road ambulance by calling **0861 009 353**

Out-Of-Hospital Benefits

- GP consults, Optical, Dentistry, Pathology and Radiology benefits
- Free access to telephonic advice via Hello Doctor
- Trauma events not requiring hospitalisation (payable from the available Overall Annual Limit) subject to clinical protocols

Maternity Benefits

- Maternity benefits subject to registration onto the programme
- Antenatal care via the network provider
- Maternity scans
- Monthly pregnancy vitamins within formulary
- Paediatric visits at a network provider

Chronic Benefits

When you register on the Chronic Medicine You are covered for 23 CDL conditions as well as:

- Depression
- Menopause
- HIV/AIDS
- Oncology

Wellness Benefits

Reduce your risk and stay healthy. **The Wellness benefit allows for early detection and pro-active management of your health you are covered by the scheme when referred by a network provider for:**

- Baby immunisation – DoH schedule
- Blood glucose test
- Cholesterol test
- Mammogram
- Pap smear
- Colorectal Screening
- HPV Vaccine
- Pneumococcal vaccination high-risk members
- Prostate specific antigen (PSA) testing
- Flu vaccines at a network Pharmacy
- TB Screening

Benefits may be subject to clinical protocols.

MONTHLY CONTRIBUTIONS			
SALARY BAND	**MEMBER**	**ADULT**	**CHILD**
R0 – R4 047	R1 402	R1 122	R359
R4 048 – R7 297	R1 475	R1 174	R372
R7 298 – R10 664	R1 615	R1 296	R404
R10 665 – R13 174	R1 846	R1 482	R471
R13 175 – R17 802	R2 571	R2 060	R645
R17 803+	R2 829	R2 265	R708

OUT-OF-HOSPITAL BENEFITS

Not sure what we mean? Refer to glossary at the end of this guide

PRIMARY CARE NETWORK

General Practitioners (GPs)	Unlimited at the primary care network service provider
Specialist Limit	M R5 000 M+ R10 000 Subject to network GP referral, pre-authorisation and managed care/Scheme protocols
Acute medicine	Unlimited at the primary care network provider – subject to network formulary
Over the Counter (OTC) medicine	Single member = 5 prescriptions Family = 7 prescriptions
Chronic medicine	23 CDL conditions as set out earlier in the guide and 2 non-CDL. Formulary available on website Subject to use of primary network provider and protocols
Optometry Optical benefit available per beneficiary every 24 months	1 optical test per beneficiary per year 1 pair of clear, standard mono- or bifocal lenses in a standard frame **OR** Contact lenses to the value of R668 R668 towards a frame outside the standard range Subject to use of primary care network service provider and protocols
Pathology and Radiology Out-of-hospital	Pathology and radiology — subject to network GP referral and formulary
Dentistry Basic - per beneficiary per annum Subject to use of primary network provider and protocols	**Per beneficiary per annum:** • One dental examination • Scaling • 4 extractions thereafter be pre-authorised • 4 fillings thereafter must be pre-authorised • Polishing Per adult beneficiary – 1 set of acrylic dentures every 24 months
MRI, CT, PET and radio isotope scans	Sub-limit per beneficiary = R3 850, subject to specialist limit
External prostheses	R12 800 per family Subject to pre-authorisation, clinical protocols and the overall annual limit
Medical and surgical appliances (in and out of hospital)	The following appliances are subject to the annual limit of R8 950 per family Subject to motivation and pre-authorisation
Glucometers Nebulisers Other appliances – once every 4 years	R1 000 per beneficiary every 2 years R1 000 per family every 3 years Subject to clinical protocols Please note hearing aids are not covered on the Custom option
Free Hello Doctor advice	Telephonic advice via Hello Doctor. Talk or text a doctor on your phone, anytime, anywhere, any official language – for free
Out of network GP or emergency visits	Per family = 3 visits to a maximum of R1 150 Approved Trauma events not requiring hospitalisation are payable from the Overall Annual limit. Clinical protocols and policies applicable
Wellness Benefit	Refer to early in the guide for the detailed benefits on free early detection, preventative care, antenatal care and patient care programmes.

THIS OPTION IS EXEMPT FROM PMB'S. Claims on this option are paid at the Scheme rate, up to limits and/or sub limits in accordance with the exemption received from the Council for Medical Schemes. Exclusions including option specific exclusions can be viewed on the Schemes website at **www.mhcmf.co.za**

IMPORTANT: Treatment performed in-hospital needs to be pre-authorised prior to commencement of treatment. Some conditions will require you to register onto the Patient Care Programme to access benefits. MHC will pay benefits in accordance with the Scheme Rules and clinical protocols per condition. The sub-limits specified below apply per year. If you join the Scheme after January your limits will be pro-rated.

IN-HOSPITAL BENEFITS

Overall Annual Limit (OAL)	Single member R500 000 Family R800 000 All services are subject to pre-authorisation and managed care protocols
State hospital	Unlimited treatment in accordance with Scheme protocols and authorisation
Private hospital **Network hospitals** Custom Hospital Network	Subject to the overall annual limit and use of a Scheme network hospital and managed care protocols A 30% co-payment will be applied for voluntary use of a non-network provider

CO-PAYMENT FOR SPECIALISED PROCEDURES/TREATMENT

Procedure/treatment Gastroscopy, colonoscopy, sigmoidoscopy, functional nasal and sinus procedures, nail surgery, treatment of headaches, removal of skin lesions	**If performed in hospital** A co-payment of R1 200 will apply per admission, which needs to be paid directly by the member to the treating practitioner. The procedure will be paid at the Scheme rate subject to pre-authorisation and clinical protocols **If performed out of hospital** No co-payment applicable. Procedure will be paid at the Scheme rate subject to pre-authorisation and clinical protocols
GPs and specialists	Treatment in accordance with Scheme protocols and use of network providers Admission to private hospital subject to OAL. Claims paid up to the agreed rate with the provider
To-take-out medicine	Up to 7 days
Internal prostheses	Per family per annum = R20 500, where approved during hospital admission subject to the OAL
Alternative care instead of hospitalisation	Per family = 30 days to a maximum of R26 900, subject to OAL
Mental health (in and out of hospital)	Subject to the overall annual limit and up to a sub-limit of R30 000 Subject to clinical protocols and pre-authorisation
Alcohol and drug rehabilitation	100% of the negotiated rate, at a South African National Council on Alcoholism and Drug Dependence (SANCA) approved facility, subject to 21 days and the mental health limit
Oncology	Per family = R90 000, subject to OAL
Pathology	Per beneficiary = R10 000, subject to OAL
Radiology	Per beneficiary = R10 000, subject to OAL
Medical and surgical appliances (in and out of hospital)	Per family = R8 950, subject to OAL
Sub-limits to Appliance Benefit	Glucometer per beneficiary every 2 years — R1 000 nebuliser per family every 3 years — R1 000
Maternity	**Confinement:** State hospital – You may use a GP or gynaecologist for to assist with the confinement Private hospital – Subject to OAL and use of the hospital network providers
Ambulance	Emergency road transport only Subject to use of a network provider, clinical protocols and pre-authorisation

THIS OPTION IS EXEMPT FROM PMB'S. Claims on this option are paid at the Scheme rate, up to limits and/or sub limits in accordance with the exemption received from the Council for Medical Schemes. Exclusions including option specific exclusions can be viewed on the Schemes website at **www.mhcmf.co.za**

Hospicare and Hospicare Network Option

Targeted at members requiring hospital cover primarily. The in and out of hospital benefits are for PMB conditions/treatment only with some value-added benefits and 26 Chronic conditions.

Members on the Hospicare Network option can enjoy significant savings on their monthly contributions and still enjoy comprehensive benefits.

Brief description of benefits offered on the Hospicare and Hospicare Network options:

Medicine Benefit

- Treatment for chronic conditions - subject to an approved treatment plan
- Chronic medication must be obtained from the Scheme's network pharmacy

In-Hospital Benefits

- Unlimited access to State facilities
- Unlimited private hospital cover for PMB treatment
- Additional benefits for selected non-PMB procedures performed in-hospital
- **AMBULANCE SERVICES:** You have 24-hour access to road and air emergency medical assistance by calling **0861 009 353**

Out-Of-Hospital Benefits

- Access to day-to-day benefits via an approved treatment plan, which includes mammograms as per clinical criteria.
- Free and unlimited access to telephonic advice via Hello Doctor.

Maternity Benefits

- Free maternity benefits subject to registration onto the programme
- Benefits include antenatal care, scans, vitamins and paediatric visits

Chronic Benefits

You are covered for the 26 CDL conditions as well as:

- HIV/AIDS
- Oncology

Patient Care Programmes

Free access to patient care programmes that manage chronic diseases such as diabetes, oncology, chronic renal disease and more.

Wellness benefits

NEW on Hospicare and Hospicare Network. **Members on these options now have access to cover for:**

- Mammogram
- Prostate test (PSA)
- Flu vaccines
- Health risk assessments
- Papsmears

Benefits subject to clinical protocols.

MONTHLY CONTRIBUTIONS			
OPTION	**MEMBER**	**ADULT**	**CHILD**
Hospicare Network	R2 817	R2 388	R704
Hospicare	R3 263	R2 760	R810

OUT-OF-HOSPITAL BENEFITS		
Not sure what we mean? Refer to glossary at the end of this guide		
	HOSPICARE NETWORK	**HOSPICARE**
Day-to-day	As part of an approved treatment plan	As part of an approved treatment plan
General practitioners (GPs) and specialists	271 DTPs; PMB treatment only Specialists subject to preferred provider rates	271 DTPs; PMB treatment only Specialists subject to preferred provider rates

MEDICINES		
Acute	271 DTPs; PMB treatment only	271 DTPs; PMB treatment only
Chronic	26 conditions (see earlier in the guide)	26 conditions (see earlier in the guide)
	HOSPICARE NETWORK	**HOSPICARE**
Network provider	Medipost Pharmacy	Scheme's pharmacy network
Co-payment for non-formulary medicine	20%	20%
Co-payment for non-network provider	30%	30%
Non-CDL chronic medicine limit	271 DTPs; PMB treatment only	271 DTPs; PMB treatment only
Optometry	271 DTPs; PMB treatment only	271 DTPs; PMB treatment only
Dentistry Basic and specialised	271 DTPs; PMB treatment only	271 DTPs; PMB treatment only
Auxiliary services	271 DTPs; PMB treatment only	271 DTPs; PMB treatment only
ADDITIONAL BENEFITS		
Free Hello Doctor advice	Telephonic advice via Hello Doctor. Talk or text a doctor on your phone, anytime, anywhere, in all official language – for free	Telephonic advice via Hello Doctor. Talk or text a doctor on your phone, anytime, anywhere, in all official language – for free
Maternity	• 12 antenatal visits • Two 2D scans per pregnancy • 3D and 4D scans are paid up to the rate of 2D scans • Two paediatric visits • Pregnancy related vitamins	• 12 antenatal visits • Two 2D scans per pregnancy • 3D and 4D scans are paid up to the rate of 2D scans. • Two paediatric visits • Pregnancy related vitamins
Medical and surgical appliances	271 DTPs; PMB treatment only	271 DTPs; PMB treatment only
Hearing aids	271 DTPs; PMB treatment only	271 DTPs; PMB treatment only
Mental health	271 DTPs; PMB treatment only	271 DTPs; PMB treatment only
Baby and child immunisations	Up to the age of 6 years, as per Department of Health protocols	Up to the age of 6 years, as per Department of Health protocols
Patient care programmes (Diabetes, HIV, oncology)	Subject to registration	Subject to registration

IMPORTANT: Treatment performed in-hospital needs to be pre-authorised prior to commencement of treatment. Conditions such as cancer will require you to register onto the Patient Care Programme to access benefits. MHC will pay benefits in accordance with the Scheme Rules and clinical protocols per condition. If you join the Scheme after January your limits will be pro-rated.

IN-HOSPITAL BENEFITS

ADDITIONAL BENEFITS	HOSPICARE NETWORK	HOSPICARE
All services are subject to pre-authorisation and managed care protocols	Network hospital: Life Healthcare PMBs only	Any hospital – PMBs only
State and private hospital	Unlimited – PMBs only 30% co-payment for use of non-network provider	Unlimited – PMBs only

ADDITIONAL BENEFITS	HOSPICARE NETWORK	HOSPICARE
GPs and specialists	271 DTPs; PMB treatment only	271 DTPs; PMB treatment only
To-take-out medicine	Up to 7 days	Up to 7 days
Organ transplant ***** Heart, liver and kidney transplants, including harvesting and transportation costs. Corneal transplant, including harvesting and transportation costs. All requests will be subject to clinical protocols and use of a national donor only.	Unlimited – PMBs only	Unlimited – PMBs only
Prostheses	Unlimited – PMBs only	Unlimited – PMBs only
Reconstructive surgery	Unlimited – PMBs only	Unlimited – PMBs only
MRI, CT, PET and radio isotope scans	Unlimited – PMBs only	Unlimited – PMBs only
Alternate care instead of hospitalisation	Unlimited – PMBs only	Unlimited – PMBs only
Mental health	100% of the Scheme rate	100% of the Scheme rate
Alcohol and drug rehabilitation	100% of negotiated rate, at a South African National Council on Alcoholism and Drug Dependence (SANCA) approved facility up to 21 days Subject to managed care protocols	100% of negotiated rate, at a South African National Council on Alcoholism and Drug Dependence (SANCA) approved facility up to 21 days Subject to managed care protocols
Dialysis	Unlimited – PMBs only	Unlimited – PMBs only
Oncology Treatment covered at DSP rates if a network provider is used	Unlimited – PMBs only	Unlimited – PMBs only
Pathology and radiology	Unlimited – PMBs only	Unlimited – PMBs only
Ambulance transport within the RSA and SADC countries	Road and air transportation PMB only Subject to use of Designated service provider,	Road and air transportation PMB only Subject to use of Designated service provider,
ADDITIONAL BENEFITS		
Only the 7 non-PMB procedures listed are covered in hospital at a network provider and is paid at the Scheme rate	• Tonsillectomy • Adenoidectomy • Basic dentistry – up to the age of 8 • Grommets • Carpal tunnel • Varicose veins • Bunionectomy	• Tonsillectomy • Adenoidectomy • Basic dentistry – up to the age of 8 • Grommets • Carpal tunnel • Varicose veins • Bunionectomy

***Organ transplant benefit includes:**

- Heart, liver and kidney transplants, including harvesting and transportation costs.
- Corneal transplant, including harvesting and transportation costs.

All requests will be subject to clinical protocols and use of a national donor only.

Classic And Classic Network Option

This new generation savings option provides members with the flexibility and independence to manage their own day-to-day expenses with hospital cover; 26 CDL and 10 non-CDL conditions. Members on the Classic Network option can enjoy significant savings on their monthly contributions and still enjoy comprehensive benefits.

Brief description of benefits offered on the Classic and Classic Network options:

Medicine Benefit

Access to acute and preventative medicines and over-the-counter medicine

Chronic medicine for 26 conditions — medicines must be obtained from the Scheme's network pharmacy. Plus, cover for 10 non-CDL conditions and medicines

- Acne
- Allergic rhinitis
- Ankylosing spondylitis
- Depression
- Eczema
- Gastro-oesophageal reflux disease (GORD)
- Gout prophylaxis
- Osteoporosis
- Osteoarthritis
- Psoriasis

In-Hospital Benefits

- Unlimited hospital cover
- **AMBULANCE SERVICES:** You have 24-hour access to road and air emergency medical assistance by calling **0861 009 353**

Out-Of-Hospital Benefits

- GP and specialist consults, optical, dentistry and other benefits
- Emergency medical care via ER made EASY
- Free and unlimited access to telephonic advice via Hello Doctor

Maternity Benefits

- Free comprehensive maternity benefits via the Baby Bumps programme subject to registration onto the programme
- Benefits include antenatal care, scans, vitamins and paediatric visits

Chronic Benefits

You are covered for 10 non-CDL conditions as well as:

- HIV/AIDS
- Oncology

Wellness Benefits

The wellness benefit allows for early detection and pro-active management of your health. You are covered by the scheme for:

- Dexa bone density scan
- Cholesterol test
- Mammogram
- Pap smear
- Prostate specific antigen (PSA) testing
- Tetanus diphtheria injection
- HPV Vaccine
- Contraception
- Basic dentistry
- Colorectal Screening
- Glucose test
- TB Screening
- Glaucoma screening
- Pneumococcal and flu vaccines - high risk
- Health risk assessment

Benefits may be subject to clinical protocols.
Don't forget to register onto the Chronic Programme.

ANNUAL SAVINGS LIMIT (ASL) This is the portion of your monthly contribution that is allocated to a savings account that is held in the principal member's name. The money in this account is used to pay for out-of-hospital medical expenses. If you join the Scheme after January your limits will be pro-rated.			
OPTION	**MEMBER**	**ADULT**	**CHILD**
Classic Network	R8 364	R7 092	R2 088
Classic	R9 804	R8 328	R2 460
MONTHLY CONTRIBUTIONS			
OPTION	**MEMBER**	**ADULT**	**CHILD**
Classic Network	R4 646	R3 942	R1 162
Classic	R5 449	R4 625	R1 364

NOTES: If you terminate your membership before the end of the year and you have used more than the ASL allocation, you will be requested to reimburse the difference to the Scheme.

OUT-OF-HOSPITAL BENEFITS

Not sure what we mean? Refer to glossary at the end of this guide

Day-to-day benefits on the Classic and Classic Network options are subject to your Annual Savings Limit (ASL), which covers non-PMB, out-of-hospital claims. Once you have exhausted your ASL, you will need to pay for any additional day-to-day claims. A portion of your monthly contribution is allocated to your ASL. The ASL amount is calculated for a period of 12 months or if you join the Scheme during the year, the amount will be calculated on a pro-rata basis. At the end of the year, any unused savings will carry over to the next year.

	CLASSIC NETWORK	CLASSIC
General practitioners (GPs) and specialists	Subject to ASL	Subject to ASL
Medicines Acute Over-the-counter (OTC) Contraceptives: Oral, devices and injectables Devices subject to pre-authorisation	 Subject to ASL R300 per beneficiary per day R1 600 per female beneficiary up to the age of 45 years per annum	 Subject to ASL R300 per beneficiary per day R1 600 per female beneficiary up to the age of 45 years per annum
Chronic benefit Benefits are subject to registration onto the chronic management programme	Provider - Medipost pharmacy 26 conditions covered as per the chronic disease list and prescribed minimum benefits earlier in the guide for more information on co-payments	Provider - Network pharmacy 26 conditions covered as per the chronic disease list and prescribed minimum benefits earlier in the guide for more information on co-payments

	CLASSIC NETWORK	CLASSIC
Optometry Subject to ASL Members may request frames and lens enhancements to be paid from their savings if the amount exceeds the above amounts Members may utilise positive savings for claim values above the annual optometry limits.	Per beneficiary: 1 composite eye examination, a frame of up to R1 150 and 2 lenses every 24 months **OR** contact lenses of up to R1 530 instead of glasses per year	Per beneficiary: 1 composite eye examination, a frame of up to R1 150 and 2 lenses every 24 months **OR** contact lenses of up to R1 530 instead of glasses per year
Dentistry Basic and specialised. Please note that, while dentures are covered, there is a limit of 1 set of dentures every 4 years per beneficiary. General anaesthetic is available for children under the age of 8 for extensive basic treatment and this is limited to once every 24 months per beneficiary. Cover is available for the removal of impacted wisdom teeth in theatre but must be pre-authorised by emailing a detailed quotation and clear panoramic radiograph to the dental department.	Subject to ASL	Subject to ASL
Auxiliary services	Subject to ASL	Subject to ASL
ADDITIONAL BENEFITS (NOT PAID FROM ASL)		
Chronic medicines	26 conditions – unlimited – plus 10 conditions, subject to sub-limits:	26 conditions – unlimited – plus 10 conditions, subject to sub-limits:
Non-CDL chronic medicine limits	M R6 100 M1 R12 050 M2 R15 040 M3 R16 270 M4 R17 690	M R6 100 M1 R12 050 M2 R15 040 M3 R16 270 M4 R17 690
Network provider	Medipost Pharmacy	Scheme network pharmacy
Co-payment for non-formulary medicine	20%	20%
Co-payment for use of non-network provider	30%	30%
Free Hello Doctor advice	Telephonic advice via Hello Doctor. Talk or text a doctor on your phone, anytime, anywhere, any official language – for free	Telephonic advice via Hello Doctor. Talk or text a doctor on your phone, anytime, anywhere, any official language – for free
Medical and surgical appliances General appliances per family	R17 050	R17 050

	CLASSIC NETWORK	CLASSIC
Sub-limits to Appliance Benefit: Glucometer per beneficiary every 2 years	R1 000	R1 000
Nebuliser per family every 3 years	R1 000	R1 000
Sub-limit: Hearing aid maintenance per beneficiary	R1 300	R1 300
External Prostheses per family	R30 050	R30 050
MRI, CT, PET and radio isotope scans 2 scans paid from risk benefits thereafter ASL	R17 400 per scan	R17 400 per scan
Hearing aids	Subject to medical and surgical appliance limit every 3 years	Subject to medical and surgical appliance limit every 3 years
Mental health	Subject to ASL	Subject to ASL
Extra consultations and medicine (Only once ASL reaches a balance of R300 or less. Medication limit R300)	Single member = 2 visits Family = 5 visits	Single member = 2 visits Family = 5 visits
Patient care programmes (Diabetes, HIV, oncology)	Subject to registration and managed care protocols	Subject to registration and managed care protocols

IMPORTANT: Treatment performed in-hospital needs to be pre-authorised prior to commencement of treatment. Conditions such as cancer will require you to register onto the Patient Care Programme to access benefits. MHC will pay benefits in accordance with the Scheme Rules and clinical protocols per condition. The sub-limits specified below apply per year. If you join the Scheme after January your limits will be pro-rated.

IN-HOSPITAL BENEFITS

Subject to pre-authorisation and managed care protocols. MHC will pay benefits in accordance with the Scheme Rules and clinical protocols per condition. The sub-limits specified below apply per year unless otherwise indicated. If you join the Scheme after January your limits will be pro-rated.

SUBJECT TO PRE-AUTHORISATION AND MANAGED CARE PROTOCOLS	CLASSIC NETWORK	CLASSIC
In-hospital limits	Network hospital - Life Healthcare	Any hospital
State and private hospital	Unlimited 30% co-payment for using non-network provider	Unlimited

CO-PAYMENT FOR SPECIALISED PROCEDURES/TREATMENT (This co-payment is only applicable to benefit below and not the entire benefit)		
SUBJECT TO PRE-AUTHORISATION AND MANAGED CARE PROTOCOLS	**CLASSIC NETWORK**	**CLASSIC**
Procedure/treatment Gastroscopy, colonoscopy, sigmoidoscopy, arthroscopy, joint replacements, diagnostic laparoscopy, urological scopes and facet joint injections	**If performed in hospital** A co-payment of R1 200 will apply per admission which needs to be paid directly by the member to the treating practitioner **If performed out of hospital** **Procedure** will be paid at the Scheme rate subject to pre-authorisation and clinical protocols	**If performed in hospital** A co-payment of R1 200 will apply per admission which needs to be paid directly by the member to the treating practitioner **If performed out of hospital** **Procedure** will be paid at the Scheme rate subject to pre-authorisation and clinical protocols
GPs and specialists	At the Scheme rate Specialists subject to preferred provider rates	At the Scheme rate Specialists subject to preferred provider rates
To-take-out medicine	Up to 7 days	Up to 7 days
Organ transplants (non-PMB cases) Includes harvesting and transportation costs National donor only	R79 500 per family	R79 500 per family
Internal prostheses	R47 500 per family	R47 500 per family
Refractive eye surgery once per lifetime	Per beneficiary per eye = R6 850 maximum of R13 700 for both eyes	Per beneficiary per eye = R6 850 maximum of R13 700 for both eyes
Reconstructive surgery (as part of PMBs)	R79 400 per family	R79 400 per family
MRI, CT, PET and radio isotope scans 2 scans per family paid from risk thereafter from ASL subject to motivation	R17 400 per scan	R17 400 per scan
Alternative care instead of hospitalisation	Per family = 30 days to a maximum of R44 750 per event	Per family = 30 days to a maximum of R44 750 per event
Mental health (in- and out-of-hospital)	100% of Scheme rate subject to clinical protocols and pre-authorisation	100% of Scheme rate subject to clinical protocols and pre-authorisation
Alcohol and drug rehabilitation	100% of negotiated rate, at a South African National Council on Alcoholism and Drug Dependence (SANCA) approved facility up to 21 days	100% of negotiated rate, at a South African National Council on Alcoholism and Drug Dependence (SANCA) approved facility up to 21 days
Oncology in and out of hospital Non-PMB cases PMB cases	Per family = R500 000 per annum 20% co-payment after limit has been reached Unlimited	Per family = R500 000 per annum 20% co-payment after limit has been reached Unlimited
Pathology and basic radiology	At the Scheme rate	At the Scheme rate
Dialysis	Subject to use of DSP,	Subject to use of DSP, protocols
General dentistry	Subject to ASL and dental protocols	Subject to ASL and dental protocols
Ambulance transport within the RSA and SADC countries	Emergency – road and air Subject to use of the designated service provider,	Emergency – road and air Subject to use of the designated service provider,

Optimum Option

This traditional option provides members with comprehensive cover, which includes extensive day-to-day benefits. The option to choose if you would like a choice of providers.

Brief description of benefits offered on the Optimum option:

Medicine Benefit

Access to:

- Acute and preventative medicines
- Over-the-counter medicine
- Chronic medicine for 26 conditions
- Additional cover for 31 non-CDL conditions and medicines

In-Hospital Benefits

- Unlimited hospital cover
- **AMBULANCE SERVICES:** You have 24-hour access to road and air emergency medical assistance by calling **0861 009 353**

Out-Of-Hospital Benefits

- GP and Specialists consults optical, dental and other benefits
- Emergency medical care via ER made EASY
- Free and unlimited access to telephonic advice via Hello Doctor

Maternity Benefits

- Comprehensive maternity benefits subject to registration onto the programme
- Benefits include antenatal care, scans, vitamins and paediatric visits

Chronic Benefits

You are covered for the 29 non-CDL conditions as well as:

- Acne
- Allergic Rhinitis
- Ankylosing Spondylitis
- Attention Deficit Hyperactivity Disorder (ADHD)
- Cystic Fibrosis
- Depression
- Eczema
- Gastro-Oesophageal Reflux Disease (GORD)
- Gout Prophylaxis
- Meniere's Disease
- Menopause
- Migraine Prophylaxis
- Motor Neuron Disease
- Narcolepsy
- Neurogenic Bladder
- Onychomycosis
- Osteoporosis
- Osteoarthritis
- Osteopaenia
- Overactive Bladder Syndrome
- Paget's Disease
- Peptic Ulcer Disease
- Peripheral Arterial Disease
- Primary Hypogonadism (hormonal levels required)
- Psoriasis
- Psoriatic Arthritis
- Renal Calculi
- Thromboembolic Disease
- Tourette Syndrome
- Trigeminal Neuralgia

Wellness Benefits

Reduce your risk. **The Wellness benefit allows for early detection and pro-active management of your health. You are covered by the Scheme for:**

- Glaucoma
- Health Risk Assessment
- Dexa bone density scan
- Cholesterol test
- Mammogram
- Pap smear
- Prostate specific antigen (PSA) testing
- HPV Vaccine
- Colorectal Screening
- Contraception
- Pneumococcal and flu vaccine for high risk members
- TB screening
- Tetanus diptheria injection
- Blood glucose test

REMEMBER: Chronic medicines approved from the additional non-PMB chronic condition benefit on the Optimum option will be paid subject to an annual limit.

Benefits may be subject to clinical protocols

MONTHLY CONTRIBUTIONS		
MEMBER	**ADULT**	**CHILD**
R10 076	R8 577	R2 524

OUT-OF-HOSPITAL BENEFITS

Not sure what we mean? Refer to glossary at the end of this guide.

All sub-limits set out below are subject to the annual day-to-day limit. MHC will pay benefits in accordance with the Scheme rules and clinical protocols per condition. The sub-limits specified below apply per year. If you join the Scheme after January, your limits will be pro-rated.

Day-to-day limit	M R33 950 M1 R47 350 M2 R55 050 M3+ R64 600
General practitioners (GPs) and specialists	Subject to day-to-day limit
MEDICINES	
Acute medicine	M R14 700 M1 R15 900 M2 R18 750 M3 R20 450 M4+ R21 800
Over-the-counter (OTC)	R300 per beneficiary per day
Contraceptives: oral, devices and injectables Devices subject to pre-authorisation	R1 600 per female beneficiary up to the age of 45 years per annum
Chronic benefit Benefits are subject to registration onto the chronic management programme	Provider - Any provider 26 conditions covered as per the chronic disease list and PMBs earlier in the guide for more information on co-payments
OPTOMETRY	
Optometry	Per beneficiary: 1 composite eye examination
Per beneficiary: A frame of up to R1 815 and 2 lenses every 24 months	Annual limit. Clinical protocols and policies applicable **OR** Contact lenses of up to R2 280 instead of glasses per year

OUT-OF-HOSPITAL BENEFITS

DENTISTRY

Basic	Single member R3 150 Family R6 300
Specialised	Single member R16 550 Family R24 550
Auxiliary services Sub-limits	At a preferred provider, subject to auxiliary sub-limit and day-to-day limits Single member R6 250 Family R18 850

ADDITIONAL BENEFITS (PAID FROM RISK BENEFITS)

Chronic medicine Non-CDL chronic medicine limit	26 conditions – unlimited – plus 31 conditions, subject to sub-limits: M R8 570 M1 R17 140 M2 R18 500 M3 R21 350 M4+ R22 550
MRI, CT, PET and radio isotope scans	Day-to-day annual limits: R17 400 per scan Per family = 2 scans paid from risk benefits thereafter from day to day limits Subject to pre-authorisation and managed care protocols
Co-payment for non-formulary medicine	20%
Free Hello Doctor advice	Telephonic advice via Hello Doctor. Talk or text a doctor on your phone, any time, any where, any official language – for free Refer to earlier in this guide
Medical and surgical appliances – general Sub-limits to Appliance Benefit Glucometer every 2 years Nebuliser every 3 years	 Per family: R12 750 Per beneficiary: R1 000 Per family: R1 000
Hearing aids Per beneficiary every 3 years Hearing aid maintenance	Unilateral: R14 350 Bilateral: R28 700 R1 300 per beneficiary
External prothesis	R35 550 per family
Patient care programmes (Diabetes, HIV, oncology)	Subject to registration and managed care protocols

IMPORTANT: Treatment performed in-hospital needs to be pre-authorised prior to commencement of treatment. Conditions such as cancer will require you to register onto the Patient Care Programme to access benefits.

IN-HOSPITAL BENEFITS

ANY HOSPITAL

Subject to pre-authorisation and managed care protocols. MHC will pay benefits in accordance with the Scheme rules and clinical protocols per condition. The sub-limits specified below apply per year unless otherwise indicated. If you join the Scheme after January, your limits will be pro-rated.

State and private hospital	Unlimited
CO-PAYMENT FOR SPECIALISED PROCEDURES/TREATMENT (This co-payment is only applicable to procedure/treatment below and not the entire benefit)	
Procedure/treatment: Gastroscopy, colonoscopy, sigmoidoscopy, arthroscopy, joint replacements, diagnostic laparoscopy, urological scopes and facet joint injections	If performed in hospital: A co-payment of R1 200 will apply per admission, which needs to be paid directly by the member to the treating practitioner If performed out of hospital: Procedure will be paid at the Scheme rate
GPs and specialists	Unlimited Specialists
To-take-out medicine	Up to 7 days
Organ transplants (non-PMB cases) Includes harvesting and transportation costs National donor only	R79 500 per family
Internal prostheses	R60 000 per family
Refractive eye surgery once per lifetime	R6 850 per beneficiary per eye; maximum of R13 700 for both eyes
Reconstructive surgery	R79 400 per family
MRI, CT, PET and radio isotope scans 2 scans from risk thereafter from the annual day-to-day limit	R17 400 per scan per family
Alternative care instead of hospitalisation	30 days per family to a maximum of R50 500 per event
Mental health (in- and out-of-hospital)	100% of the Scheme rate
Alcohol and drug rehabilitation	100% of negotiated rate, a South African National Council on Alcoholism and Drug Dependence (SANCA) approved facility up to 21 days
Oncology	Unlimited
Pathology and radiology	Unlimited
Dialysis	Unlimited and subject to use of DSP
Ambulance transport within the RSA and SADC countries	Emergency road and air transport subject to use of the designated service provider, clinical protocols and pre-authorisation

Important To Remember

- Have an annual check-up at your general practitioner so if there are any concerns, request your doctor to start treatment sooner rather than later.
- Remember to check if your option has network providers – using these providers will reduce or even prevent a co-payment.
- Where possible, use a day clinic for day procedures, e.g. for a tonsillectomy or adenoidectomy.
- Register on the chronic medicine programme as soon as you are diagnosed with a chronic condition.
- Visit **www.mhcmf.co.za** for any new or updated information.

IMPORTANT: Treatment performed in-hospital needs to be pre-authorised prior to commencement of treatment. Conditions such as cancer will require you to register onto the Patient Care Programme to access benefits. MHC will pay benefits in accordance with the Scheme rules and clinical protocols per condition. The sub-limits specified below apply per year. If you join the Scheme after January, your limits will be pro-rated.

Member online access

(Web-based self-help facility)

Using the Scheme's self-help facility at **www.mhcmf.co.za** and the Moto app allows you to check your personal and medical scheme information. You can update your contact details and other information and view your benefit information and claims statements.

PLEASE FOLLOW THESE STEPS:

1. Go to **www.mhcmf.co.za**.
2. On the Scheme's homepage in the menu bar, click on the login button and then on member login.
3. You can now view the online solutions box that will give you the option to log in, register or obtain a new username and password if you have forgotten your previous one. If you want to register or obtain a new username and password, fill out the required details.
4. The Scheme will send you an One Time Pin (OTP), which you need to enter and answer a security question, after which you will be prompted to change your password.
5. Once you are logged in, you will see the Member Online homepage. You can check your personal membership information; for example, click on the claims menu to view your claims information or update your communication details.

Scheme Exclusions

All medical schemes have a list of services and products that they will not pay for. The Scheme's exclusions are split into general and dental exclusions to make it easy for you to determine what will not be covered by the Scheme.

IMPORTANT: Treatment performed in-hospital needs to be pre-authorised prior to commencement of treatment. Conditions such as cancer will require you to register onto the Patient Care Programme to access benefits. MHC will pay benefits in accordance with the Scheme rules and clinical protocols per condition. The sub-limits specified below apply per year. If you join the Scheme after January, your limits will be pro-rated.

General exclusions

- Search and rescue
- Complications, or the direct and indirect expenses, that arise from receiving treatment that is excluded
- Purchase of patent food, including baby food, patent medicines, preparations of the type generally promoted to the public to increase consumption, cosmetics, proprietary preparations, biological substances, medicines advertised to the public and domestic, biochemical or herbal remedies, except when prescribed by a homeopath
- Slimming preparations, anti-smoking treatment and substances except for the Classic and Classic Network options (where the benefit may be paid from the members accumulated savings)
- Contraception except for the Classic, Classic Network and Optimum options
- Experimental, unproven or unregistered treatment or practices
- Expenses arising from, or connected to, misconduct, other operations/procedures of choice, other than circumcisions, and preventive procedures
- Treatment or operations for purely cosmetic purposes, obesity, including Pickwickian syndrome, infertility and artificial insemination, as described in the Human Tissue Act, Act 65 of 1983. Except for PMB conditions/treatment, consultations, investigations, examinations, the treatment of infertility and the artificial insemination is an exclusion
- Treatment for Alzheimer's disease
- Frail care and sickbay care in retirement villages, old age homes or private residences
- Treatment rendered by naturopaths and any other person not registered with the South African Medical and Dental Council as a medical auxiliary or registered with the South African Nursing Council as a registered nurse
- Medical cover outside the borders of South Africa: the Scheme will cover medical treatment rendered in the Southern African Development Community (SADC) only; treatment will be paid in accordance with the Scheme's prescribed rate and the South African currency exchange rate applicable on the date the treatment was rendered will apply

- Members travelling outside the borders of South Africa to participate in non-professional or professional sports must ensure he or she takes out additional cover, as this will not be covered by the Scheme
- Reports, examinations and tests requested for emigration, immigration, visas, insurance policies, employment, scholastic abilities, readiness for school, admission to school and universities, court medical reports, muscle-function tests for fitness, fitness examinations and tests, adoption of children and retirement because of ill health
- 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
- Breathing exercises for chronic airway diseases
- Toiletries, cleansing agents, anabolic steroids and sunblock
- Accounts for appointments not kept by members
- All complementary medicines, including vitamins that can be obtained without a prescription
- Aphrodisiacs
- Cochlear implants
- Ante- and post-natal exercises or classes, or mother-craft and breast-feeding instructions, unless it forms part of a birth management programme
- Costs that are higher than the annual maximum benefit due to the member and his or her dependants in a given calendar year
- Contact lens cleaning materials and spectacle/contact lens cases
- Experimental, unproven or unregistered treatment or practices
- Medical treatment in a research environment
- Maintenance is only covered for hearing aids as per individual plan benefit annexures
- Skin lesions, except where cancer is proven by submission of histology results
- No benefit will be paid for sunglasses or lenses for sunglasses
- Sleep clinics and holidays for recuperative purposes
- Operations, medicines, treatment and procedures for gender alteration or realignment for personal reasons and not directly caused by or related to illness, accident or disease
- Furthermore, any medical condition or complication that arises at a later stage, whether directly or indirectly, as a result of the original, excluded treatment, is similarly excluded from benefits unless complications qualify as a prescribed minimum benefit
- Any condition that arises from the deliberate refusal of medical treatment, except in the case of terminally ill patients
- Reversal of vasectomies/sterilisation
- Pain relief machines
- Hyperbaric oxygen therapy
- Professional speed contests or professional speed trials (professional is defined as the beneficiary's main form of income is derived from taking part in these contests)
- Prophylactic treatment prescribed for malaria by a medical practitioner

Dental exclusions

Unless otherwise decided by the Board of Trustees, costs and or expenses incurred by the member and or any dependant in connection with any of the following dental treatment will not be paid by the Scheme:

THE FOLLOWING DENTAL SERVICES ARE EXCLUDED:

- Treatment mentioned in the rules of the applicable benefit options where authorisation is required;
- The cost of general dentistry performed in hospital for beneficiaries older than 8 years;
- The cost of gold, metal or other inlays in a denture; crown and/or natural tooth/teeth;
- Fee for after-hours visits that the Scheme considers as convenience visits;
- Bleaching;
- Unregistered items and items listed as 'by agreement' or 'not applicable' in the tariff code listing;
- Lingual orthodontic treatment;
- Services which deviate from the available guidelines of the Department of Health and which are deemed to be excluded from benefits after evaluation of the available information;
- Gum guards for sport purposes;
- Laboratory costs, which according to the Scheme's norms and judgement, seem to be above the general cost claimed by other dental service providers and dental laboratories treating similar conditions;
- Services or procedures which are regarded by the Scheme as cosmetic, when alternative functional services exist (in which case the benefit will be excluded entirely or in part and/or paid in accordance with the cost of such functional alternative service);
- The cost of a written report compiled by a dental practitioner or specialist for which prior authorisation was not granted by the Scheme.

TREATMENT LISTED BELOW:

- Any specialised treatment listed by the Scheme rules as requiring prior authorisation and no authorisation was prior obtained
- Orthodontic treatment for beneficiaries older than 18 years of age
- Orthodontic procedures are limited to once in a life time including retainers
- Electrognathographic recordings and other such electronic analyses
- Metal base to full dentures, including the laboratory cost
- Soft base to new dentures
- Diagnostic dentures
- Provisional and emergency crowns and associated laboratory cost
- Pontics on second molars
- Ozone therapy
- Resin bonding for restorations charged as separate procedure
- Porcelain veneers
- Laboratory fabricated crowns and root canal treatment on primary teeth
- Gingivectomies
- Periodontal flap surgery and tissue grafting
- Surgical tooth exposure that was not pre-authorised as part of an orthodontic treatment plan

- Orthodontic re-treatment or unauthorised initial treatment commencing an orthodontic treatment plan
- Orthognathic (jaw correction) surgery and related hospital cost
- Multiple hospital admissions for extensive conservative (basic) dentistry in young children. Only 1 admission per child every 24 months
- Laboratory delivery fees
- Cost of mineral trioxide
- Cost of gold, precious metal, semi-precious metal and platinum foil
- In-hospital treatment for procedure not considered as invasive based on fear and anxiety in adults
- In-hospital dental implants, dentectomies, and apisectomies
- Oral hygiene instructions; perio chip;
- Mouth guards and snoring appliances

Complaints And Disputes

MEMBERS MAY LODGE A COMPLAINT WITH THE SCHEME BY:

Contacting the call centre: **0861 000 300**;
Emailing: **complaints@mhcmf.co.za**.

When receiving your complaint, the Scheme will acknowledge receipt. All complaints will be investigated and the Scheme will respond to your complaint within 30 days of receipt. Complaints that need clinical input and investigation may take longer to resolve.

How to lodge your complaint

1. Call the Customer Service Centre on **0861 000 300** and speak to a service consultant; remember to obtain a reference number when making the complaint **OR** email and remember to take note of the reference number which you receive back.
2. If you are not satisfied with the outcome of the complaint, you may send a letter of appeal to the Scheme (**complaints@mhcmf.co.za**). This can be in the form of a formal letter or an email. Remember to include all information including the confirmation on the declined decision.
3. This appeal will be sent to the Scheme's Board of Trustees for review.

Dispute Process

1. Once you have exhausted the complaint process with the Scheme, the member may declare a dispute. On written request from the member, the Principal Officer may convene the Dispute Committee to decide on the matter.
2. If the member is not satisfied with the ruling of the Dispute Committee, the member may lodge an appeal with the Council for Medical Schemes.

MHC's Partners

We have contracted a network of service providers who provide specialist services ensuring access to quality healthcare.

- Dental provider network management
- Dental managed care
- Dental pre-authorisation

- Medicine Formulary management
- Pharmacy benefit Management

- Administration services
- Managed care services
- Primary care service management

- Optometry provider network management

Glossary: What Do We Mean?

We have included a glossary to make the terminology in this member guide easy to understand. Please contact us should you need assistance or require a better understanding of the benefits and what they entail.

Acute medicine

This is medicine that is prescribed for a short period of time to alleviate the symptoms of an acute illness or condition, such as antibiotics for an infection.

Alternative care

This is care approved instead of hospitalisation for services such as wound care upon submission of a treatment plan.

Annual savings limit (ASL)

This is the portion of your monthly contribution that is allocated to a savings account held in the principal member's name. The money in this account is used to pay for out-of-hospital medical expenses.

Appliance

Devices that are used to benefit or support a patient, it is prescribable such as dressings, mechanical supports, diabetic supplies such insulin pumps, etc.

Beneficiary

A beneficiary is a principal member or a person registered as a dependant of a principal member.

Benefits

Your benefits are the amounts that are available for medical services provided to you or your dependants in terms of the Scheme rules.

Brand-name/Patented medication

Pharmaceutical companies incur high costs for research and development before a product is finally manufactured and released on the market. The company is given a patent to be the sole manufacturer of the specific medication brand for a specified number of years to recover these costs. This medication does not yet have generic equivalents.

Capitation options

Options that provide cost-effective and specified health care coverage at a prescribed network of service providers. These options may be income based and offer access to network providers, e.g. GPs.

Chronic disease list (CDL)

The CDL consists of 26 chronic conditions that are covered by the Scheme in terms of the regulations governing all medical schemes.

Chronic diseases

These are illnesses or conditions requiring medication and/or treatment for prolonged periods of time. The Medical Schemes Act 131 of 1998 provides a list of Prescribed Minimum Benefits (PMBs) that indicate the chronic conditions a medical scheme must cover.

Chronic medication

This refers to medication prescribed by a healthcare provider for a prolonged period of time. It is used for a medical condition that appears on the Scheme's list of approved chronic conditions according to a medicine formulary.

Claim

A claim is a request for payment following medical treatment that has been provided by a healthcare provider, such as a general practitioner, specialist or hospital.

Consultation

This refers to an appointment with a healthcare provider, such as your general practitioner or specialist, for treatment.

Contribution

Your contribution is the fixed monthly amount that you pay to be registered as a member of the Scheme. Your employer deducts your contribution from your salary or if you are a continuation member, your contribution will be debited directly each month. Remember that you pay your contribution in arrears, this means that at beginning of a month contributions for the previous month are due.

Co-payment

A co-payment is a portion of the cost of treatment or medication for which you are responsible.

Designated service provider (DSP)

This is a healthcare provider or group of providers contracted by the Scheme to provide diagnoses, treatment and care to members in respect of one or more prescribed minimum benefit conditions. This includes doctors, pharmacies and hospitals. When you choose not to use a DSP, you may have to pay a portion of the cost from your own pocket.

Dependant

This is a member's spouse or partner, who is not a member or a registered dependant of a member of a medical scheme; a dependant child who is not a member or a registered dependant of a member of a medical scheme; a member's immediate family who is financially dependent of a member of a medical scheme.

Diagnostic treatment pairs (DTP)

A DTP links a specific diagnosis to a treatment and therefore broadly indicates how each of the approximately 270 PMB conditions should be treated.

Exclusions

Exclusions include medical treatment and care not covered by the Scheme.

External prosthesis

Refers to an artificial device that is worn on the outside of the body and is intended to replace or supplement a missing or non-functional body part.

Facility fee

Facility fees are the extra costs charged by hospitals to members when they provide services in an outpatient location. For instance, members may be expected to pay a facility fee for consulting a physician in a hospital-operated outpatient facility.

General practitioners (GPs)

GPs are doctors who provide general or primary healthcare services, but do not offer a specialised service.

Generic medicine

This is medicine that has the same chemical ingredients, strength and form (such as a tablet or syrup) as the original, brand-name product. Generic medicine is as safe and effective as the original, brand-name product but is usually more cost-effective.

General waiting period

This is a three-month period during which a beneficiary is not entitled to claim any benefits.

Internal prosthesis

Refers to artificial device that is surgically implanted to replace or support a missing or dysfunctional body part that is intended to stay in permanently or for an extended time.

Late-joiner penalty (LJP)

A LJP is imposed on the contributions of persons joining a medical scheme when they are 35 years of age or older and have not been members of a medical scheme before 1 April 2001 or have had a break in membership exceeding three consecutive months since 1 April 2001.

Moto Health Care (MHC) tariff

This is the rate at which healthcare providers are paid for services rendered to Scheme members.

Medicine formulary

A medicine formulary is a list of cost-effective medicines that guides the doctor in the treatment of specific medical conditions. Medicine formularies are continuously reviewed and updated by medical experts to ensure that they are consistent with the latest treatment guidelines.

Network providers

This is a list of service providers who have been contracted by the Scheme to provide medical care to members at an agreed rate.

Network pharmacy

For acute medicine, use the Scheme's network of pharmacies. To see if your pharmacy belongs to the network, contact the call centre on **0861 000 300** or visit the Scheme's website at **www.mhcmf.co.za**

Network hospitals

The Life Healthcare Group of hospitals is the preferred network of hospitals for the Custom, Classic Network and Hospicare Network options.

Overall annual limit

This limit is the overall maximum benefit that members and their registered dependants are entitled to according to the Scheme rules. This is calculated annually to coincide with the Scheme's financial year (January to December).

Prescribed minimum benefits (PMBs)

This is a list of conditions that medical schemes have to cover in full according to the Medical Schemes Act.

Pre-authorisation

The confirmation received from the Scheme when a member requires hospitalisation or specialised treatment. Keep in mind that pre-authorisation is not a guarantee of payment but provides confirmation that the member may have access to benefits.

Primary care network

This is a group of healthcare professionals that delivers primary care services, for example, general practitioners, dentists and optometrists. Members on the Custom and Essential options are required to obtain out-of-hospital benefits from these network providers.

Principal member

A principal member is the main member that is registered on the Scheme.

POPIA

Protection of Personal Information, Act 4 of 2013.

Registered dependant

A registered dependant is a person who is dependent on the principal member and is registered by the Scheme to share in the benefits provided to the principal member.

Sub-limit

This is the maximum amount of money you can claim for a specific service, which is also subject a larger annual amount.

Waiting period

A waiting period is a period during which beneficiaries are restricted from claiming for benefits. This happens when beneficiaries have no previous cover or a break in medical aid cover.

There are two kinds of waiting periods:

1. A general waiting period of up to 3 months.
2. A condition-specific waiting period of up to 12 months, where pre-existing health conditions are excluded; all medical costs during this period will be the members responsibility.

Wellness benefits

Wellness screening is an important way to detect some medical conditions given.

Contact Details

CONTACT	CONTACT NUMBER	EMAIL ADDRESS
Call Centre	0861 000 300	info@mhcmf.co.za
Ambulance Emergency	0861 009 353	
Hospital authorisations	0861 000 300	auths@mhcmf.co.za
Authorisation for chronic medication (Optimum, Classic + Classic Network, Hospicare + Hospicare Network)	0861 000 300	chronic@mhcmf.co.za
Authorisation for chronic medication (Custom and Essential Options)	0861 000 300	chronic@mhcmf.co.za
Claims	0861 000 300	claims@mhcmf.co.za
Membership applications and enquiries	0861 000 300	membership@mhcmf.co.za
Confidential HIV Programme	0860 109 793	ha@mhcmf.co.za
Oncology Treatment Programme	0861 000 300	oncology@mhcmf.co.za
HealthSaver	0861 000 300	info@mhcmf.co.za
Fraud line	0800 000 436	mhcmf@tip-offs.com
POPIA	0861 000 300	popia@mhcmf.co.za
Medipost	012 426 4000	info@medipost.co.za
MOTO HEALTH CARE WALK-IN CENTRES 2026		
Western Cape	Momentum, 2nd Floor, Birkdale House 2, Riverpark Offices, Parklane Road, Mowbray	
Eastern Cape	Momentum, Waterfront Business Park, Unit 5, 1st Floor, 1 Pommern Street, South End, Gqeberha	
KwaZulu-Natal	Momentum, 201 Umhlanga Ridge Boulevard, Cornubia, Durban	
Gauteng	Momentum, 268 West Avenue, Centurion	

Notes

moto
HEALTH CARE

taking care of our own

Taking care of our own at every stage
of their health journey