



**moto**  
HEALTH CARE

*Taking care of our own*



**MEMBER GUIDE**  
**2010**



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## MOTO HEALTH CARE WALK-IN CENTRES • • • •

Moto Health Care has a number of walk-in centres throughout the country that are equipped to offer our members personal service, some of which include claims and billing enquiries, membership updates and new membership applications.

Below is a list of walk-in centres that are available to assist you. These centres are open during normal office hours from Monday to Friday.

### Cape Town

River Park Offices  
1st Floor Liesbeeck House  
River Lane  
Mowbray  
Cape Town  
Tel: 021 680 7400

### Gauteng

33 Princess of Wales Terrace  
Cnr of Princess of Wales and Carse  
O' Gowrie  
Parktown  
Tel: 011 485 7497

Momentum Building  
268 West Avenue  
Centurion  
Tel: 012 671 8911/5666

Munimed Building  
67 Koranna Avenue  
Dooringkloof  
Centurion  
Tel: 012 673 1000

JHB Life Centre  
45 Commissioner Street  
Johannesburg  
Tel: 011 491 6601

### Bloemfontein

No. 9 Office Park  
Cnr President Reitz Street and 3rd  
Avenue  
Westdene  
Bloemfontein  
Tel: 051 448 4632

### KwaZulu Natal

1-3 Canegate Road  
La Lucia Ridge  
Umhlanga  
Tel: 031 573 4000

11 Walnut Road, Gate C  
Durban Exhibition Centre  
Durban  
Tel: 079 410 9493

### Port Elizabeth

3rd Floor, Greyville Building  
Cnr of Cape Road  
and Greyville Road  
Greenacres  
Port Elizabeth  
Tel: 041 373 8773



## MEMBERSHIP ● ● ● ●

### Proof of Membership ● ● ● ●

Your membership card reflects your membership number, your name and the names and dates of birth of your registered dependants, as well as the dates from which you are entitled to benefits. Please take care of your medical aid card. Do not lend it to anyone. Only you and your registered dependants are allowed to claim benefits. Fraudulent use of cards may lead to a suspension or termination of membership.

### Who is eligible? ● ● ● ●

A member must be employed by an employer that belongs to MIBCO (Motor Industry Bargaining Council).

### Who can be registered as dependants? ● ● ● ●

- your spouse or partner, dependant children and special dependants  
SPECIAL DEPENDANTS:
  1. Step Child
  2. Legally adopted child
  3. Foster child
  4. Grandchild
  5. Parents
- a full-time student at a university or other recognised institute of higher learning; not receiving a regular income exceeding the social pension; or
- a child who owing to mental or physical defects, is not in receipt of a regular remuneration of more than the social pension.

### Documents required for dependant registration

Spouse	Marriage certificate
Natural child	ID, birth certificate
Natural child with different surname to principal member	ID, birth certificate, affidavit
Stepchild	ID, full birth certificate, marriage certificate , affidavit
Adopted child/foster child	ID, full birth certificate, proof of adoption, court order
Mentally/physically disabled child (over 21)	ID, full birth certificate, written confirmation from treating doctor of nature of disability, proof of state grant/pension
Traditional/polygamous spouse	ID, affidavit/certificate of customary union
Parents/siblings of principal member	ID, affidavit, proof of income
Common-law partner/same gender partner	ID, affidavit
Student	ID, proof of registration at tertiary institution
Unemployed child (over 21)	ID, affidavit confirming unemployment





MEMBERSHIP CARD

## What about pensioners, surviving spouses and ill health members? ● ● ● ●

Pensioners, spouses and dependants of deceased members and members retiring due to ill health have the same benefits as other members, provided that:

### Pensioner members:

- are of retirement age; and
- are members of the Fund immediately prior to retirement.

### Surviving spouse and dependant members:

- are registered as dependants at the time of the member's death.
- a surviving spouse cannot register an adult dependant or their dependants

### Surviving spouse membership stops:

- when membership is terminated in writing.

### Members requesting continuation of membership due to ill-health

- are members of the Fund prior to date of ill health;
- are placed on ill health through their employer's disability insurers - proof from Pension Fund or doctor required

## IMPORTANT

- Advise the Fund of any changes (e.g. address, marital status - if divorced, termination of ex-spouse) by completing the relevant forms available from your employer and on the website.
- Membership ceases when you leave the service of your employer. It is your duty to notify your medical service providers of your termination from the Fund. Any attempt to obtain benefits after you have left the Fund is fraudulent.
- A full set of rules is available on the Moto Health Care website [www.motohealthcare.org.za](http://www.motohealthcare.org.za)
- You or your dependants cannot have membership on more than one Fund at the same time.
- Membership ceases when you leave the service of your employer. If you are moving to another employer in the industry, please advise both your current and new employer that you wish to remain on the Fund.

For all your membership queries, please contact us on:  
Call Centre: 0861 000 300



## MONTHLY CONTRIBUTIONS • • • •

As a member of Moto Health Care a set monthly payment, specific to the option you are on and the number of dependants registered with Moto Health Care, will be deducted from your salary. Your employer then pays your contribution over to the Fund on your behalf. These funds are utilized to pay for the medical expenses incurred by you and your dependants.

How it works:

Employer deducts your set monthly contribution % from your salary at the end of each month

Your employer pays the full contribution over to the Fund

Moto Health Care pays medical claims (within the limits of the relevant option you have selected) on your behalf



## CLAIMS - GUIDE TO PROBLEM FREE ADMINISTRATION • • • •

Nothing is more annoying than wondering where your refund is, or not knowing what you are allowed to claim for. Some of the answers to your everyday administration queries can be found in the details of your benefit summary, which are included in this document, but the majority of your queries could be eliminated by knowing how the "claim chain" works:

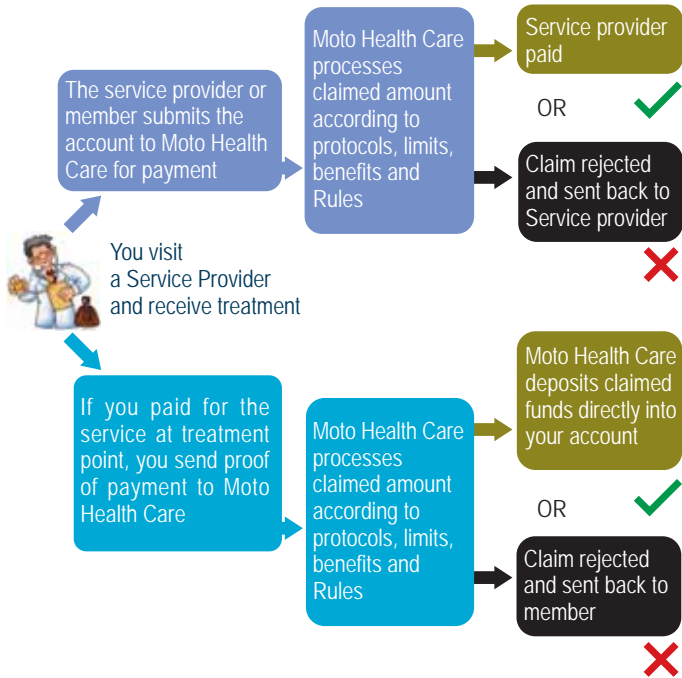
### How to submit your accounts • • • •

- Ensure your membership number is clearly stated on your account.
- Please post, email, fax or deliver your account as quickly as possible to the administrator. Only claims received within four months of treatment will be paid.
- Send the first account you receive. Do not send statements.
- If you have already paid the account please attach your receipt and clearly mark the account "paid by member". Accounts without a receipt and balance owing will be paid to the provider of service.
- Please do not submit accounts marked "FOR YOUR INFORMATION ONLY" or accounts showing only a balance brought forward. Such accounts are for your records and should be used to check against payments reflected on your Claims Advice Statements.
- The Medical Schemes Act requires that the supplier of service provide full details on all accounts. Please check that your account shows:
  - your name and initials;
  - your medical aid number;
  - the treatment date;
  - name of patient (as indicated on the Membership card - not a nickname);
  - amount charged;
  - tariff code (where applicable); and
  - ICD-10 code.
  - valid practice number

## IMPORTANT

- Accounts charged at the Moto Health Care Rate will be paid directly to the medical aid service provider.
- Accounts charged above Moto Health Care Rate and accounts with a receipt that prove that members have paid them, will be refunded to the member. You are then responsible for paying the medical aid service provider.
- Check your Claims Advice Statement before submitting a second account.
- Accounts are paid according to tariff and subject to benefits available.
- Refunds are paid directly into your bank account. This is a secure method of payment. Contact the service centre to find out about this facility.

## HOW IT WORKS:



### Tips for claiming

- Check that prescriptions for medicine show all your details. If the pharmacy omits any of these details, the administrator is unable to process your claim, and this may lead to delays.
- Specialised dental treatment often requires additional work by a dental technician or dental laboratory. Technician's claims are normally included with the dentists' claims. Please ensure that both the dentist and the dental technicians claims (where applicable) are submitted to the administrator for payment and that your medical aid details are reflected on each document.

## When can I expect payment?

The administrator has regular payment cycles as follows:

- Weekly cheque runs for members and hospital groups
- Fortnightly cheque runs for all other service providers

All valid claims received will be processed on this basis.

## How will I know what was paid?

A Claims Advice Statement is sent to you if the administrator has processed an account during that month. This statement will indicate all payments made to you or to your service provider as well as indicate all claims rejected. Please ensure that you/your dependants did actually receive the services reflected on your statement. If not, please contact the Fund immediately.

## UNDERWRITING • • • •

### Waiting periods and late joiner penalties • • • •

#### When waiting periods apply

Less than twenty four months continuous membership and a break of more than three months between medical aids.

The Fund may impose two types of waiting periods:

- A general waiting period of three months; and
- A condition specific waiting period of up to twelve months for certain pre-existing conditions.

#### When a late joiner penalty would apply • • • •

Late joiner penalties may be imposed on the main members and/or their adult dependants if both of the following circumstances apply:

- The applicant or the adult dependant of the applicant is 35 years of age or older at the date of application and has not belonged to a Fund previously or has had a break in cover for more than three consecutive months.
- The applicant has not been a beneficiary who enjoyed coverage with one or more Funds as from 1 April 2001, without a break in coverage exceeding three consecutive months since 1 April 2001.

A penalty is applied and is worked out in the following way:

"Age upon application" minus "35 years" minus "previous cover" = Total years uncovered.

A schedule of penalties is provided for in the Medical Schemes Act, and penalties are calculated in terms thereof. The resulting penalty is added to the contribution of the affected member or dependant for the duration of membership.

#### Maximum Penalty • • • •

##### Uncovered years

1 – 4 years	0.05 x contribution
5 – 14 years	0.25 x contribution
15 – 24 years	0.50 x contribution
25 + years	0.75 x contribution



### Example

- You are 50 years old.
- You are applying for membership in March 2005
- The last time you were on a Fund was December 2003
- You were previously on a Fund for four years

### Calculation

50 years (age at application) minus 35 years minus 4 years (previous cover)  
= 11 years (uncovered)

Late joiner penalty = 0.25 x contribution

### Please Note:

- To ensure that the correct contribution and/or penalty is charged, we require the following:
- The section at the bottom of the second page of the membership application form entitled, "Details required, if applicant belonged to another Fund" is to be completed by the main member; and
- Proof of cover on previous Fund(s), i.e. certificate of membership.
- The penalty amount is percentage driven, therefore, it will increase/decrease under the following circumstances:
  - as and when the Fund announces an overall contribution increase/decrease;
  - if a salary adjustment results in a change in salary category of the principal member;
  - or
  - when there is a change in plan/option.
- The percentage added to the contribution is not a once-off fee and will be payable for the duration of the member's/dependant's membership.
- Late joiner penalties and/or waiting periods may be waived if an exception has been granted to the employer group.

## NETWORK PROVIDERS • • • •

### Valuable information only applicable to members of the Custom and Essential option

#### WHAT/WHO is a network provider?

A Network Provider deals with you and your family's day-to-day basic healthcare needs, e.g. the treatment of flu. The network provider network used by Moto Health Care is CareCross. CareCross makes use of the services of general practitioners (GP's) at CareCross facilities countrywide and also makes use of the services of contracted doctors (GP's) in areas where there are no CareCross facilities.

Information and details of the nearest CareCross facilities or doctors can be found on [www.motohealthcare.org.za](http://www.motohealthcare.org.za) or you may call client services on 0861 000 300.

#### What services are offered by my network provider?

##### GP Consultations

The first and most important step to ensure that you receive full access to the benefits is to consult your chosen CareCross GP. Your CareCross GP is also referred to as your Network Provider. If you follow this step, you are able to

- access all medically necessary primary care GP consultations.
- 
- 
-

## Acute Medication

### What is acute medication?

It is medication that is used for a short period of time to help a patient recover from a common illness, such as influenza (flu).

If your Network Provider needs to prescribe acute medication, he/she will do so according to the CareCross Acute Formulary.

## There are two types of CareCross GP's:

### Dispensing GP

A large percentage of the CareCross GP's have a license to dispense acute medication from their consulting rooms which means you will not need to visit a Pharmacy to obtain the medication.

### Non-dispensing GP

If your CareCross GP is a non-dispensing GP, then he/she will provide you with a prescription (Script) which you will need to take to a Pharmacy to obtain the medication.

Whether you obtain your medication from a Dispensing GP or Non-dispensing GP, your medication will be paid in full PROVIDED you have visited your CareCross GP and they have prescribed medication from the CareCross Acute Formulary.

Please ask your non-dispensing GP to direct you to the nearest Medikredit enabled pharmacy.

### Radiology

The Custom and Essential benefits make provision for the CareCross GP to request selected X-rays. Your GP may perform the x-ray or refer you to a Radiologist who will perform the x-ray/s according to the CareCross formulary.

### Pathology

The Custom and Essential benefits make provision for the CareCross GP to request selected Blood tests. Your GP may perform (draw) the blood tests or refer you to Pathology rooms where blood tests will be performed according to the CareCross formulary.

Any radiology or pathology requested by a Non-CareCross GP is not covered under the Custom and Essential Option.

The following benefits are NOT available under the Custom and Essential Option even if performed by a CareCross Dentist:

- Root canal treatment
- Specialised dentistry (e.g., Crowns)
- Orthodontics (e.g. Braces)

The Custom option does cover one set of acrylic dentures per adult over a 2 year cycle.  
Essential members do not qualify for dentures.



## Optometry

You must consult your CareCross Optometrist to receive the full primary care optical benefits.

The following benefits are available per beneficiary and in a 24-month cycle:

- 1 eye test
- 1 pair of mono focal lenses with a standard frame; OR
- 1 pair of bi-focal lenses with a standard frame

The following benefits are NOT available under the Custom and Essential Option even if obtained from a CareCross Optometrist:

- Tinting
- Scratch resistant coating
- Designer frames

If you choose a frame outside of the specified selection, you will be required to pay the difference in price for the frame at point of sale. You will also need to pay the Optometrist directly for any additional services such as tinting and scratch resistant coating.

## Maternity - Custom Option

Consultations to your CareCross GP in relation to your or your beneficiary's pregnancy will be covered provided you register on the maternity programme. Home births benefits will be 100% of the prescribed tariff and subject to annual hospital limit.

Please note: Cover in hospital is subject to registration on the maternity programme and pre-authorisation and subject to annual hospital limit.

## Maternity - Essential Option

This benefit only allows for consultations during your or your beneficiary's pregnancy.

Consultations to your CareCross GP in relation to your or your beneficiary's pregnancy will be covered provided you register on the maternity programme.

There is however cover in a public facility in respect of the confinement (birth) of your child or for home births and subject to annual hospital limit.

## FAQ's – Frequently Asked Questions

### 1. Why can I only visit CareCross Doctors?

These doctors have partnered with your medical aid and are committed to reduce costs while giving top quality service to all patients.

### 2. Where do I find a list of the Network Providers?

The list for the Custom and Essential Option is available on the Moto Health Care website. Alternatively, you may during normal business hours call the Service Centre line on 0861 000 300 for the details of your the nearest CareCross Health General Practitioner.



3. **What happens if I have an emergency and my chosen doctor is not available?**

- You may consult with any GP or Outpatient facility in an emergency, after hours or when you are out of town.
- The benefit for visits outside of the network is however limited to R1 000 per family per annum.
- You will also be required to pay for this treatment and any medication received.
- The costs for these services may however be claimed back by completing a reimbursement form obtainable from CareCross Health.
- Complete the form and submit the account to CareCross Health for evaluation.
- Once validated, CareCross Health will refund you the appropriate costs within 30 days from date of receipt of your claim. Please note that your claim must reach CareCross Health within 4 months from the date of treatment.

4. **What happens if my CareCross GP closes his/her practice?**

When a GP closes his practice or moves to a different area, Moto Health Care will contact you to let you know the details of the alternative doctor in the area that you may go and see in the future.

5. **What are the CareCross GP's practice hours?**

CareCross GP's are expected to allow unlimited access during normal room/business hours to a minimum of his/her normal hours and a maximum of:

Monday to Friday: 09:00 to 18:00

Saturdays: 09:00 to 12:00 noon

They are not required to be open after hours, Sunday's or public holidays

6. **Can I get Chronic medication under the Essential Option?**

Chronic medication is not covered under the Essential Option and the cost of the medication will be for your own account.

7. **What happens if my CareCross GP refers me to a Specialist?**

Custom members have a monetary limit of R2 500 for a single member and R5000 for a family to visit the specialist **upon referral by their CareCross GP**. The specialist consult and all other services requested by the specialist will be paid from these limits. Members need to call us on **0861 000 300** to pre-authorise all specialist visits. Essential members do not have any specialist benefits.

8. **Important points to remember:**

Any service or medication that is obtained outside of the Custom and Essential Option benefits/formulary, are payable by the member.

**Note: When visiting your CareCross Provider, always take your Moto Health Care membership card with you. This will ensure that you do not pay for any services rendered.**



## Benefit Exclusions

Please read the list of Exclusions carefully and ensure that you know what services or items the Fund will not pay.

### 1 List of Exclusions:

1. 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 shall not be paid by the Fund:
  - 1.1 Treatment arising out of any injury or incident sustained for which compensation may be provided for by any other Law or Statute.
  - 1.2 Purchase of patent foods including baby foods, patent medicines, preparations of the type generally promoted to the public to increase consumption, cosmetics, proprietary preparations, biological substances, contraceptives and slimming preparations, medicines advertised to the public and domestic, biochemical, or herbal remedies except when prescribed by a homeopath, anti-smoking treatment and substances.
  - 1.3 Expenses arising out of willful self-injury; or attempted suicide or professional sport or speed contests and/or speed trials; provided that an accident resulting from participation in school organised sports shall not be deemed to be excluded in terms of the Fund Rules.
  - 1.4 Treatments or operations for purely cosmetic purposes, obesity, infertility and artificial insemination, as described by Act 65 of 1983, The Human Tissue Act, or undertaken to facilitate pregnancy except for the Pickwician syndrome.
  - 1.5 Expenses arising from or connected with venereal disease, misconduct, other operations/ procedures of choice other than circumcisions, preventative procedures, addiction to drugs, alcoholism or the abuse of drugs or alcohol.

Note: 'Preventative procedures' do not include the following:

- Preventative influenza measures prescribed by a medical practitioner;
- Hiblitter and Tetratiter vaccinations;
- Vaccinations as approved by the Department of Health;
- Preventative malaria measures prescribed by a medical practitioner.

- 1.6 Expenses arising from any event, which is connected with war, invasion, act of foreign enemy, hostilities (whether war be declared or not), civil war, rebellion, revolution, insurrection, military or usurped power. Any foreseeable act, of any person acting on behalf of or in connection with any organisation, with activities towards the overthrow, by force of any government (whether with legal authority or not) or by any foreseeable act of terrorism or violence.
- 1.7 Treatment for Alzheimer's disease, frail care and sickbay care in retirement villages, old age homes or private residences.
- 1.8 Services rendered by naturopaths and any other person not registered with the Health Professions Council of South Africa (HPCSA) as a

medical auxiliary or registered with the South African Nursing Council as a registered nurse.

- 1.9 Medical cover outside the borders of South Africa. Moto Health Care will cover medical services rendered in the SADEC regions only, treatment will be paid in accordance with the prescribed tariff and the Fund will apply the South African currency exchange rate applicable on the date the treatment was rendered. Members travelling outside the borders of South Africa to participate in non-professional or professional sports must ensure they take out additional cover as this will not be covered by Moto Health Care.
- 1.10 No benefits shall be paid for sunglasses or lenses for sunglasses.
- 1.11 Sleep clinics and holidays for recuperative purposes.
- 1.12 The cost of contraceptives, examinations, preparations and apparatus, and treatment exclusively for the purpose of contraception.
- 1.13 Examinations or tests requested for emigration, immigration, insurance policies, employment, and admission to schools, school camps or universities, court medical reports, fitness examinations and tests.
- 1.14 Any costs as a result of a member and/or his dependants being under the influence of alcohol, drugs or narcotics unless administered by a physician and/or unless prescribed by and taken in accordance with the directions of a physician.
- 1.15 Breathing exercises for chronic airway diseases.
- 1.16 Toiletries, cleansing agents, anabolic steroids, sunblock.
- 1.17 Account for appointments not kept by members.
- 1.18 Efamol-G® and related products, vitamins, tonics and minerals except for potassium with a diuretic and pre-natal vitamin.
- 1.19 Telephonic consultations with medical practitioners.
- 1.20 Aphrodisiacs.
- 1.21 Batteries for hearing aids.
- 1.22 Ante-and post-natal exercises or classes, or mother-craft and breast feeding instructions.
- 1.23 Costs, which are more than the annual maximum due to the member and his/her dependants in a given medical year.
- 1.24 Contact lens cleaning materials and spectacle/contact lens cases.
- 1.25 Experimental, unproven or unregistered treatment or practices.



- 1.26 Injuries on duty or occupational disease (the member must advise the service provider that he/she was injured on duty [IOD] or that the problem is related to the occupational environment [i.e. an occupational disease case] which is not the medical fund's responsibility; the Workman's Compensation Act covers claims of such nature.)
- 1.27 Medical treatment in a research environment.
- 1.28 Operations, medicines, treatment and procedures for gender alteration or re-alignment for personal reasons and not directly caused by or related to illness, accident or disease. 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.
- 1.29 Travelling expenses.
- 1.30 Blood, which has been ordered by the service provider but not used in a procedure, including the transportation thereof.
- 1.31 Drugs, where there is no evidence to prove efficiency or cost-effectiveness for chronic conditions.
- 1.32 Cost of repairs, maintenance, parts or accessories of external appliances.
- 1.33 Skin lesions, except where cancer is proven by submission of histology results.
- 1.34 Any condition which arises from the deliberate refusal of medical treatment except in cases of terminally ill patients.
- 1.35 Reversal of vasectomies/sterilisation.
- 1.36 The following dental services are excluded:
  - 1.36.1 Dental Services performed under general anaesthetic, where no written authorisation was given by the Fund;
  - 1.36.2 The cost of gold, metal or other inlays in a denture or crown;
  - 1.36.3 Fee for after hours visits which the Fund considers as convenience visits;
  - 1.36.4 Bleaching of vital teeth;
  - 1.36.5 Unregistered items and items listed as 'by agreement' or 'not applicable' in the National Health Reference Price List by the Department of Health for dentistry and dental technician list of fees;
  - 1.36.6 Lingual orthodontic treatment;
  - 1.36.7 Services which deviate from the available guidelines of the National Health Reference Price List by the Department of Health/South African Dental Association and which are deemed to be excluded from benefits after evaluation of the available information;
  - 1.36.8 Gum guards for sport purposes;
  - 1.36.9 Laboratory costs, which according to the Fund's norms and judgement, seem to be above the general cost claimed by other dental service providers and dental laboratories treating similar conditions;



- 1.36.10 Services or procedures which are regarded by the Fund 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);
- 1.36.11 The cost of a written report compiled by a dental practitioner or specialist for which prior authorisation was not granted by the Fund.

## Internet Facility

For those with Internet access, a visit to [www.motohealthcare.org.za](http://www.motohealthcare.org.za) will allow you to get details of the benefits and view your claims that have been processed. Members can access their details protected by a password. First you are required to apply for login, after which you will receive an e-mail giving you a password.

To access your personal information, follow these steps:

- Go to [www.motohealthcare.org.za](http://www.motohealthcare.org.za)
- Click on Member Zone
- Then click on Apply for login
- Complete the application for on-line access and fax to (031) 573 0480
- Your password will be e-mailed to you
- Click on the login options to obtain your personal information.

### Private

- Do not divulge your password to anyone. The administrator will not be held liable if, through your own negligence, your password is divulged to a third party.
- If you experience any problems with the on-line registration process or you have forgotten your password, please call 0861 000 300 (during office hours) for assistance.  
You can also submit queries to [info@motohealthcare.org.za](mailto:info@motohealthcare.org.za).

## PRE-AUTHORISATION ● ● ● ●

### What is Pre-authorisation? ● ● ● ●

The confirmation received from the Fund when a member requires hospitalisation, a specialised procedure or specialised radiology. The Fund will then be able to monitor the quality of care that you will receive. Pre-authorisation does not guarantee payment of claims but is merely a pre-notification mechanism whereby the Fund is advised of a pending procedure/ treatment and provides confirmation that the member may have access to benefits.

#### **PENALTIES APPLICABLE TO THE OPTIMUM, CLASSIC, HOSPICARE, CUSTOM AND ESSENTIAL OPTION**

Pre-authorisation must be obtained from the Fund within 48 hours before the beneficiary is admitted to a hospital or day clinic (except in the case of an emergency). Failure to pre-authorise will result in a member penalty.

In the event of an emergency the Fund shall be notified of the emergency within one working day after admission failing which a penalty will apply.

The penalties per admission are as follows:

Classic & Optimum: R2 500	Hospicare: R1 500
Custom: R 750	Essential: R 500

## DISEASE MANAGEMENT • • • •

### Chronic Medication • • • •

Chronic medications are those that are seen as life-sustaining and require ongoing management.

In terms of the Medical Schemes Act, treatment of the 26 CDL conditions, including medication, consultations and diagnostic tests, must be paid at 100% when obtained from a Designated Service Provider (DSP). On the Hospicare and Custom Options, the DSP for chronic medicines is Chronicare. Please check the website for further details of the appointed DSP's or alternatively contact Customer Services on 0861 000 300.

#### NOTE:

**Remember you need to renew your script for chronic medication every 6 (six) months.**

The Chronic Care Management (CCM) team is responsible for the management of Chronic Medication Benefits. The CCM staff use set guidelines and protocols to clinically assess each application for chronic benefits and ensure that the drugs used are appropriate, cost-effective and prescribed in the correct therapeutic dosages. CCM clinical guidelines are maintained in conjunction with medical specialists as well as local and international treatment protocols. Members' applications are assessed by registered pharmacists and clinicians.

CCM ensures that chronically ill members will remain as healthy as possible by taking the appropriate medication in the correct dosages. This in turn means fewer doctor consultations, hospital admissions and less acute symptomatic relief medication. An effectively managed chronic illness will result in fewer acute or long-term medical complications or side effects. This valuable benefit covers medication for the PMB-CDL conditions for Classic, Optimum, Custom and Hospicare members only. The Optimum and Classic option covers additional chronic conditions.

Please advise the Fund if your doctor changes any of your acute medication to chronic. If this happens, you need to immediately check with the Fund whether you may register that medicine on your chronic profile. For example, certain acute conditions such as gout, acne, depression etc. may need to be treated on an extended basis and will therefore require that the medication used to treat these conditions is registered through the CCM department. If you fail to register chronic medicines (where appropriate), you run the risk of depleting your day-to-day benefits to pay for these.

For a simple, paperless, telephonic process, your doctor or pharmacist should contact Moto Health Care on 0861 000 300, where our team of pharmacists and assistants will process your authorisation on-line.

Detailed clinical information, including the condition's ICD-10 code and severity status, are required to register a member's chronic condition.

Once a member's chronic condition has been registered, the member will have access to the full formulary list. This is a list of drugs, appropriate for the treatment of the chronic condition.



If you are currently registered for a chronic condition with the Fund, you are reminded that as per Pharmacy legislation, chronic authorisations are only valid for 6 (six) months. This would mean that your pharmacy would require a new prescription every six months. Please consult with your doctor to provide and arrange for the renewal of your authorisation closer to the time of your authorisation expiring.

FORMULARY drugs – these are drugs that are available to members with the specified condition to which no reference price apply, providing they are claimed in appropriate quantities. Reference pricing may apply to NON-FORMULARY drugs for both PMB-CDL and non-PMB-CDL conditions, in accordance with the option selected by the member.

**HOSPICARE & CUSTOM Members who require Chronic Medication** Members can contact the call centre on 0861 000 300 to register for their PMB-CDL condition. Chronicare has been approved as the designated service provider (DSP) for your chronic medication. If you do not obtain your medication from Chronicare, you will be liable for payment at the point of service. Please contact Chronicare on 011 660 4005 for further information.

### **HIV Management** ● ● ● ●

Moto Health Disease Management Programme is a complete HIV disease management programme.

- The first step is to find out whether you have been infected with HIV. The blood test determines whether you are positive or negative.
- On the Essential Option members only have benefits at Provincial Facility.
- On the Optimum, Classic, Custom and Hospicare Option, benefits are provided.

**If your test shows you are HIV-positive you must register with the Moto Health HIV Programme as soon as possible to make use of this benefit.**

### **Benefits of Joining the Moto Health HIV Disease Management Programme**

- Telephonic patient support include guidance, counseling and advice on lifestyle management, diet, sexual behavior, the nature of the disease etc, to optimize the patient's health and prevent deterioration of their condition.
- Regular monitoring of disease progression and response to therapy.
- Regular monitoring tests to pick up possible side-effects of treatment.
- Clinical guidelines and telephonic support for doctors.
- If you are exposed to HIV infection through sexual assault or needle-stick injury, please ask your doctor to contact Moto Health Disease Management Programme to authorise special anti-retroviral medicine to help reduce your risk of being infected.

### **You or your doctor can call**

- 0861 000 300 for Moto Health HIV Management or 082 821 0994.



## Once you or your doctor has contacted us

- Moto Health Disease Management Department will provide an application form, which you and your doctor need to complete and return to the Moto Health Disease Management Department.
- A highly qualified medical team will examine your details and if necessary, discuss cost-effective and appropriate treatment with your doctor. Once treatment has been agreed upon, your doctor will be sent a detailed treatment plan, which explains the approved medicine as well as the regular tests that need to be done to ensure that the drugs are working correctly and safely.

Contact Number: 0861 000 300  
Cell: 082 821 0994  
Fax: 031 580 0533  
E-mail: moto.hiv@momentum.co.za

**PLEASE NOTE:** We encourage members to join the Programme as soon as possible to ensure optimal management. HIV is a chronic condition that can be managed.

## YOUR CONDITION WILL STAY CONFIDENTIAL

HIV is a sensitive matter and every effort is made to keep your condition confidential. The staff members at our unit have all signed confidentiality agreements which bind them to practice accordingly.

## HOSPITAL BENEFIT MANAGEMENT ●●●●

Hospitalisation is the single most expensive healthcare benefit provided by Moto Health Care.

Pre-authorisation ensures that costly hospital procedures are medically appropriate and necessary.

Moto Health Care requires all members to obtain pre-authorisation prior to admission to hospital as well as for certain out-patient procedures. In an emergency, a member is required to obtain pre-authorisation within 48 hours of the emergency admission or procedure. Failure to pre-authorise will result in a member being required to make a co-payment.

## Always ask your doctor for a full description of:

- The reason for admission.
- The associated medical diagnosis with ICD-10 codes.
- The prospective treatment as well as the procedure code he intends to use.

To obtain pre-authorisation, members must please call 0861 000 300  
Members should ensure that they have the following information on hand when calling for pre-authorisation:

- Membership number;
- Name of patient;
- Name of admitting doctor and the name of the treating doctor if different;
- Name of hospital;
- Diagnosis;
- Procedure to be performed with relevant CPT / Tariff codes
- ICD-10 code

Pre-authorisation is given once benefits have been checked and Fund rules have been applied.

Please note that a pre-authorisation reference number does not guarantee that all costs of the authorised procedure will be paid. Benefits will be paid according to what is permitted in terms of the rules of the Fund. Services must commence within thirty days of approval and will be subject to the benefits of the year in which the services are rendered.

A penalty for no pre-authorisation or late pre-authorisation per admission will apply. Please refer to page 15 for the list of penalties per option.

## MATERNITY BENEFIT ● ● ● ●

The Fund offers a Maternity Management Programme to assist members during pregnancy and confinement.

The Maternity Management Programme provides you with vital clinical and statistical data (e.g. types of delivery, complications and additional pre-natal healthcare). Quality care for pregnant mothers can reduce the risk of medical complications.

The utilisation of scans, consultations and emergency room visits are managed for members throughout the term of their pregnancy.

All members who register on the programme will receive the Tina Otte's Pregnancy & Birth Book - this is a highly acclaimed book on pregnancy and childcare as well as other comprehensive literature.

### IMPORTANT:

Registration on the Maternity Management Programme is compulsory between 12 to 20 weeks!

Please contact the pre-authorisation department on 0861 000 300.



## ONCOLOGY MANAGEMENT ● ● ● ●

The treatment for malignant diseases has shifted from being hospital based to that of outpatient facilities hence the reason for Moto Health Care to develop an Oncology programme which forms part of Disease Management which is a holistic approach to patient care. Cancer is a high profile and emotional/sensitive condition and relatively high costing.

The focus is to ensure that members receive appropriate oncology related benefit cover at a preferred rate on the cost of treatment, and this includes chemotherapy, radiation, hormone therapy and palliative care. The Fund will only pay the set tariff rate and will not be responsible for any shortfalls which may occur.

This is a specialised programme that assists and supports members with all aspects of the disease. Members are assisted with the authorisation of their oncology treatment requests. Members are also supported emotionally by the Disease Manager who is a qualified nursing sister who will call members to offer assistance and advice.

Registration onto the programme takes place when the Specialist Oncologist sends through an oncology treatment request via South African Oncologist Consortium (SAOC) treatment motivation form. This can be faxed to us on 031 580 0446.

Treatment requested is reviewed and approved according to guidelines and protocols supported by Specialist Oncologists and the South African Oncology Consortium (SAOC), registered indications for the drugs and standard of care is taken into consideration.

Guidelines are evidence based and comply with Prescribed Minimum Benefits compiled by the Council for Medical Schemes in 2004. All treatment plans are reviewed with prognosis of the patient, indication of treatment, history of patient, stage of the cancer, surgical intervention, co-morbidities, number of cycles and cost per cycle. In consultation with the oncologist consultant and the South African Oncology Consortium, the treatment is approved or rejected.

Oncology treatment falling outside the above guidelines will not be funded by the Fund.

Whilst a patient is on oncology treatment, the cost of the treatment, consultation with the oncologist and screening is paid from the Oncology Programme according to the member's specific Fund and policy option that he/she has purchased, and will not affect day-to-day benefits. It is important that the member chooses the right policy option for this benefit.

## PREScribed MINIMUM BENEFIT (PMB) ● ● ● ●

Prescribed Minimum Benefits (PMB) is a set of defined benefits to ensure that all medical scheme members have access to certain minimum health services, regardless of the benefit option they have selected. The aim is to provide people with continuous care to improve their health and well-being and to make healthcare more affordable.



PMBs are a feature of the Medical Schemes Act, in terms of which medical schemes have to cover the costs related to the diagnosis, treatment and care of:

- any emergency medical condition;
- a limited set of 270 medical conditions (defined in the diagnosis treatment pairs);  
It is not possible to list the 270 conditions which are classified as PMB's, but these would include various surgical and medical procedures for a number of life-threatening conditions.
- and- 26 chronic conditions (refer to website for list)

When deciding whether a condition is a PMB, the doctor should only look at the symptoms and not at any other factors, such as how the injury or condition was contracted. This approach is called diagnosis-based. Once the diagnosis has been made, the appropriate treatment and care is decided upon as well as where the patient should receive the treatment (at a hospital, as an outpatient or at a doctor's rooms).

Medical schemes are entitled to stipulate in their rules that services must be obtained from a Designated Service Provider (DSP), failing which a co-payment may be applied. Medical schemes may also utilise appropriate managed care programmes and interventions to assist in the management of PMB's. These include pre-authorisation, treatment protocols, formularies, etc.

#### Treatment Plans and ICD-10 Codes

For each of the 26 chronic diseases a clinical treatment plan has been published by the Department of Health and the Fund is obliged to pay benefits according to this treatment plan only. Approved treatment plans will be paid from the hospital benefit and will not affect your day-to-day benefit. Benefits for these particular conditions will continue according to the approved treatment plan for the year.

Please remember that if you chose to go to a non-DSP, where required, the Fund will pay a benefit as though the condition were not a PMB, from day-to-day benefit.

The Fund is making every effort to contract with the service providers that you use to manage your chronic condition more appropriately. In essence, the Fund is endeavouring to negotiate that you will be charged at the 2010 Moto Health Care tariff for the treatment of your chronic condition. These costs would then be met at 100%. However, if your service providers do not agree to this or if you use another service provider, the "normal" benefit will be applied, that being the appropriate Moto Health Care tariff, which may result in you having to pay a co-payment. Please assist the Fund in this process if requested to do so.



It became compulsory from 1 January 2005 for all service providers to state the applicable ICD-10 code on all accounts for claims. ICD-10 stands for the International Classification of Diseases, Volume 10. Every disease has a code with these specific codes being used worldwide. Without these particular codes on the claims, claims will not be able to be processed from the relevant benefit, and this may result in your normal benefits being incorrectly utilised. The ICD-10 codes were developed by the World Health Organisation and are reviewed every ten to fifteen years. Your medical practitioner must provide this code on his or her account in order for these claims to be paid from the appropriate benefit.

### **What do you need to do?**

Members/beneficiaries who suffer from one or more of the above PMB conditions must apply to the Fund's administrator to register their conditions as chronic. In addition to receiving a letter confirming the period of authorization for their medication, members will also receive a detailed treatment plan from the Fund. The treatment plan will contain necessary blood tests or X-rays or consultations that form part of the member's chronic treatment. It is very important for the service providers who perform these services to use the stipulated ICD 10 code as shown in the treatment plan in order for the services to be correctly paid from the chronic benefit.

### **RENAL MANAGEMENT • • • •**

The Fund proactively manages the high cost of renal dialysis and renal transplants through its Renal Management Programme for the Optimum and Classic option members. For Hospicare option members treatment is obtainable at a provincial facility.

Pre-authorisation for renal dialysis is obtained through written application from a Specialist to Moto Health Care's Renal Committee. This request can be faxed through to 031 5800 527.

Once the application has been assessed and authorised by the Renal Committee (in accordance with strict criteria established in consultation with specialist practitioners) pre-authorisation is given for the commencement of the appropriate dialysis treatment subject to Fund limits. A similar process is followed with an application for a renal transplant.

The Fund's pre-authorisation system ensures that correct renal treatment protocols are adhered to.

To manage the costs of this expensive benefit, a preferred recommended tariff reimbursement for dialysis has been negotiated with the various providers. In order to avoid shortfalls it is necessary for members to establish that their doctor charges the preferred rate. The Fund will only pay the set tariff rate and will not be responsible for any shortfall.



## IMPORTANT

Members who are currently approved for Renal Dialysis and transplant will continue with their current programme (Specialist and Facility). Treatment will be covered subject to the benefits available for 2010.

## NETCARE 911 • • • •

Netcare 911 is the largest private emergency service in South Africa with ambulances, response cars and helicopters and is staffed by highly qualified paramedics and doctors. Callers dialling 082 911 from a Telkom land-line or cellular phone will be assisted telephonically and if the situation warrants further action, an emergency response vehicle, ambulance or helicopter will be dispatched immediately. Stickers are available for car windows and should be prominently displayed on the rear windscreen in the bottom left corner to alert people.

By using Netcare 911 you and your registered dependants will have access to the following benefits:

- Emergency telephonic "911" medical advice and information;
- Emergency medical response by road or air from scene of medical emergency;
- Transfer of patient to most appropriate medical facility;
- Emotional support and tele-counselling routine medically justified ambulance transfers;
- Transfer of life saving medication and emergency blood;
- Companionship and/or care of stranded minors;
- Repatriation of patient or return of mortal remains;
- Confidential non-emergency medical information and advice;
- Nurse line, non emergency medical advice;
- Rape crisis assistance;
- Free travel health advice from SAA Netcare travel clinics;
- Free HIV counselling, social support, nutritional guidance and advice; and
- Free transfer of donor organs.



## IMPORTANT MEMBER INFORMATION • • • •

It is important that we have your correct contact details so that we are able to keep in touch with you, but more importantly, your correct details are required so that we can mail you your membership statements. These statements contain vital information regarding your claims. Your correct contact and membership details will also enable us to ensure that you are updated with the latest news regarding your membership.

If you have not been receiving any communications from us via post or e-mail, it is likely that we do not have your correct contact details. Please call Moto Health Care on 0861 000 300 or visit the website [www.motohealthcare.org.za](http://www.motohealthcare.org.za) and update your contact details.

### Membership updates • • • •

#### Do we have your correct banking details?

It is essential that we have your correct banking details as this is the safest way for us to refund money that is owed to you and the most effective way for you to do your payments to the Fund.

Please call 0861 000 300 and up-date your banking details and ID numbers to enable us to provide you with a better and more efficient service.

## MULTIPLY WELLNESS PROGRAMME • • • •

All Moto Health Care members have access to Momentum's Wellness Programme, Multiply, which offers exclusive discounts on gym membership, movie tickets, CD/DVDs, travel and leisure facilities, flights and other exciting offers. Details are available on the Moto Health Care website ([www.motohealthcare.org.za](http://www.motohealthcare.org.za)). Should you wish to join Multiply, please call the Multiply call centre directly on 0861 100 789. (refer to the advert on pg. 25 for more information)



I count my steps,  
do you?

*Elana Meyer*

Elana Meyer



To find out how to get  
hold of your pedometer  
visit [www.multiply.co.za](http://www.multiply.co.za)  
or call **0860 66 66 77**

making a success of life

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Momentum's  
Wellness Programme  
**Multiply**

Momentum is an authorised financial services and credit provider



**moto**  
HEALTH CARE

*Taking care of our own*

**SUMMARY  
OF BENEFITS**

**2010**



## INTRODUCTION TO 2010 BENEFITS • • • •

### Moto Health Care Remains Committed! • • • •

Ghandi once said that health is the real wealth - not gold or silver. From hospital care to dentistry, no other medical scheme understands the healthcare needs of the motor industry employers and employees better than Moto Health Care.

Moto Health Care is a closed medical scheme and is offered exclusively to the Motor Industry employers, employees and continuation members.

That's right, you are one of us, so we have gone to great lengths to offer you an exclusive medical scheme designed to give you more of the best possible healthcare you really need.


Moto Health Care remains committed to delivering sustainable, cost-effective and valuable healthcare solutions that respect and preserve the uniqueness of employers and employees operating in the Motor Industry –


#### Taking care of our own


The five options available to you, our valued members, are:

 **Optimum**  
The Optimum option is the flagship option of the Fund and offers comprehensive in and out of hospital cover plus cover for a total of 61 chronic conditions.

 **Classic**  
The Classic option offers comprehensive in hospital cover with generous out of hospital benefits plus cover for a total of 35 chronic conditions.

 **Hospicare**  
The Hospicare option offers comprehensive in hospital cover plus cover for 26 CDL conditions. Chronic medication is available through a DSP (Chronicare 011 660 4005).

 **Custom**  
The Custom option offers hospitalisation up to R150 000 per member family per year. Day to day benefits are unlimited through the CareCross network of doctors.

 **Essential**  
The Essential option offers unlimited day to day benefits through the CareCross network. The essential option will be available only to members who earn less than R3 500 per month.

It is of utmost importance that you study and understand the benefits relevant to the option you have selected for 2010.

Do not hesitate to contact the Call Centre on 0861 000 300 for more information.

OPTIONS	OPTIMUM	CLASSIC
<b>Hospitalisation - Subject to pre-authorisation</b>		
	Subject to pre-authorisation	Subject to pre-authorisation
Hospital limit	Unlimited	Unlimited
<b>Provincial Hospitals</b>		
Ward Fees (general ward only)	100% of the prescribed tariff	100% of the prescribed tariff
Theatre fees & Care units	100% of prescribed tariff	100% of prescribed tariff
Unattached theatre units & day clinics	100% of prescribed tariff	100% of prescribed tariff
Outpatient treatment	Emergency only	100% of prescribed tariff, Subject to savings and emergency only
To Take Out (TTO) medicine	Limited to 7 days only	Limited to 7 days only
Psychiatric Treatment	100% of negotiated tariff. 21 days per beneficiary per fund year	100% of negotiated tariff. 21 days per beneficiary per fund year
Transplants	100% of prescribed tariff	100% of prescribed tariff
Outpatient treatment for cancer and kidney dialysis	100% of prescribed tariff	100% of prescribed tariff. R214 000 per family per annum
<b>Private Hospitals</b>		
Ward fees (general ward only)	100% of negotiated tariff	100% of negotiated tariff
Theatre fees & Care unit	100% of negotiated tariff	100% of negotiated tariff
Unattached theatre units & day clinics	100% of negotiated tariff	100% of negotiated tariff
Transplants	100% of negotiated tariff	100% of negotiated tariff
Outpatient treatment for cancer and kidney dialysis	100% of negotiated tariff	100% of negotiated tariff. R214 000 per family per annum
Outpatient treatment	100% of negotiated tariff emergency only	100% of negotiated tariff payable from savings emergency only
To Take Out (TTO) medicine	Limited to 7 days only	Limited to 7 days only
Psychiatric Treatment	Up to 100% of prescribed tariff. 21 Days per beneficiary per fund year	Up to 100% of prescribed tariff. 21 Days per beneficiary per fund year
<b>Operations &amp; Procedures in provincial and private hospitals</b>		
Payment rate	200%	150%
Co-payments	850	850
Procedures subject to co-payments	some scopes unless DSP used Specialists, GPs, Anaesthetist, Assistant, etc. up to 200% of the prescribed tariff	non PMB procedures in hospital unless DSP used Specialists, GPs, Anaesthetist, Assistant, etc. up to 150% of the prescribed tariff
<b>Maternity - subject to pre-authorisation and registration on the maternity programme</b>		
Consultation	12 Ante-natal visits 2 Scans	12 Ante-natal visits 2 Scans
Confinement	200% of prescribed tariff Unlimited	150% of prescribed tariff Unlimited

HOSPICARE	CUSTOM	ESSENTIAL
Subject to pre-authorisation	Subject to pre-authorisation	Subject to pre-authorisation
Unlimited	R150 000 per family per annum	R50 000 per family p.a. for provincial facilities
100% of the prescribed tariff	100% of the prescribed tariff until hospital limit is reached	100% of UPFS rate until limit reached
100% of prescribed tariff	100% of the prescribed tariff until hospital limit is reached	100% of UPFS rate until hospital limit reached
100% of prescribed tariff	100% of the prescribed tariff until hospital limit is reached	100% of UPFS rate until hospital limit reached
Emergency only	Emergency only. Subject to hospital limit	Emergency only. Subject to hospital limit
Limited to 7 days only	Limited to 7 days only	Limited to 7 days only
100% of negotiated tariff. 21 days per beneficiary per fund year	100% of negotiated tariff. 21 days per beneficiary per fund year. Subject to hospital limit	100% of UPFS rate. 21 days per beneficiary per fund year subject to hospital limit
100% of prescribed tariff PMB only	No Benefit	No Benefit
100% of prescribed tariff PMB only. R107 000 per family per annum	No Benefit	No Benefit
Only in hospitals where there is a DSP specialist	Only in hospitals where there is a DSP specialist	
100% of negotiated tariff	100% of negotiated tariff until hospital limit is reached	No Benefit
100% of negotiated tariff	100% of negotiated tariff until hospital limit is reached	No Benefit
100% of negotiated tariff	100% of negotiated tariff until hospital limit is reached	No Benefit
No Benefit	No Benefit	No Benefit
No Benefit	No Benefit	No Benefit
Emergency only	Emergency only. Subject to hospital limit	Emergency only. Subject to hospital limit
Limited to 7 days only	Limited to 7 days only	No Benefit
Up to 100% of prescribed tariff. 21 days per beneficiary per fund year	Up to 100% of prescribed tariff. 21 days per beneficiary per fund year. Subject to hospital limit	No Benefit
100%	100%	100%
none	none	none
25% levied if non-DSP used	N/A	N/A
Specialists, GPs, Anaesthetist, Assistant, etc. up to 100% of the prescribed tariff	Specialists, GPs, Anaesthetist, Assistant, etc. up to 100% of prescribed tariff. Subject to hospital limit	Specialists, GPs, Anaesthetist, Assistant, etc. 100% UPFS tariff. Subject to hospital limit
4 Ante-natal visits and 2 scans subject to DSP	Included in General Practitioner benefit	Included in GP benefit
100% of prescribed tariff DSP only	100% of prescribed tariff subject to hospital limit	100% of prescribed tariff subject to hospital limit

OPTIONS	OPTIMUM	CLASSIC
Home births	200% of prescribed tariff	150% of prescribed tariff
<b>Plastic Surgery</b>		
	100% of the prescribed tariff subject to exclusions. Management board may authorise reconstructive surgery and autoplasty as hospital annual sub-limit of R37 450	100% of the prescribed tariff subject to exclusions until annual savings limit. Management board may authorise reconstructive surgery and autoplasty as hospital annual sub-limit of R37 450
<b>Out of hospital limits , savings and thresholds</b>		
Savings or limits	none	22%
Member		4,404
Adult		3,732
Child		1,104
<b>General Practitioners</b>		
	100% of prescribed tariff	100% of tariff subject to savings
<b>Specialists</b>		
Enhanced Specialist benefit	100% of prescribed tariff	100% of tariff subject to savings
<b>Medicines</b>		
Acute/Prescribed Medication	100% of MHR & dispensing fee until annual limit	100% of MHR & dispensing fee subject to savings
	Maximum per fund year:	
	M: R6 630	
	M+1: R7 920	
	M+2: R9 200	
	M+3: R10 060	
	M+4+: R10 800	
Pharmacist Advised Therapy (OTC)	R120 per event deducted from Acute medicine benefit	R120 per event. Subject to savings
Chronic/Life Sustaining Medication	100% of MHR and disp.fee.st approval by Fund and evidence-based medicine principles	100% of MHR & disp.fee 26 CDL conditions plus 8 non CDL conditions. Maximum per fund year (for non-CDL conditions): M: R2 675 M+: R5 350
<b>X-Rays &amp; Pathology</b>		
In Hospital	Up to 100% of prescribed tariff	Up to 100% of prescribed tariff
Out of Hospital	Up to 100% of prescribed tariff	Up to 100% prescribed tariff subject to savings
Out of Hospital Scans	Pre-auth required for MRI Scans, CAT scans & angiographies (max 2 scans per beneficiary per annum)	Pre-auth required for MRI Scans, CAT scans & angiographies (max 2 scans per beneficiary per annum). Subject to savings



HOSPICARE	CUSTOM	ESSENTIAL
100% of prescribed tariff	DSP only 100% of prescribed tariff subject to hospital limit	DSP only 100% of prescribed tariff subject to hospital limit
100% of the prescribed tariff subject to exclusions. Management board may authorise reconstructive surgery and autoplasty as hospitalisation annual sub-limit of R37 450	No Benefit	No Benefit
none	none	none
No benefit out of hospital	Unlimited at selected network providers	Unlimited at selected network providers
No benefit out of hospital	Maximum per fund year: M: R2 500 M+: R5 000	No Benefit
No benefit	Unlimited as dispensed by selected network provider according to formulary	Unlimited as dispensed by selected network provider according to formulary
No benefit	No benefit	No benefit
100% of MHR & disp.fee 26 CDL conditions only from DSP	100% of MHR & disp.fee 26 CDL conditions only from DSP	No benefit
Up to 100% of prescribed tariff	Up to 100% of prescribed tariff. Subject to hospital limit	Up to 100% of prescribed tariff. Subject to hospital limit
No benefit out of hospital	Basic services at network providers on referral from selected network provider	Basic services at network providers on referral from selected network provider
No benefit out of hospital	No benefit	No benefit



	OPTIMUM	CLASSIC
<b>Dentistry</b>		
Basic Dentistry	100% of prescribed tariff	100% of the prescribed tariff subject to savings
Specialised Dentistry	100% of prescribed tariff	100% of the prescribed tariff subject to savings
	Max per fund year:	
	M:R7 930	
	M+:R11 790	
Maxillo-Facial & Oral Surgery	Pre-auth. 100% of prescribed tariff. May be paid as hospital benefit	Pre-auth. 100% of prescribed tariff. Subject to savings. May be paid as hospital benefit
<b>Paediatric dentistry</b>		
	Pre-auth( children under the age of 7 years).May be paid as hospitalisation	Pre-auth ( children under the age of 7 years ).May be paid as hospitalisation
<b>Optometry</b>		
Consultation	100% of prescribed tariff	100% of prescribed tariff subject to savings
Spectacles	R900 per frame. 1 frame per beneficiary per 2-year cycle. Lenses at approved tariff	Payable from savings
Contact Lenses	100% of prescribed tariff R1 930 per beneficiary per year	Payable from savings
Refractive surgery (Keratotomy or Lasik procedure)	100% of prescribed tariff subject to pre-authorisation and R3 210 per beneficiary per annum. R6 420 per family per annum	100% of prescribed tariff subject to pre-authorisation and R3 210 per beneficiary per annum. R6 420 per family per annum
<b>Supplementary services</b>		
Supplementary service limits	Max per fund year M:R2 975 M+:R8 920	Payable from savings.
Speech Therapy & Occupational Therapy	In hospital up to 100% of prescribed tariff. Out of hospital 100% of prescribed tariff. Subject to supplementary limit	In hospital up to 100% of prescribed tariff. Out of hospital payable from savings
Physiotherapist and biokineticist	In hospital 100% of prescribed tariff. Out of hospital subject to supplementary limit	In hospital 100% of prescribed tariff. Out of hospital subject to savings
Home nursing, rehabilitation, step-down and hospice service	100% negotiated or prescribed tariff in lieu of hospitalisation. 30 days per family per fund year. May be extended to 60 days subject to fund approval	100% negotiated or prescribed tariff in lieu of hospitalisation. 30 days per family per fund year. May be extended to 60 days subject to fund approval
Psychologist, Psychiatrist and Psychiatric treatment and all other services related thereto	100% of prescribed tariff subject to supplementary services limit	Payable from savings

HOSPICARE	CUSTOM	ESSENTIAL
No benefit	2 examinations per beneficiary per annum at network provider	2 examinations per beneficiary per annum at network provider
No benefit	Denture benefit per adult beneficiary per 2 year cycle	Denture benefit excluded
No benefit	No benefit	No benefit
No benefit	Basic dentistry benefit at a network provider	Basic dentistry benefit at a network provider
No benefit	1 x optometric examination per beneficiary every two years at a network provider	1 x optometric examination per beneficiary every two years at a network provider
No benefit	One pair of frames and two lenses per beneficiary on a 2 year cycle at network provider	One pair of frames and two lenses per beneficiary on a 2 year cycle at network provider
No benefit	No benefit	No benefit
No benefit	No benefit	No benefit
In hospital up to 100% of prescribed tariff.	In hospital up to 100% of prescribed tariff. Subject to hospital limit.	No benefit
No benefit	No benefit	No benefit
No benefit	No benefit	No benefit
No benefit	No benefit	No benefit
No benefit	No benefit	No benefit



OPTIONS	OPTIMUM	CLASSIC
Chiropractors and Homeopaths	100% of prescribed tariff subject to supplementary services limit	Payable from savings
Dieticians	100% of prescribed tariff subject to supplementary services limit	Payable from savings
Blood transfusion	In hospital 100% of prescribed tariff. Out of hospital subject to supplementary services limit	In hospital 100% of prescribed tariff. Out of hospital payable from savings
<b>Ambulance Services</b>		
Not between hospitals	100% of negotiated tariff Emergency only	100% of negotiated tariff Payable from savings Emergency only
Between hospitals	100% of negotiated tariff	100% of negotiated tariff
Air ambulance	100% of negotiated tariff	100% of negotiated tariff
<b>Appliances</b>		
Internal and external prosthesis	100% of approved cost of prosthesis. Annual limit R46 900 per family subject to pre-authorisation and protocols	100% of approved cost of prosthesis. Annual limit R39 700 per family subject to pre-authorisation and protocols
Medical Appliances	100% of approved cost Annual limit R9 630 subject to pre-authorisation and protocols. Wheelchairs and hearing aids per 3-year cycle	100% of approved cost Annual limit R8 560 subject to pre-authorisation and protocols. Wheelchairs and hearing aids per 3-year cycle. Payable from savings after limits exhausted
<b>HIV Benefit</b>		
	Subject to registration on program	Subject to registration on program

#### EXPLANATORY NOTES

Hospital limit	Services received while in hospital.
Day to Day	Services related to day-to-day expenses. i.e. GPs, specialists, dentistry, optometry, medicine, etc.
Annual limits	The amount you have for a specific benefit for the fund year. Certain options have limits to hospital, day-to-day benefits and medication. Use your benefits wisely.
Fund year	From January to December of any year. Funds not used in a specific year cannot be transferred to the next fund year, except for the savings left on Classic.
Pre-authorisation	Approval required from the Fund before certain (planned) procedures can be performed. If pre-authorisation has not been obtained for such procedures, a penalty will apply. Pre-authorisation is not required for emergency procedures.
Planned procedures	An operation or other procedure, that the member and provider know about at least 24 hours before it is going to be performed. These are the procedures that need to be pre-authorised.
MHR	Moto Health Care reference price list and formulary for medication.
CDL	Chronic Disease List.
PMB	Prescribed Minimum Benefits.
DSP	Designated Service Provider.
UPFS	Uniform Public Fee Schedule.

HOSPICARE	CUSTOM	ESSENTIAL
No benefit	No benefit	No benefit
No benefit	No benefit	No benefit
No benefit	No benefit	No benefit
Emergency only	IF PATIENT ADMITTED 100% of negotiated tariff subject to hospital limit and emergency only	Emergency only. Subject to hospital limit
100% of negotiated tariff	100% of negotiated tariff subject to hospital limits and pre-authorisation	100% UPFS tariff. Subject to state hospital limit
100% of negotiated tariff	100% of negotiated tariff Subject to hospital limits and pre-authorisation	100% UPFS tariff. Subject to state hospital limit
100% of approved cost of prosthesis. Annual limit R32 100 per family subject to pre- authorisation and protocols	No benefit	No benefit
No benefit	No benefit	No benefit
Subject to registration on program	Subject to registration on program	No benefit

**DISCLAIMER:**

This summary does not supersede the Rules of the Fund.  
In the event of a discrepancy between the summary and the Rules, the Rules shall prevail.  
Non PMB claims will be paid from the relevant benefits on your option.  
PMB claims will be paid in accordance with the Medical Schemes Act.

**Contribution Table 2010** ● ● ● ●

	OPTIMUM	CLASSIC	HOSPICARE	CUSTOM	ESSENTIAL
<b>Contributions</b>					
Principal member	R 2797	R 1667	R 889	R 630	R 213
Adult dependant	R 2382	R 1415	R 756	R 454	R 109
Child dependant (under 21 years)	R 699	R 418	R 223	R 140	R 98

## DEFINITIONS • • • •

### 100% OF COST

The full fee charged by a doctor who does not charge NHRPL rates. Note that the Fund rules will usually provide for 100% of cost where this is less than or equal to the tariff.

### 100% OF TARIFF

A charge that is equal to 100% of the rate that the Fund decides to pay for services.

### ACUTE MEDICINES

Medicines used for short term illness and medical problems, also called day-to-day medication. Medicine prescribed for a temporary / short term illness or condition and cannot be obtained without a doctor's prescription.

### ANGIOGRAMS

An x-ray of blood vessels; the person receives an injection of dye to outline the vessels on the x-ray.

### BENEFICIARY

A beneficiary is either the Principal Member or one of his / her registered dependants. Also see dependant.

### BENEFIT LIMIT

The maximum amount of a specific benefit that you are covered for in a benefit year (calendar year). Benefits will be allocated on a pro-rata basis if you join the Fund after January (e.g. if you start in May, you will receive 7/12ths (or 58.33%) of the benefit allocation).

### CHILD DEPENDANT

See dependant.

### CHRONIC DISEASE LIST (CDL)

A list of chronic illnesses for which Moto Health Care pays from the Major Medical Pool (chronic medicine benefit). The Council for Medical Schemes legislate a list of 26 specific chronic conditions for which a minimum level of treatment is compulsory.

### CHRONIC MEDICATION BENEFIT ENTRY CRITERIA

In most instances the Fund requires specific diagnostic tests/ examinations/ reports to confirm a chronic illness, e.g., blood tests or ECG reports, etc. Please call the Fund on 0861 000 300 for specific information.

### CHRONIC MEDICINES

Medicines used to manage conditions as listed in the Fund's chronic disease list, available from the Call Centre on 0861 000 300. These medicines are prescribed by a medical practitioner for an uninterrupted period of at least three months (e.g. for heart conditions, high blood pressure, etc.).



## CONSULTATION

A visit to your doctor, surgeon or other service provider to get a diagnosis and/or treatment for your specific condition.



## CT AND MRI SCANS

These are specialised X-rays taken using magnetic resonance which will give an overall image to your attending physician to detect and find any anomalies.

## COMPUTERISED AXIAL TOMOGRAPHY

Cat Scans. See CT and MRI Scans.

## DAY-TO-DAY BENEFITS

Benefits obtained outside of hospital and include some of the visits to your doctor, acute medication, dentistry and optical benefits and are defined as such in this member guide.

## DENTAL CARE

### LINGUAL ORTHODONTICS

This form of therapy requires the placement of bands and or braces on the inside of a person's teeth, generally for cosmetic reasons.

### MALOCCLUSION

The incorrect alignment of the upper and lower teeth. This is very common and does not necessarily need to be treated.

### MAXILLO-FACIAL SURGERY

The treatment of all traumas to the bone and soft tissue of the face; or the surgical removal of teeth that require cutting into a persons jaw bone.

### SPECIALISED DENTISTRY

Advanced dental work that involves the fitting of caps, crowns and bridges. This typically requires the services of a dental technician and dental laboratory to prepare the necessary material to be used by the dentist.

## DEPENDANT

A dependant is-

1. A member's spouse or common law spouse who is not a member or registered dependant of another Fund;
2. A dependant child who is not a member or a registered dependant of a member on another Fund;
  - A child dependant who is under the age of 21
  - Or not self supporting due to a physical or mental incapacity.
3. A registered dependant is person or persons fully dependent on the principal member and registered by the Fund to share in the benefits provided to the principal member.

## DESIGNATED SERVICE PROVIDER (DSP)

Funds sometimes enters into special agreements with doctors or doctor groups and in some cases hospitals to provide discounted rates and/or guaranteed access to their facilities for members of that Fund.



## **ELECTRO-CONVULSIVE THERAPY (ECT)**

Also known as "shock therapy". This is done by causing a brief seizure through an electric current sent through the brain for the treatment of nervous disorders.

## **GENERAL PRACTITIONER (GP)**

A doctor whose practice consists of providing general or ongoing care covering a variety of medical problems in patients of all ages. The GP may refer patients with complex or very serious diseases or illnesses to appropriate specialists. The GP is also called "family doctor."

## **GYNAECOLOGIST**

A doctor that specialises in the treatment of diseases in and around the female reproductive organs. Gynaecologists also treat pregnancy and are tasked with the duty of delivery during childbirth.

## **HEALTH PROFESSIONS COUNCIL OF SOUTH AFRICA (HPCSA)**

The HPCSA is the regulatory and registration body of the Medical, Dental and other health professionals. Registration for practicing health professionals is compulsory (including traditional healers, when the new law that will be passed soon comes into effect).

## **HIV/AIDS**

### **ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS)**

AIDS is a collection of symptoms and infections resulting from the contraction of the Human Immuno virus from one person to another. If not properly treated, AIDS may result in a persons' immune system weakening to such an extent, that the person may die of common illnesses such as pneumonia or influenza.

### **ANTIRETROVIRAL THERAPY / TREATMENT (ART)**

These are medicines used to treat HIV. ART's maintain critical levels of white blood cells that protect the body against damage caused by HIV to the immune system. ART's do not get rid of HIV.

### **HUMAN IMMUNE DEFICIENCY VIRUS (HIV)**

This is the virus that enters the blood stream and causes AIDS. This virus is passed from one person to another through blood-to-blood and sexual contact. In addition, an infected pregnant woman can pass HIV to her baby during pregnancy or delivery, as well as through breast-feeding. People with HIV have what is called HIV infection. Eventually HIV infected individuals will develop AIDS as a result of their HIV infection.

### **VOLUNTARY COUNSELLING AND TESTING (VCT)**

In order to establish whether a person has HIV, they may request to be tested voluntarily and if so they may require counselling depending on their status. This is a confidential process and it is in most instances a free service.

## **HOMEOPATHY**

Treatment based on the use of small doses of medicine to introduce a particular disease into the body so that a person's body develops a resistance to that disease naturally. Homeopathy also uses natural or herbal products to treat diseases.



## **LAPAROSCOPIC SURGERY**

A laparoscopy is a type of surgical procedure in which a small incision is made, usually in the navel, through which a viewing tube (laparoscope) is inserted. The viewing tube has a small camera on the eyepiece. This allows the doctor to examine the abdominal and pelvic organs on a video monitor connected to the tube.

## **LATE JOINER PENALTY**

This is a charge over and above the normal premium rate that is imposed for members who are older than a certain age and who have never been members of medical funds in their lives. Depending on the years that the person has not had cover on a registered Fund, he may be given a pro rated late joiner penalty.

## **MAJOR MEDICAL EXPENSE**

These are high cost events and/ or items such as hospitalisation and chronic medication.

## **MANAGED CARE**

Managed Care Programmes aim to manage healthcare costs and access by promoting appropriate and cost-effective utilisation of services at an affordable price and encourages the participation of the patient's doctor to better manage that patient's health.

## **MEDICINES**

### **MEDICINE EXCLUSION LIST (MEL)**

An exclusion list specific to the Fund that excludes payment for certain medicines for various reasons.

### **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 checked and updated by medical experts to ensure that they are consistent with the latest treatment guidelines.

### **MOTO HEALTH CARE RATE**

A rate that is higher than the NHRPL, applicable to a range of services, including Specialists and General Practitioners.

### **OVER THE COUNTER (OTC)**

This benefit is payable from the members' medical savings account or day to day limits. PAT medication is schedule 1 and 2 medicine that is recommended by your pharmacist, without a doctor's script. It is also known as "self medication" or "over the counter medicine".

### **PROFESSIONAL DISPENSING FEE (PDF)**

A legislated maximum fee that a pharmacist or dispensing doctor may charge for services rendered.

## **OCCUPATIONAL THERAPY**

The practice of mental and/ or physical activity designed to help you recover from an injury or a disease. It is essential to obtain a treatment plan from your Occupational Therapist to ensure that your available Funds are optimally used.

## **OUTPATIENT DEPARTMENT**

This is the Emergency Room (ER) of a hospital where patients treated and then sent home without being admitted into the hospital itself.

## **PATHOLOGY**

The study of diseases with the aim of understanding their nature and cause. This is achieved by observing, blood, urine and faeces samples from the patient.

## **PHYSIOTHERAPY**

The physical treatment of disease, injury or deformity using methods such as heat, massage and exercise.

## **PRE-AUTHORISATION**

The confirmation received from the Fund when a member requires hospitalisation, a specialised procedure or specialised radiology. The Fund will then be able to monitor the quality of care that you will receive. Pre-authorisation does not guarantee payment of claims but is merely a pre-notification mechanism whereby the Fund is advised of a pending procedure/ treatment and provides confirmation that the member may have access to benefits.

## **PRESCRIBED MINIMUM BENEFIT (PMB)**

The Fund must pay for, as a minimum, a specified list of minimum benefits for its members and their dependants. PMB's also include the in and out-of-hospital care for 26 chronic conditions. Please obtain pre-authorisation.

- Custom & essential members do not qualify for PMB's as per scheme Rules
- Members with no previous cover or more than 90 days break in membership prior to joining the Fund do not qualify for PMB's during any waiting periods that may apply.

## **PREVENTATIVE TREATMENT**

Treatments that will stop a condition from developing or getting worse. For example, going to your dentist to have your teeth checked and cleaned regularly helps to stop you from getting more serious problems (like tooth decay or infected gums) that would be more costly and difficult to fix at a later stage.

## **PRO-RATED BENEFITS**

Funds, including Moto Health Care, provide cover for a calendar year - that is January to December. Should you join the Fund in July, you would have access to only half of the benefit values for the six months from July to December, because you are only contributing to the Fund for six months instead of twelve months. These are called pro-rated benefits. For example, if you are allowed R1,000.00 for doctor's visits, the pro-rated benefit will be R500.00.

## **PROSTHESIS**

An artificial replacement for a body part, such as a leg, arm or breast (non-surgical) and items such as hip or shoulder replacements (surgical) which will be performed by an orthopaedic surgeon.

## **RADIOLOGY**

The use of X-rays to check for broken bones or diseases.



## **REFERENCE PRICE LIST (RPL)**

The benchmark tariff published by the Council for Medical Schemes.

## **REHABILITATION**

Treatment to help you get back to a normal life following injury or disease. Rehabilitation treatment is provided at step down facilities or by registered nurses, physiotherapists or chiropractors.

## **SADA**

The South African Dental Association is a professional association for dental practitioners. The SADA rates as set by this Association are also referred to as private fees or "contracted out" fees. This tariff is higher than the NHRPL tariff. Membership of this association is not compulsory.

## **SAMA**

The South African Medical Association is a professional association for medical practitioners. The SAMA rates as set by this Association are also referred to as private rates or "contracted out fees". This tariff is higher than the NHRPL tariff. Membership of this body is not compulsory for medical practitioners.

## **SINGLE EXIT PRICE (SEP)**

This is a legislated price charged for medication by a pharmacist or dispensing doctor.

## **SPECIALISTS**

Doctors who have specialised in a particular medical field, such as oncology, paediatrics, gynaecology, etc.

## **SUB-ACUTE FACILITY**

Also known as a step-down facility or a nurse-based unit. It is similar to a hospital but without all of the specialised areas such as theatres, Intensive Care Units, High Care Units, X-ray departments, casualty units, pharmacies, laboratories etc. The ratio of nursing staff to patients is also relatively lower than a fully fledged hospital ward which means that sub-acute facilities should cost much less than a hospital to run.

## **TREATMENT PROTOCOLS**

Rules and processes that are followed for treating a specific condition. These protocols are usually decided in consultation with an authoritative body of that particular condition, e.g. Oncology protocols will be discussed with the South African Oncology Association, etc.

## **TO-TAKE-OUT MEDICINE (TTO)**

This is medication prescribed by your doctor, for use at home once you have been discharged from hospital and normally consists of a seven day supply of the relevant medicines.

## **X-RAYS**

An image of parts of the body (usually bones) produced on photographic film.

## **WAITING PERIOD**

The Fund may restrict members from claiming for any benefits within the first three months of the member joining the Fund. This is usually done when members have no previous medical aid cover or have had a break more than 90 days in medical aid cover.



# NOTES



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## IMPORTANT CONTACT DETAILS

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*Taking care of our own*